with a previous audit from 2012; following which recommendations were made, including efforts to contact the source patients.

**Results**
A total of 126 patients attended for PEPSE during the 2014 audit period; median age 28 years (range 17–53); majority male (93.7%); homosexual (81.0%); White British (79.4%). Baseline HIV tests were performed in 99.2%; PEPSE was prescribed in accordance with BASHH recommendations in 98.4% and 97.6% were provided <72 h. In 15.1% the source was contacted.

In comparison with our 2012 audit, there were fewer women (6.3% vs 20.6%) who accessed PEPSE and there was an improvement in PEPSE being prescribed in accordance with BASHH recommendations (98.4% vs 92.7%). There was a statistically significant improvement in the number of source patients contacted (15.1% vs 2.9%; p < 0.01). In the case of 19 patients in whom the source was contacted, 4 were able to stop taking PEPSE (21.1%).

**Discussion/conclusion**
The number of patients accessing PEPSE has remained high and forms an important part of service provision in sexual health clinics. Contacting the source is an important step to reduce the unnecessary prescribing of PEPSE.

---

**P74 POST EXPOSURE PROPHYLAXIS: BASHH REGIONAL AUDIT 2014**

Olivia Drew*, Emily Clarke, Alison Blume, Leela Sanmani, Neelam Radja, Sangeetha Sundaram, Cecilia Priedek, Royal Bournemouth Hospital NHS Trust, Bournemouth, UK; Solent NHS Trust, Southampton, UK; Solent NHS Trust, Portsmouth, UK; Solent NHS Trust, Winchester, UK; Salisbury NHS Trust, Salisbury, UK; Weymouth Community Hospital, Weymouth, UK.

**Background/introduction**
In 2011 British Association of Sexual Health and HIV (BASHH) updated their guidelines on HIV post-exposure prophylaxis (PEP).

**Aim(s)/objectives**
To audit the management of patients treated with PEP for both sexual and non-sexual risk in GUM clinics against BASHH PEP guidelines.

**Methods**
A retrospective case notes review was performed on patients attending for PEP following both sexual and non-sexual risk in 7 GUM clinics in Wessex between January–December 2013. Data collected included indication for PEP, time to commence, STI screening, completion rates and HIV testing done at baseline and 3 months post-PEP.

**Results**
98 case notes were reviewed. 77 patients had a sexual risk (47/77 men who have sex with men) and 21 a non-sexual risk. 92% of patients had a baseline HIV test at <72 h (target 100%). 73% of PEPSE prescriptions fitted within recommended indications, however only 28% of PEP prescriptions following non-sexual risk fitted within the recommended indication (target 90%). 100% of patients received PEP within 72 h and 62% of patients completed 4 weeks PEP (target 75%). 54% of patients had an HIV test at 3 months post-PEP (target 60%) and 70% of patients receiving PEPSE had an STI screen (target 90%).

**Conclusion**
This audited demonstrated some good management such as baseline HIV testing and the time to commence PEP. It also revealed areas to be improved, in particular PEP prescribing in a non-sexual risk situation, where often the risk was not a recommended indication. This highlights the importance of continued education to all PEP prescribers.
6 months, 78 (64%) reported being sexually active. 14 (12%) reported at least 1 new partner in the last year, 52 (35%) were offered STI screening in the last year and 32 accepted (62%). 9 (28%) were diagnosed with STIs: Gonorrhoea, chlamydia, warts, LGV, syphilis and hepatitis C. Those reporting partner change were more likely to be diagnosed with STIs (58% of those screened vs 10% not reporting partner change, p = 0.002).

Discussion/conclusion A high prevalence of STIs was observed. Sexual history taking is essential to identify those most at risk. However, STIs were diagnosed in those reporting no partner change, supporting routine STI screening among our cohort.

Background/introduction Public Health England report (Nov 2014) the number of HIV tests is increasing, number of positive diagnoses decreasing, but proportion undiagnosed HIV unchanged. We aimed to suggest new local strategy. Demographically identifying late diagnoses (CD4 < 350 cells/mm³) would find groups within the population more likely to be diagnosed late. Testing that group could uncover undiagnosed early HIV.

Methods Data gathered about HIV diagnosed in our city Jan 2009–Dec 2014: age, gender, ethnicity, orientation, previous test, indication, place tested. Chi-Square compared early/late diagnoses. Under-served compared to well-served demographics.

Results 251 new diagnoses in 5 years. 125 early, 126 late. Disproportionate late diagnoses:
• females (p = 0.023) without previous test (p = 0.006)
• HSM (heterosexual males) (p = 0.068) without previous test (p = 0.004)

No significant difference between early/late diagnosis:
• ethnicity: Caucasian, sub-Saharan African, other (p = 0.103)
• age: <50 vs >50 (p = 0.74)
• bisexual males (p = 0.87)

Disproportionate early diagnoses:
• MSM males (p = 0.032) with previous test (p = 0.052)

Discussion/conclusion Barriers to earlier self-presentation of females and HSM should be examined. MSM benefit from specialised clinics yet are <50% diagnoses. Likely public and clinician unawareness of risk excludes earlier testing.

Background/introduction Routine HIV testing in acute medical admissions is recommended in areas of high HIV prevalence. A local sero-anonymous prevalence study suggested high rates of undiagnosed HIV in both medical and surgical admissions. We have developed a successful non-clinician based model of HIV testing using a dedicated Health Care Assistant (HCA) in medical admissions. We are keen to move back to clinician-based HIV testing using the HCA as a testing-facilitator offering education and a bespoke HIV testing training resource to support HIV testing. This model will allow roll-out of HIV testing to all admissions.

Methods A service evaluation through purposive sampling to assess whether nursing staff would be willing to perform routine HIV testing and to pilot the HIV testing training resource.

Results 10 nurses from the Emergency Department, Acute Medical Unit, and medical wards responded. 4/10 felt that current coverage (a single HCA) was inadequate. 8/10 said they would be willing to routinely test admissions for HIV provided support and training from the HIV Screening HCA was given, especially around the informed consent process. 1/10 suggested routine screening would make discussing HIV testing less awkward. 8/10 felt the training resource was comprehensive and helpful.

Discussion/conclusion This pilot suggests that Routine HIV testing by nursing staff admitting patients is feasible with the support of an HIV testing facilitator and an HIV testing training resource.