

Results A 23 year Caucasian lady was referred to lymphoma clinic by her GP with a three month history of lymphadenopathy and fatigue. She was diagnosed with a primary CMV infection and lost to follow up after her symptoms resolved. One year later she attempted to donate blood. Positive syphilis serology with a low RPR was detected on routine blood screening by the transfusion service. The patient was referred to Bristol Sexual Health Centre where sexual history taking revealed she had a bisexual partner at the time of her illness who also tested positive for syphilis. An archived blood sample from the time of her illness revealed active syphilis infection with a high RPR.

Discussion/conclusion Secondary syphilis can mimic numerous illnesses. However syphilis testing remains uncommon outside of sexual health clinics for a variety of reasons. A change of culture is required to ensure medical professionals are prepared for routine sexual enquiry and consider syphilis as a potential cause for lymphadenopathy.

P234 EXPLORING SERVICE USER NEEDS AND STREAMLINING DELIVERY THROUGH TRIAGE BY SENIOR CLINICIANS IN AN INTEGRATED SEXUAL HEALTH WALK-IN

Sophia Davies, Rachel Amherst*, Jane Bush. *Northern Devon Healthcare Trust, Exeter, UK*

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Background/introduction On-going procurement exercises in Sexual Health inevitably require that efficiencies are sought whilst maintaining high quality and equity of access.

Aim(s)/objectives This test of change aimed to inform a streamlining of a city centre walk-in service and to test the feasibility of delivering an integrated service using staff with mixed skill sets. Means were sought to reduce re-attendances to the co-located Contraception and GU Medicine services.

Methods For two weeks in January 2016 patients attending the walk-in service were triaged by a senior dual trained clinician. Triage notes were made and patients were subsequently seen by another clinician who could meet all of their needs. Data was collected regarding staff skillsets, waiting times, patient-perceived versus clinician-assessed needs as well as services actually delivered and staff feedback.

Results 324 patients were seen (236 females, 88 male). Approximately 40% of women had mixed (GU and contraception) needs, whilst of those believing themselves to have a solely contraception need, half were identified as also having a GU need. A third of patients were symptomatic Two thirds had a sexual health screen. Nursing staff saw 66% of patients. 80% of staff reported similar or increased job satisfaction (qualitative data are available).

Discussion/conclusion Service users perceived needs are often less than those assessed by experienced clinicians. Delivering an integrated walk-in service whilst maintaining specialist skills is feasible if triage is effective; missed opportunities are minimised. Work to assess the utility and cost-effectiveness of different types of triage is required

P236 A REVIEW OF A YEAR OF NEW HIV DIAGNOSES AT A SINGLE CENTRE – WHAT CAN WE LEARN? HOW PEOPLE TEST, PRIMARY INFECTION AND HOSPITALISATION

¹Sarah Cavilla*, ^{1,2}Daniel Richardson. *¹Brighton & Sussex University Hospitals NHS Trust, UK; ²Brighton & Sussex Medical School, Brighton, UK*

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Introduction A large proportion of new HIV diagnoses are incident and hospitalised. HIV testing can be accessed by various means. HIV incidence in UK men who have sex with men (MSM) continues to increase. HIV testing is an important public health intervention to reduce incidence. Locally we have a high prevalence (8:1000) and an HIV cohort of 2300 mainly MSM.

Methods New diagnoses from January- December 2015 were identified from our local database, clinical records were examined. Data was collected on patient characteristics, medical history, results, the method and location of testing.

Results There were 57 new diagnoses; 50 (88%) MSM, 4 (7%) heterosexual females and 3 (5%) heterosexual males. 24 (42%) had tested negative in the previous year, 24 (42%) more than 1 year ago and 9 (16%) had never tested. Testing locations included: 27 (47%) GUM clinic, 14 (25%) GP, 5 (9%) home test kits, 4 (7%) THT, 3 (5%) inpatient, 2 (3.5%) hospital outpatients, 1 (1.75%) sauna and 1 (1.75%) private clinic. Reasons for testing encompassed: 17 (30%) GUM screening, 10 (18%) HIV symptoms, 2 (4%) post exposure prophylaxis, 2 (4%) partner notification, 2 (4%) malignancy, 1 (2%) assault, 1 (2%) condom break, 1 (2%) intravenous drug use and 1 (2%) insurance. 12/49 (24%) avidity results were incident. 10/57 (18%) were hospitalised within 3 months of diagnosis; 3 malignancies, 2 opportunistic infections (Pneumocystis, Mycobacterium avium complex), 1 STI (Shigella), 1 abscess, 1 seroconversion, 1 treatment toxicity and 1 for investigations.

Discussion/conclusion Locally a large proportion of new HIV diagnoses are incident, MSM and hospitalised. Continued innovation is vital in community and hospital admission testing to reduce undiagnosed HIV and incidence.

P237 ASSESSING THE IMPACT OF A HIV TESTING POLICY

¹Sarah Allstaff*, ²Ewan Barrack, ¹Ciara Cunningham. *¹NHS Tayside, Dundee, UK; ²University of Dundee, Dundee, UK*

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Background/introduction Mirroring national data, HIV testing in our local board is failing to reduce the high proportion of late diagnoses. Healthcare Improvement Scotland (HIS) HIV standards 2011 recommended the development and promotion of a written HIV testing policy. A local HIV testing policy was introduced in 2013 based on the UK National testing guideline (BHIVA), recommending routine testing in certain clinical areas, in high risk groups and all individuals with “clinical indicator conditions” regardless of perceived risk. The introduction of the policy was supported by staff training.

Aim(s)/objectives Review the impact of a HIV testing policy on staff knowledge and levels of HIV testing.

Methods In November 2015 a survey was undertaken to question staff awareness of the policy, understanding of HIV testing and levels of HIV testing. The survey was advertised on local websites to healthcare, social work, third sector and substance misuse staff.

Results The survey had 120 respondents, with the largest proportion from Consultant and GP staff. Over 70% of respondents were aware of the policy. 25% reported that the policy had changed their clinical practice by increasing their confidence in testing. There has been a corresponding increase in HIV testing figures. Interestingly over 70% responded that a detailed HIV risk assessment was required even in the presence of a clinical indicator condition.