(67.2% In-patient, 20.3% Emergency Dept, 10.9% Nursing Home and 1.6% GP surgery). The remainder were in the community: 14.2% educational establishments; 12.8% places of work; 3.4% hostels/homeless shelters and 16.9% other venues e.g. pubs, restaurants, shops, religious centres. 9.5% related to airline travel and were not assessed by our service. Following specialist risk assessment, 45.9% of our incidents required further management. 2450 non-household contacts were identified: 1344 were screened, 763 ‘inform and advise’ letters were sent, and in 343 investigation is on-going. A median of 12 (IQR: 5–20) contacts were screened per incident. 64 LTBI cases and two with active TB were identified. A median of 4.1% (IQR: 3.9–5.2) of screened contacts had latent TB infection (LTBI) across a range of settings (figure 1). 46 (71.9%) of the LTBI cases started treatment. In 2016–17, of 1389 non-incident close contacts screened in our network, 258 (18.6%) were diagnosed with LTBI, and 42 (3%) active TB.

Conclusion The large number of healthcare-related events, which are mostly in a hospital setting, following systematic non-household TB incident investigation is a concern. This highlights the need for on-going healthcare worker education regarding TB transmission and infection control. The yield of new LTBI cases in schools, colleges and places of work provides the opportunity for a ‘teachable moment’ in community settings which can be facilitated by the TBN screening lead.

Objective To explore patient’s perceptions and experiences of DOT in TB treatment within the UK.

Method A qualitative, semi-structured interview design was employed. Eight patients from across Wessex who had received DOT as part of their TB treatment were purposively selected. Interviews were audio-recorded and transcribed verbatim. Data were analysed using thematic analysis and NVivo 11. Negative case analysis and peer review were used to enhance rigour.

Results

• Adherence and non-adherence to TB treatment was influenced by socio-cultural, mental health, employment and discrimination factors (figure 1).
• DOT seemed to be valued by socially marginalised patients’ for the support and social connection it afforded. However, those in employment feared DOT could lead to disclosure and social discredit.
• Patients perceived observing the swallowing of medication without additional elements of support to be of limited value.
• Patient accounts suggest TB Specialist Nursing teams evolved DOT to provide highly individualised expert care.

Conclusions DOT offers a degree of social connection and support for marginalised patients but often fails to tackle fundamental barriers to adherence such as mental health, addictions, housing and discrimination.

Practice implications All TB patients should be offered a choice of flexible patient-centred support. It is unrealistic for one team to address all the barriers to treatment adherence. Multi-agency responsibility for TB control needs to be commissioned and evaluated across the UK and not just in high TB incidence areas. A multi-agency approach should include mental health, housing, homeless, addictions, social and TB teams.

Introduction Patient adherence to medical intervention is vital for tuberculosis (TB) management to be effective. For patients with difficulty adhering to treatment, directly observed therapy (DOT) is commonly used. However, no single DOT protocol is known to be optimal and evidence suggests that as adherence to DOT is poor, it does not currently provide a solution. Calls have been made for TB policy makers to address the effectiveness of DOT or identifying more effective solutions is to motivate patients. The first step to either improving the effectiveness of DOT or identifying more effective solutions is to understand the patient experience and issues surrounding adherence to DOT.

Introduction and objectives Pulmonary tuberculosis (TB) is an important risk factor for chronic respiratory disease due to lung damage. Yet, the WHO End TB strategy does not mention post-TB chronic lung disorders (PTBLD) and...