approaches to routine testing. A recent study showed that when a physician led model of testing is in place, 39.7% of all general medical patients are offered HIV tests.
Aim(s)/objectives Assess the feasibility and acceptability of a non-physician directed (NPD) model of HIV testing.
Methods Retrospective cohort study involving a review of the proportion of all medical admissions offered tests by a NPD model of HIV testing.
Results 57.9% (1973/3409) of all general medical admissions aged 18–79 were offered HIV tests. Acceptability was high with 96.7% (1908/1973) of offered patients having HIV tests. The mean age of patients offered and tested was 56.8 years.
Discussion/conclusion This study demonstrates superior feasibility and efficacy of a non-physician directed model of routine HIV testing. Although cost and culture remain important barriers of employing this strategy in many hospitals, the use of allied health professionals may be an important step in achieving National and International guidelines for HIV testing.

P89 DISCUSSION OF PARTNER NOTIFICATION, HIV TRANSMISSION, MEDICO-LEGAL ISSUES AND VOLUNTARY SECTOR SUPPORT AT FIRST HIV SPECIALIST REVIEW: AUDIT REPORT

[1]Josh Brown, [2]Cara Saxon, [2]Sameena Ahmad*. *[1]University of Manchester, Manchester, UK; [2]University Hospital South Manchester, Manchester, UK*

10.1136/sextrans-2015-052126.132

Background/introduction BHIVA testing guidelines recommend that partner notification, transmission of HIV and the medico-legal issues are discussed with patients at their first review with an HIV specialist. This should ideally occur within 48 h but no later than 2 weeks after diagnosis. Consideration of additional support from the voluntary sector is also advised.
Aim(s)/objectives To audit the documentation of the recommendations above.
Methods A retrospective audit of electronic clinic letters and paper records of all HIV patients diagnosed at our service between 01/2008–04/2014.
Results Overall, 182/187 (97%) had all the information discussed with them and documented in the notes. In 2008, three patients had missing information. One failed to return following a positive test so all information was missing. One had no record of voluntary sector discussion. One was missing information about transmission and medico-legal issues. In 2011, another patient tested positive and failed to return for review so all information was missing. In 2013, one patient had a missing record of medico-legal issues discussion. In all other years all information was discussed and recorded in patient records.
Discussion/conclusion Each of the recommendations were discussed and documented in nearly all cases, with an improvement noted after 2008 (the year the guidelines were published). Each recommendation has important public health implications with the potential to reduce onward transmission. The provision of voluntary sector information is crucial for providing patients with additional support during the challenging time following diagnosis and has the potential to impact on future retention in care.

P90 HOSPITALISATION IN HIV PATIENTS: ARE THE CAUSES OF ADMISSION CHANGING?

Catherine Kirby*, Marie-Pier Lirette, Martin Fisher. *Lawson Unit, Brighton, UK*

10.1136/sextrans-2015-052126.133

Background With an ageing HIV cohort and increasing use of antiretroviral (ART) therapy it may be expected that HIV associated morbidity causing hospitalisation is changing.
Aim To describe hospital admissions over 2 years, and compare this to 2006 data to ascertain if there has been any change.
Methods Retrospective case review of HIV admissions during 2013–14. Patient diagnoses were classified as AIDS related, HIV related, ART toxicity related, and non-HIV related, with one main admission diagnosis.
Results 286 patients were hospitalised during 2013–14, accounting for 458 admissions. Mean age was 48 years, and 71% (203/286) of patients were on ART on admission. 35% (99/286) patients were admitted more than once in the same calendar year. CD4 count was <200 cells/mm^3 in 25% of admissions. 15% (69/458) were admitted for AIDS related causes compared with 20% reported in our 2006 data ($p = 0.23$). Pneumocystis pneumonia (PCP) was the commonest diagnosis, comprising 33% (23/69) of AIDS admissions. 40% (185/458) of admissions were HIV related, including bacterial causes which accounted for 31% (142/458) of all admissions. Non-HIV causes accounted for 45% (204/458) of hospitalisations. There were no admissions for ART toxicity.
Discussion The number of admissions in HIV patients remains high, with a fifth of patients severely immunocompromised on admission. Although admissions secondary to AIDS-defining diagnoses have decreased this is not statistically significant. There is a need to improve strategic HIV testing to prevent late diagnosis and AIDS related conditions, with increased promotion and access of testing in non-GU settings.

