Abstract P32 Table 1 Partner notification of chlamydia positive patients in 2011

	March	April	May	June	July	August	September	October	November	December
Chlamydia positives	38	39	49	67	40	68	63	43	36	39
% of positives with consent for PN	8	10	16	34	40	32	38	47	56	62

Methods A sexual health adviser was appointed to manage the positive Chlamydia diagnoses made out with the specialist services. This service commenced in March 2011 and coincided with the roll out of Chlamydia and Gonorrhoea PCR testing to these areas. Providers were informed to seek consent for referral at the time of testing and acquire the individual's mobile number. The PN service was advertised through email to all providers who undertake testing and in addition, educational sessions and updates were provided.

Results The table shows progressive improvement in the uptake of PN over the course of the year (see abstract P32 table 1).

Discussion Despite a marked increase in the referral rate for PN, uptake remains suboptimal. Specific GP practices that rarely test for Chlamydia or refer for PN are identified and contacted, reminding them of the importance of PN.

P33 GONORRHOEA IN YOUNG HETEROSEXUALS: OUTBREAK MANAGEMENT AND SAFE SEX MESSAGES

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Background Increases in gonorrhoea infection in young heterosexuals have been reported in two distinct areas of the North East of England over the past 6 months. Multi-agency working between GUM, public health, health protection and communication teams has attempted to increase awareness and reduce transmission. From initial case and partner notification information, there appeared to be misunderstandings about the routes and risks of transmission, along with a perception that a negative chlamydia test could be regarded as an STI "all clear".

Methods Following the report of increase in area 1 in September 2011, a number of interventions were put in place, including enhanced surveillance, network mapping of contacts and cases, raising awareness among healthcare professionals, other organisations working with young people and with young people themselves. An increase in cases in area 2 was reported in November 2011. Similar interventions are being introduced and ongoing work to explore any links between the clusters.

Results 65 cases of gonorrhoea have been reported in area 1 since May 2011 (compared to a usual annual number of 15); in area 2 clustering of cases has occurred at higher rates than previously seen, although overall number of cases has not increased. Partner notification and network mapping has shown multiple casual partners although no large extended sexual networks. Dual-testing of chlamydia screening samples is now being considered to further outbreak control. We report the lessons learnt from managing these two clusters and how they can be applied to future STI clusters.

P34 PARTNER NOTIFICATION FOR HIV: A REGIONAL OUTCOME AUDIT

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Background Partner notification (PN) for HIV facilitates early diagnosis among those at highest risk. Health advisers and HIV nurses from eight clinics (7 GUM, 1 ID) formed a regional HIV network public health group to optimise PN across the region by sharing intelligence of local HIV transmission and monitoring practice against national guidelines and standards. Since there is no national standard for HIV PN outcomes, we undertook a baseline local audit to inform discussion on the possibility of setting a regional standard.

Objective To conduct a baseline audit for HIV PN outcomes across the regional HIV network.

Methods HIV services across the network undertook a retrospective case note review of all patients newly diagnosed with HIV in 2011. Data were collected on the number of partners verified/reported as tested negative/positive before the index, or within 90, 180 or 360 days, following patient or provider referral.

Results Results received from 7/8 clinics are presented below (see abstract P34 table 1).

Conclusions Overall PN outcomes are good across the region, although there was wide variation between clinics which makes it difficult to set a single regional standard that is both challenging and achievable for all. Outcomes were verified for most partners, but not possible if tested at an unknown clinic or abroad. The majority of tested partners attended within 3 months, but a small number took up to a year, suggesting PN efforts should continue until the partner is deemed untraceable.

Abstract P34 Table 1 HIV partner notification

	Range per clinic	Overall
Number partners verified tested per case <90 days	0.17–1.3	1.05 (118/112)
Number partners verified or reported tested per case <90 days	0.66–1.33	1.15 (129/112)
Number partners verified tested per case <1 year	0.17–1.38	1.17 (131/112)
Number partners verified or reported tested per case <1 year	0.66–1.53	1.27 (142/112)

P35 A COLLABORATIVE APPROACH TO CONTROLLING AN HIV OUTBREAK AMONG INTRAVENOUS DRUG USERS

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Background In 2008 an intravenous drug user (IVDU) admitted to the infectious diseases unit was diagnosed with late-stage HIV. He named five injecting partners, of whom three tested negative for HIV, one refused, and one was untraced. In early 2010 another IVDU was diagnosed, naming two injecting partners of the previous case who had either declined or tested negative in 2008.

Objective To control an outbreak of HIV among IVDUs

Interventions A multidisciplinary outbreak control team was convened in 2008 and 2010 with representation from the Health Protection Unit, the Drug and Alcohol Action Team, Genitourinary Medicine, Infectious Diseases, and Virology to develop a control strategy. Traditional partner notification was supplemented by cluster testing among associates in housing projects and drop in centres used by IVDUs. Opportunistic screening of IVDUs attending health services was promoted. Laboratory investigations included phylogenetic analysis and the recent infection testing algorithm.

