

**Aims/Objectives** To promote the importance of HIV testing, and to see if the outreach was successful in targeting a less tested population of MSM.

**Methods** The promotion was determined by the “opportunities to view” key messages. Individuals tested in the bar completed a form collecting age, gender, orientation, time since last HIV test, unprotected anal (UAI) or vaginal sex. Similar information was collected from 100 patients walking into the generic service for an HIV test on the same day. Age groups <25, 26–30, 31–39, >40 were chosen.

**Results** There were 890 000 opportunities to view the key messages. 467 individuals tested in the gay bar, but only 441 forms were sufficiently complete for this analysis. MSM in the gay bar were younger than the clinic (54% and 44% respectively <30;  $p=0.027$ ), and more likely to have never tested (18% and 6%;  $p=0.007$ ). In the gay bar, only 9/89 (10%) of MSM aged 31–39 had never tested, only 2/9 (22%) reporting UAI. This contrasted to the 15%–24% of 54 MSM in the other age groups that had never tested, 60%–77% of whom reported UAI. Only five MSM attending clinic had never tested, 4 (80%) of whom were <25 (see abstract P7 table 1).

**Discussion** As well as promoting the benefits of regular testing to the wider gay community, the event was successful in reaching a less tested, but nonetheless high risk population of MSM, in particular, those <25.

Abstract P7 Table 1 Demographic characteristics of individuals accepting HIV testing

	Gay Bar (n=441)	Clinic (n=100)
Male	379 (86%)	91 (91%)
MSM	355 (80%)	80 (80%)
<25 years	167 (38%)	15 (15%)
MSM <25	131 (37%)	12 (12%)
No previous test	101 (23%)	15 (15%)
Never tested, reporting UAI/UIV	52 (51%)	9 (60%)
MSM never tested, reporting UAI	39 (62%)	2 (100%)

## P8 TESTS OF RECENT HIV INFECTION IN CLINICAL PRACTICE: THE PATIENT PERSPECTIVE

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<sup>1</sup>E R Anderson,\* <sup>2</sup>M Taegtmeyer, <sup>3</sup>V Delpech, <sup>4</sup>A Chawla, <sup>3</sup>V Gilbart. <sup>1</sup>Royal Liverpool University Hospital, Liverpool, UK; <sup>2</sup>Liverpool School of Tropical Medicine, Liverpool, UK; <sup>3</sup>Health Protection Agency; <sup>4</sup>Royal Liverpool Hospital, Liverpool, UK

**Background** A test for recent infection (avidity test) is offered for all patients newly diagnosed with HIV in England and Wales as part of an HIV incidence surveillance programme. The UK is currently the only country to return these results to individual patients.

**Objectives** To determine the acceptability and patient experience of receiving a RITA test result soon after HIV diagnosis.

**Methods** This was a qualitative study using semi-structured interviews. 14 people recently diagnosed with HIV who had a RITA result consented to participate. Analyses were based on the framework method using N-Vivo software. Interviews were transcribed, coded and emergent themes identified.

**Results** All participants agreed that the more information available to them about the possible duration of infection the better. Unsurprisingly the HIV diagnosis and the emotions and practical issues associated with it had far more impact than the RITA result. None of the participants experienced any problems with former partners as a consequence of their RITA result although some could see the theoretical potential for such problems. “Recently infected” RITA results were felt to be potentially useful for identifying “at risk” partners. However partner notification was not altered in the study group because the individuals concerned had other reasons to suspect recent

infection. Other major themes identified were the perceived stigma; the difficulty of sharing the diagnosis of HIV with family and friends; and the many conflicting emotions that people had to deal with at diagnosis including anger, grief, self-blame, fear and depression.

**Conclusion** RITA testing is a potentially useful epidemiological tool. These interviews demonstrated that receiving a RITA result, while useful to some people, is a minor issue compared with dealing with the HIV result itself. Reassuringly none of the participants reported negative outcomes from receiving the RITA result.

## P9 SUSTAINABLE AND EMBEDDED OPT OUT HIV TESTING ON AN ACUTE MEDICAL ADMISSIONS UNIT

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A Palfreeman,\* G Mckinnon. University Hospitals Leicester, Leicester, UK

**Background** Opt out testing for HIV in our hospital’s acute medical unit (AMU) had been successfully piloted between August 2009 and September 2010. Our trust was selected a pilot site to implement the 2008 national HIV testing guidelines as an area of high HIV prevalence outside London. (Data from this pilot were presented at BASHH in Gateshead in 2010). However, could opt out testing for HIV on an AMU be sustained beyond the pilot?

**Methods** HIV testing in the pilot was embedded into the normal working of the AMU, clinical aides did the phlebotomy, medical admission proformas were modified to include HIV testing and consent was obtained by a widely distributed information leaflet. One of the GU consultants attended the AMU to remind doctors to test several times a week. After the pilot finished, the GU consultant stopped attending the ward HIV testing is now part of routine care on the AMU. It is explained at each junior doctors induction which includes a patient video. Electronic blood test requests for AMU automatically include an HIV test as part of the AMU blood bundle set. A CQUIN target that 25% of all admissions are to be tested for HIV has been set by commissioners. Testing has been expanded from the 16–60 age range to the 16–80 age range.

**Results** The rate of HIV testing has risen from 80 a month to 140 a month in 2011 the number of new +ves diagnosed has risen from 10 per year to 25 in 2011

**Conclusion** Sustainable opt out testing for HIV on an AMU can be achieved by embedding the testing process in the clinical pathways that already exist upon an AMU. This requires no extra manpower or resources to achieve within an AMU setting. Since the withdrawal of consultant support our average testing rate has gone up. Our model for opt out HIV testing is therefore sustainable, requires little extra resource and should be easy to reproduce in other centres.

## P10 VITAMIN D LEVELS IN A SAMPLE OF HIV+ PATIENTS

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G Brook,\* J Alagaratnam, K Barai. North West London Hospitals NHS Trust, Central Middlesex Hospital, London, UK

**Background** In the last few years it has been highlighted that vitamin D deficiency is common in the general population however, the extent of the problem in different HIV+ cohorts is less clear.

**Aims** In a cohort of HIV+ patients in North West London we looked at the vitamin D levels to see what the prevalence of deficiency was and see if there were any correlates with ethnicity or season.

**Methods** All HIV+ patients at this centre and who had a recorded vitamin D test result in the last 2 years were identified. The first result while not on treatment was recorded. The patients’ electronic