P91 HIV IN SCOTLAND: PREDICTING THE NUMBER OF PEOPLE WHO ARE UNDER CD4 MONITORING AND RECEIVING ANTIRETROVIRAL THERAPY

[1]Stephen Corson*, [1,2]Christopher Robertson, [2]Glenn Codere, [2]Lesley Wallace, [2]David Goldberg. *[1]University of Strathclyde, Glasgow, UK; [2]Health Protection Scotland, Glasgow, UK*

10.1136/sextrans-2015-052126.134

Background/introduction The number of people living with HIV in Scotland has increased in recent years as a result of the widespread use of antiretroviral therapy, improvements in testing, inward migration and new infections. Since these increases are expected to continue, it is imperative that HIV specialist care services understand how the number of people requiring care is going to change over time.
Aim(s)/objectives To predict the number of HIV positive individuals who are under CD4 monitoring (and thus in HIV specialist care) and receiving ART in Scotland for 2013–2020.
Methods Using CD4 monitoring data collected in Scotland for 2007–2012 we develop a statistical model that groups the HIV infected population into several categories depending on their CD4 count and ART status. The model is based upon a Markov

process which predicts the status of individuals in year i+1 from their status (category) in year i. Historical data is used to estimate the transition probabilities which are modelled using a multinomial trend model. Confidence intervals are calculated using boot strap procedures.

Results By 2020 there will be a 54% increase in the number of individuals who are receiving ART and a 42% increase in the number of individuals under CD4 monitoring. Results for individual HIV risk groups predict increases of at least 34%, 77% and 35% for heterosexuals, people who inject drugs and men who have sex with men, respectively.

Discussion/conclusion With such large increases in the number of people who are under CD4 monitoring and receiving ART, NHS boards will need to plan ahead to ensure they have adequate resources to treat those in need.

P92 A COMPARISON OF BLOOD AND SALIVA SAMPLING FOR HOME HIV TESTING

Lauren Bull*, Marco Rossi, Alan McOwan. *Chelsea and Westminster Hospital, London, UK*

10.1136/sextrans-2015-052126.135

Background HIV home sampling offers an acceptable and convenient method for HIV testing and may provide a practical solution for increasing testing in high risk groups. However, we are unaware of any data comparing the effectiveness of different sampling methods. From August 2013 users of our online HIV testing service were offered an informed choice between blood and saliva HIV sampling.

Method We interrogated the database of all HIV home sampling requests and analysed any differences in demographics and return rates for both blood and saliva samples.

Results Between 15.8.13 and 31.11.14, 14312 home tests were requested. Blood tests were preferentially chosen (9532, 66.6% vs 4780, 33.4%). 7257 samples (50.7%) were returned, this encompassed 4758 blood samples and 2499 saliva samples (49.9% of requested blood samples vs 52.2% of requested saliva samples $p = 0.01$). The service is predominantly aimed at men who have sex with men and of the returned samples the majority were from men (6416, 84.7%) Men were significantly statistically more likely to request blood samples than women (67% vs 51%, $p < 0.00001$). In total there were 123 reactive samples (1.7%, 116 men, 7 women), 82 from blood samples (77 men, 5 women) 41 from saliva (39 men, 2 women).

The average age of all requests was 30.3 years, 30.8 years in persons who returned samples and 29.7 years for those who did not ($p < 0.00001$). There was a significant difference in the ages of people requesting saliva versus blood samples (29.7 years vs 30.6 years $p < 0.0001$). The average age of persons with negative samples was 30.8 years vs. 33.0 years in those with positive samples ($p < 0.05$). The median number of days from when the sample was ordered to when it was collected back was 6 days in all groups (negative samples, reactive samples, men, women, blood and saliva).

Discussion Despite being more invasive when given an informed choice, more people chose blood over saliva sampling. However saliva samples were more likely to be returned. Women were statistically more likely than men to choose saliva sampling. There was no difference in the length of time it took to return reactive and negative samples.

P93 HIV TESTING IN AN INTEGRATED SEXUAL HEALTH SERVICE

Mamatha Oduru*, Matthew Hamill, Nisha Pal, Noreen Desmond. *The Garden Clinic, Slough, UK*

10.1136/sextrans-2015-052126.136

Abstract P93 Table 1 Summary of SHHAPT code data for HIV testing uptake

Patient group	Codes	Week 1	Week 2	Week 1 and week 2 comparison
Total sample population N = 205		**N = 114**	**N = 91**	
	P1A + T4	61.4%	65.9%	4.5% increase
	P1B	25.4%	23.1%	2.3% decrease
	P1C	13.2%	11%	2.2% decrease
Total GU presentations N = 126 (61%)		**N = 72**	**N = 54**	
	P1A + T4	76.4%	87%	10.6% increase
	P1B	18.1%	11.1%	7% decrease
	P1C	5.6%	1.9%	3.7% decrease
Total contraception presentations N = 67 (33%)		**N = 33**	**N = 34**	
	P1A + T4	30.3%	29.4%	0.9% decrease
	P1B	42.4%	44%	1.6% increase
	P1C	27.3%	26.5%	0.8% decrease
Total combined GU and contraception presentations N = 12 (6%)		**N = 9**	**N = 3**	
	P1A + T4	55.6%	100%	44.4% increase
	P1B	22.2%	0%	N/A
	P1C	22.2%	0%	N/A
Comparative percentage accepting and declining HIV tests in GU v contraception sub-groups	**P1A + T4 (accept)**			GU = 81% Contraception = 30%
	P1B (decline)			GU = 15.1% Contraception = 43.3%

SHAAPT HIV codes:
T4 + P1A = HIV test done
P1B = HIV test offered + declined
P1C = HIV test inappropriate