Outcomes A further 6 cases were identified in 2010: two through hospital screening and four through partner notification. Cluster testing did not yield any further cases among associates (0/29), but presented an opportunity to raise awareness of local HIV risk among IVDUs. Joint working between services was a feature of all interventions. All 8 cases 2008–2010 are the same strain, and 7/8 are linked to at least one other case. Despite extended surveillance at centres providing treatment for substance misuse, no further new cases have been identified since September 2010.

Conclusion An HIV outbreak among a hard-to-reach population has been successfully controlled by a prompt and close collaboration between services to deliver a range of complementary control strategies. We remain vigilant to the possibility of further cases since the source of one case has not been identified.

P36

EVALUATION TO ASSESS PATIENTS' PERCEPTIONS OF RECEIVING THE RECENT INFECTION TESTING ALGORITHM (RITA) RESULT

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Background In the UK the primary objective of RITA has been to measure HIV incidence. The UK is the first country to routinely return results to patients and with over 7000 tests returned to clinicians so far, RITA is now seen as part of baseline HIV clinical care in participating centres.

Objectives To evaluate patients' experience of receiving a RITA result, including effects on identifying likely timing of infection, partner notification and relationships.

Methods Five HIV centres in England asked their patients to complete a questionnaire on their experience of receiving a "recently infected" RITA result soon after their HIV diagnosis.

Results Forty patients with newly diagnosed HIV and a "recent" RITA result completed the questionnaire (93% MSM). The majority (30/40, 75%) said that receiving the recent RITA result was helpful; 10 were unsure how helpful it was, and no participants found it unhelpful. 24 patients (60%) reported RITA helped identify partners who may be at risk of HIV and 24 (62%) felt it helped them to better understand how they may have been infected. Most (35, 88%) either felt neutral or "not more upset" when they learnt that they were likely recently infected. Of those in a relationship 33/37 (89%) reported RITA testing had not caused any relationship problems.

Conclusion The majority of patients receiving recent RITA results found this information helpful and no-one found it unhelpful. The result was felt to be useful in increasing an understanding of the likely timing of infection and for identifying "at risk" partners.

P37

SEX, DRUGS, RISK TAKING AND STIS

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Background Hazardous alcohol consumption (HAC) and recreational drug (RD) use are associated with risky sexual behaviour but there is little hard evidence about actual sexually transmitted infection (STI) acquisition in these cohorts.

Aim To investigate the association between HAC, RD use, risky sexual behaviour and STI acquisition.

Methods Patients self-completed the Fast Alcohol Screening Test (FAST), a validated screening tool to identify HAC, and questions on RD use. Markers of sexual risk-taking and STI diagnoses were obtained from patient records. Three cohorts: those with/without HAC (ie FAST positive/ negative respectively), RD use ever/never and recent/no recent RD use were analysed. Statistical significance ($p < 0.05$) was calculated using Pearson's χ^2 test.

Results Convenience sampling identified 221 new/re-book patients, 21 were excluded due to administrative errors. Respondents included 70 (35%) men and 130 (65%) women (age range, 15–69 years; median 25.105 (53.6%) and 91(46.4) identified as FAST positive and FAST negative, 85 (43.6%) and 110 (56.4%) reported RD use ever and never and 33 (16.8%) and 163 (83.2%) reported RD use and no RD use in the last 1/12 respectively. 67/102 FAST positives reported a new sexual partner in the previous 3/12 compared to 29/88 FAST negatives ($p < 0.001$). Recent RD users were also more likely to report partner change (23/32 compared to those with no recent RD (75/159, $p = 0.011$). There was an increase in STI diagnoses in FAST positive compared to FAST negative patients (34/105 and 17/91 $p = 0.029$), no difference was observed in the other cohorts.

Discussion HAC is very common among our patients and appears to be linked to increased STI acquisition. Recent RD use is not uncommon. Our findings support the recommendations of the recent Alcohol and Sexual Health Working Party that identification of hazardous drinkers and brief interventions may improve sexual health outcomes.

P38

QUANTIFYING THE PUBLIC HEALTH VALUE OF PROVIDER-LED PARTNER NOTIFICATION USING AN EVIDENCE-BASED ALGORITHM WITH ROUTINELY-COLLECTED DATA

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Objectives To assess (i) the public health benefit of provider-led partner notification (PN) and (ii) the importance of taking into account the number and types of partners when assessing the cost-benefit of provider-led PN.

Method We used data on 346 partners reported by 220 chlamydia index patients ($n = 127$ men) seen by a PN professional at one GUM clinic, April–June 2011. We used a published, evidence-based algorithm to quantify PN impact, including the measure the "Number Needed to Treat to Interrupt Transmission" (NNTIT), defined as the number of partners who need to be treated to interrupt 1 onward (secondary) transmission. A lower NNTIT indicates less PN effort is required to prevent onward transmission.

Results Men reported 216/346 partners and women 130/346. Men more often described partners as casual (56% vs 28%), while women more often reported regular (40% vs 30%) and ex-partners (23% vs