Discussion SMS follow-up of clinic defaulters improves subsequent re-attendance rates if a health promotional message is included. The addition of a health promotional message to current routine clinic reminder texts may reduce DNA rates and warrants further study.

012 HSV-1 COUNSELLING WHAT ACTUALLY HAPPENS IN CONSULTING ROOMS? A QUALITATIVE EVALUATION OF PRACTICE USING MYSTERY SHOPPING IN ENGLISH LEVEL 3 GUM CLINICS

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Background Guidelines indicate best practice for HSV management and topics that should be covered during counselling. Consultations can be difficult, since many complex issues must be explained carefully, and there is opportunity to confuse HSV-1 and HSV-2.
Aims To evaluate the quality, accuracy and differences in advice given by staff (doctors (D), nurses (N) and health advisors (HA)) in Level 3 sexual health clinics (L3SH) on an initial consultation for HSV-1 infection recently diagnosed elsewhere. To assess whether a professional patient mystery shopping approach provides useful information for L3SH.
Methods A prospective qualitative evaluation of 20 consultations was performed. Clinical leads within each unit gave permission for participation; details of the exact nature or time of visit were not shared. A professional patient visited each unit as a patient new to the area seeking advice for a standard complex scenario —various probes gauged management of different clinical scenarios. Field notes were made immediately following each consultation in the form of a written transcript and audio notes. Anonymised written transcripts were provided to a panel of clinicians to classify overall and specific aspects of care as ACCEPTABLE (A), UNACCEPTABLE (U) or a CAUSE FOR CONCERN.
Results Consultations were supported well with written information (not HSV-1 specific). Staff frequently declined to give prognostic information and some confused HSV-1 and HSV-2 guidance. Although many centres are quick to offer patient-initiated therapy this was virtually always at doses that have been superseded in current guidance. The majority of N-led consultations were A with only limited trends in favour of D-provided consultations. HA did not always provide A consultations.
Conclusion PPMS appears to be feasible for assessing some aspects of L3SH care which may otherwise be difficult to gauge. Some aspects of HSV-1 management are well handled but most units do not provide convenient patient-initiated therapy, or support consultations with disease-specific information.

Session title: Risk assessment, screening tools and infections in MSMs

Session date: Thursday 28 June 2012; 11.30 am—1.00 pm

013 HIV INCIDENCE IN AN OPEN NATIONAL COHORT OF MSM ATTENDING GUM CLINICS IN ENGLAND

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Background Endemic HIV transmission in men who have sex with men (MSM) is a major concern in England. Since 2008, a new national anonymised genitourinary medicine (GUM) clinic reporting system provides follow-up data on clinic attendees.
Objective To calculate HIV seroconversion rates and identify predictors of acquisition in MSM clinic attendees to inform the development of further HIV prevention initiatives.
Methods National cohort of MSM who tested HIV negative at a GUM clinic in England in 2009 and had a follow-up test within 1 year were included in these analyses. HIV seroconversion rates (per 100 person-years (py)) with 95% CI were calculated by subgroups and risk markers. HR with 95% CI are reported for significant ($p<0.05$) predictors of HIV seroconversion identified using Cox regression analyses. Population attributable risk was calculated to estimate the importance of each predictor for HIV infection.
Results Among the 15 500 men who attended in 2009, there were 277 seroconversions, giving an overall incidence of 2.7/100 py (95% CI 2.4 to 3.1). Incidence was higher among MSM aged 35—49 years (3.4/100 py), of black ethnicity (4.1/100 py) and with a previous gonorrhoea or chlamydia infection (8.6/100 py and 9/100 py, respectively). In multivariable analysis, risk of acquiring HIV was higher among MSM with a previous gonorrhoea (HR: 2.4, 95% CI 1.4 to 4.1) or chlamydia infection (HR: 3.0, 95% CI 2.0 to 4.7) or who received treatment as a STI contact (HR: 1.8, 95% CI 1.1 to 2.9). Age predicted HIV acquisition in 30% of new infections and clinical risk markers from the previous year another 10%.
Conclusions Annual HIV incidence among MSM re-attending GUM clinics is very high at almost 3%. None of the clinical risk factors were important predictors of HIV acquisition. Therefore more discriminatory behavioural information is required to identify MSM at higher risk of HIV and facilitate better triaging of HIV prevention measures in GUM clinics.

014 INVESTIGATING THE RECENT INFECTION TESTING ALGORITHM (RITA): PREDICTORS OF RECENT HIV INFECTION AMONG GUM CLINIC ATTENDEES

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Background Testing for recent infection with HIV has been part of routine national surveillance in the UK since 2009. These data can be used to estimate HIV seroincidence in populations. For these estimates to be accurate, HIV testing behaviour must be independent of HIV acquisition risk. This is unlikely to be true, as much testing may be motivated or clinically indicated.
Aims To identify demographic and behavioural differences between individuals diagnosed with recent (<6 months) vs longstanding HIV infection, and to assess the possible level of bias introduced by motivated testing.
Methods Recent Infection Testing Algorithm (RITA) results were linked to Genitourinary Medicine Clinic Activity Dataset attendance records (providing data on attendance and sexual health) for the year preceding the date of RITA test and/or HIV diagnosis. Univariate analyses were performed examining age, sexual orientation, GUM clinic attendances, and STI history, to identify predictors of being diagnosed at early stages of HIV infection.
Results Preliminary analyses show that among 628 newly diagnosed HIV-positive individuals, 14% (85/628) were diagnosed with recent HIV infection. Being diagnosed with a recent HIV infection was positively associated with younger age, men who have sex with men and having been diagnosed with any bacterial STI in the year preceding the HIV diagnosis (see Abstract O14 table 1). Those