

background. 16/23 (70%) worked at one of the four previous services. Staff experience of the tender/integration process in terms of 'stress'/'excitement' levels are reported in the Table 1.

Abstract P184 Table 1 Staff survey

| | Pre 09/2013 (%) | Months 0–6 (%) | Months 7–12 (%) | Month 12 onwards (%) |
|-------------------------|-----------------------|-------------------|--------------------|-------------------------|
| Moderate-Very Exciting | 0 (0) | 1 (5) | 3 (15) | 11 (50) |
| Mildly exciting | 0 (0) | 0 (0) | 4 (20) | 2 (9) |
| No different | 4 (27) | 0 (0) | 2 (10) | 0 (0) |
| Mildly stressful | 3 (20) | 2 (10) | 3 (15) | 4 (18) |
| Moderate-Very Stressful | 9 (60) | 17 (85) | 13 (65) | 7 (32) |
| Total respondents* | 15 | 20 | 20 | 22 |

*Respondents were able to tick multiple answers

14/22 (64%) of staff believe that SH services should be integrated. 17/22 (77%) feel patients are now getting a better service (with further improvements needed).

Themes Main 'positives experienced': new skills gained, increasing integration/offer of a 'one-stop-shop' service. Main 'challenges experienced': resistance to change, clash of specialty 'cultures'. The predominant 'suggestion for improvement' was better communication with all staff throughout the process.

Discussion/conclusion The experience of the tender process and early months in the new ISH service was stressful for many staff. This improved with time and staff reported feeling increasingly excited about the new service. Better communication from commissioners and service providers to all staff involved may improve the overall experience of those going through the process in the future.

P185 USING THE STIF PORTFOLIO IN AN "INTEGRATION" TRAINING STRATEGY

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Background Many UK sexual health clinics are in the process of integrating Sexual and Reproductive Health (SRH) and GUMedicine (GUM) services. Amongst the many challenges they face is that of appropriately training newly integrated staff. Our unit has recently undergone integration of contraception, termination, outreach and GUM/HIV services. Central to this process was the establishment of a comprehensive training strategy for all clinical staff.

Objectives To describe the successful implementation of an integration training strategy using BASHH's STIF portfolio between 2012–2014.

Methods An initial baseline staff survey demonstrated a lack of consistency of formal sexual health qualifications amongst both SRH and GUM staff. It also highlighted considerable skills amongst some HCAs who had lacked opportunity to formalise them. Our desire was to use existing national qualifications and provide equality of access to all grades of staff.

Results Between 2012–2014 we ran 2 STIF theory courses and 4 STIFLevel 1 assessments. In total 53 staff attended STIF theory and 45 successfully completed STIFLevel 1 (including 8 HCAs). A further 7 senior nurses and 2 SRH doctors have

completed STIFIntermediate. One band 7 GUM nurse has also completed STIFAdvanced.

Conclusion The STIF portfolio has provided practical and effective tools in training and assessing staff during our local integration process. We believe that the existence of a clear training strategy helped maintain moral and staff retention during a potentially difficult time and the high level of national qualification amongst our staff will hopefully stand us in good stead in the current commissioning climate.

P186.1 DOES CHLAMYDIA TESTING IN GENERAL PRACTICE MEAN MISSED OPPORTUNITIES FOR THE DIAGNOSIS OF OTHER STIs?: A COMPARISON OF THE POPULATION TESTED IN GENERAL PRACTICE VERSUS SEXUAL HEALTH CLINICS IN BRITAIN

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Background Chlamydia testing in general practice may provide opportunities to diagnose those who do not attend sexual health (GUM) clinics. However, as comprehensive STI testing is less likely to be offered in general practice, opportunities could be missed to test, diagnose and treat other STIs including HIV if people at higher sexual risk test in general practice.

Aim To compare demographic, behavioural, and HIV testing characteristics of those tested for chlamydia in general practice with those tested in GUM.

Methods A probability sample survey of the British population undertaken 2010–2012. We analysed weighted data on individuals aged 16–44, reporting at least one sexual partner ever, who reported a chlamydia test in the past year (n = 1583).

Results 26.0% (24.7–27.4) of women and 16.1% (14.9–17.3) of men reported testing for chlamydia in the past year, of whom 41.4% (38.6–44.2) of women and 20.5% (17.4–24.0) of men tested in general practice. Women tested in general practice were more likely to be older, in a relationship, and to live in rural areas. Men and women tested in general practice reported lower STI risk in terms of (past 5 years): partner numbers, same-sex partners, and overlapping partnerships. Those tested in general practice were less likely to report an HIV test (past 5 years).

Discussion/conclusion While those tested for chlamydia in general practice generally reported lower risk behaviours, rural populations were over-represented, and HIV testing was lower. Pathways to comprehensive STI care need to be universally available for higher risk individuals.

