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Commissioning responsibility for such services in the NHS in England is unclear, and such services are therefore subject to uncertainty with decommissioning of services in some parts of England.

There is therefore a pressing need to be able to demonstrate the value of similar services.

**METHODS**

**Identification of all patients under the care of the HIV CNS service between 1 July 2015 and 1 February 2016**

**Calculation of the proportion of time under follow-up covered by an active ART prescription**

**Cross-reference against attendance at Homerton ED over same time period**

**Comparison with ED attendances for resident non-CNS PLWHIV**

**SERVICE MODEL**

- Acute/Rescue: Direct contact 3 times per week, Establishing linkage into care, Liaison with other health and care agencies
- Stabilisation: Direct contact 1 time per week, Optimising linkage into care, Liaison with other health and care agencies
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- Check-in: Direct contact 1-2 times per month, Re-engagement with care, Liaison with other health and care agencies

**COMPLEXITY**

- Medical co-morbidities
- Mental Health Diagnosis
- Physical disability
- Substance/alcohol misuse
- Insecure housing
- IPV / safeguarding issues
- Criminal justice involvement
- History of TB infection
- Sex work

**ART PRESCRIBING PROPORTION COVERAGE BY ACTIVE ART PRESCRIPTION**

**UNSCHELDED CARE USE OF THE EMERGENCY DEPARTMENT (ED)**

The CNS cohort is a vulnerable group with multi-morbidity and social predictors of poor health outcomes.

CNS care is associated with:
- Improved ART coverage
- Reduced attendance at ED

**R**

- **R** = 0.69
- [95% CI 0.49-0.97]

**Aims**

This retrospective service evaluation sought to describe the medical multi-morbidity and psychosocial vulnerability factors in this patient sub-population and to assess whether the impact of CNS care could be demonstrated in clinically relevant outcomes.

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