INTRODUCTION

- Robust data are needed to identify the met and unmet needs of people living with HIV to inform HIV service planning and provision.
- In the UK, national HIV surveillance provides patient-level clinical and demographic data for epidemiological monitoring. HIV surveillance can be improved by supplementing clinical data with patient-reported behavioural and healthcare needs data from a nationally representative patient survey.
- The Positive Voices pilot RCT study was designed to develop and evaluate the best method to deliver a cross-sectional, representative survey of people with HIV that is feasible to implement at the clinic-level, and results in high response rates at patient-level, while requiring minimal resources to run.

METHODS

- Study design: a cluster RCT with factorial design to evaluate the effect of both clinic level and individual level interventions to improve response rate and representativeness.
- Study population: adults living with HIV attending for routine care at one of 30 HIV clinics in England and Wales between May and November 2014.
- Interventions:
  - Recruitment method: pre-selected (a random sample of patients drawn from previous year’s national surveillance records to invite to take part in the survey) vs sequential (consecutive patients that attend clinic for routine care invited) (open, cluster randomised)
  - Incentive: control (no incentive) vs prize draw (offer entry to win one of 10 prizes of £200 high street vouchers) (blinded, individual randomised)
- Sample size: The study was powered to detect a difference in response rate of 50% and 60% with a design effect for clustering.
- Outcome measures: The primary outcomes were response rate, representativeness of respondents compared to SOPHID, and data quality.
- Data collection: an anonymous, self-completed, web-based survey covering a broad range of topics was developed with input from stakeholders and HIV patients.

RESULTS

- From May-November 2014, 4,350 survey invitations were distributed in 30 HIV clinics (Figure 1).
- 1,305 (30%) survey invitations were not passed on to patients. Reasons include non-attendance in the study (pre-selected arm only), invitations lost, no English language, no internet or computer access, and loss to follow up (Figure 2).
- A higher proportion and total number of survey invitations were passed on to patients in the sequential arm (87.3%, 1,632/2,252) compared to the pre-selected arm (53.7%, 1,210/2,252), (X² = 0.001).

CONCLUSIONS

- The overall response rate in the RCT was lower than expected at 18%, rising to 22.5% when including only patients that had been approached to take part.
- Pre-selected recruitment resulted in a significantly higher response rate (26.7% vs 19.8%).
- However, sequential recruitment was a more efficient and less resource-intensive method than pre-selected recruitment methods, passing on 50% more survey invitations to patients in a shorter period of time.
- Around one in 10 patients who were approached declined to accept the survey invitation.
- A prize draw incentive had no impact on the response rate to the survey, nor did it have a differential effect on recruitment from any particular demographic group.
- Data quality was very good, with high completion rates for a survey of such length.

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- Addenbrooke’s Hospital, Cambridge
- Gloucester Royal Hospital, Gloucester
- York Teaching Hospital, York
- Royal Victoria Infirmary, Newcastle upon Tyne
- Kingswood Hospital, Kingston
- Royal Greenwich Hospital, Newport
- Ipswich Hospital
- Queens Elizabeth Hospital, Birmingham
- North Manchester General Hospital
- Blackburn Hospitals, Blackburn
- Cheltenham Hospital, Plymouth
- Great Western Hospital, Swindon
- The James Cook University Hospital, Middlesbrough
- Royal Blackburn Hospital, Blackburn
- Worcestershire Community Hospital, Wyreley
- Manor Hospital, Watford
- Southend University Hospital
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