P186 HIGH LEVELS OF USE OF RECREATIONAL DRUGS AND ALCOHOL WITHIN AN INNER LONDON SEXUAL HEALTH CLINIC

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Background Drug and alcohol use by patients attending sexual health clinics is not widely assessed as routine. BASHH history taking guidelines and position statement on recreational drug use

Abstract P186 Table 1 Recreational drug use

| N (%) | Cocaine | Ecstasy | Ketamine | Meph | GBL/GHB | Crystal Meth | Poppers | Nitrous Oxide | Cannabis | Where help would be preferably be sought |
|-----------------|---------|---------|----------|---------|---------|--------------|---------|---------------|----------|--|
| | | | | | | | | | | N = (15) |
| MSM (n = 20) | 12 (63) | 7 (37) | 6 (32) | 11 (58) | 8 (42) | 4 (21) | 8 (42) | 3 (16) | 8 (42) | GUM Clinic 6 (32) |
| WSM (n = 19) | 70 (14) | 6 (30) | 3 (15) | 3 (15) | 2 (10) | 2 (10) | 5 (25) | 4 (20) | 1 (5) | GUM Clinic 8(50) |
| Het Men (n = 3) | 1 (33) | 1 (33) | 1 (33) | | | | | | 1 (33) | GP 1 (33) or Drug Clinic 1 (33) |

recommend obtaining such histories, enabling identification of patients at risk and refer appropriately.

Aim To identify drug and alcohol use among GU patients attending a routine clinic appointment.

Methods Anonymous questionnaires were offered to all patients over a five day period. Drug and alcohol use over past 6 months, whether it was patient-identified as problematic and where help would be sought were obtained

Results Of the 116 respondents, with an average age of 30 years, there were 61 (52%) women, 30 (26%) MSM and 25 (22%) heterosexual men. Of these 60 (52%) disclosed drug use and 105 (81%) disclosed drinking alcohol; 4 respondents were concerned about their drug use and 48 (49%) reported high alcohol intake.

Conclusion There is a high level of drug and high alcohol use by a significant number of patients of all genders and ages. However it is self-deemed as problematic by only a small proportion. More routinely collected data is required to fully understand this and the potential impact it may have on sexual health.

Intensive pharmacokinetic sampling was undertaken on days 0, 15 and 16. Differences in pharmacokinetic parameters of sildenafil, N-desmethyl-sildenafil and boceprevir between phase 4 and earlier phases were evaluated by changes of geometric mean ratios (GMR).

Results All drugs were well tolerated with no safety concerns arising. In the presence of boceprevir (phase 4 versus phase 1), sildenafil GMR maximum plasma concentration (C_{max}) and area-under-the-concentration-time-curve (AUC₂₄) increased by 1.9 fold (95% CI: 1.5–2.4) and 2.7 fold (95% CI: 2.1–3.4), respectively whereas a reduction in N-desmethyl-sildenafil C_{max} was observed (GMR 0.5, 95% CI: 0.4–0.7). No significant changes in boceprevir exposure were observed between phases 4 and 3.

Discussion/conclusion Sildenafil exposure is increased in the presence of boceprevir. Dose adjustment of sildenafil is necessary. An initial dose of 25 mg of sildenafil is suggested.

Category: Miscellaneous

P187 A PHASE 1 STUDY TO ASSESS THE SAFETY, TOLERABILITY AND PHARMACOKINETIC PROFILE OF BOCEPREVIR AND SILDENAFIL WHEN DOSED SEPARATELY AND TOGETHER, IN HEALTHY MALE VOLUNTEERS

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Background/introduction Boceprevir is a first generation direct-acting antiviral (DAA) licensed for the treatment of hepatitis C infection. Sildenafil is an oral therapy for erectile dysfunction. As boceprevir is a potent inhibitor of CYP3A4, potential pharmacokinetic interactions may occur when co-administered with sildenafil.

Aim(s)/objectives The aim of this study was to assess the pharmacokinetic profile of sildenafil and boceprevir when dosed separately and together in healthy volunteers.

Methods Thirteen male subjects completed the following study procedures: phase 1 (day 0), single dose sildenafil 25 mg was administered; phase 2 (days 1–9), washout period; phase 3 (days 10–15), boceprevir 800 mg three times a day was administered; phase 4 (day 16), boceprevir 800 mg and sildenafil 25 mg were administered. All drugs were administered in a fed-state.

P188 'FIND YOUR MATE!' AN INTERACTIVE GAME TO SUPPORT THE TEACHING OF SEXUAL HISTORY TAKING TO MEDICAL STUDENTS

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Background/introduction Standard methods of teaching sexual history taking are heavily reliant on role-play which many students find threatening. We took a fresh look at this with particular reference to the learning environment and learner diversity.

Aim(s)/objectives To develop a new resource as an alternative to role-play which allows students to practice the key components of sexual history taking in a fun and memorable way.

Methods The concept of 'find your mate' grew through brainstorming sessions with a medical student and an F2 trainee. The idea of a 'party atmosphere' with background music allows those with 'musical intelligence' to create a link whilst also masking individual conversations and reducing embarrassment. Provision of party snacks and soft drinks addresses players' basic physiological needs.

Results An interactive game was developed with flexibility to accommodate any number of participants from 6–30. Feedback was universally positive with players reporting marked improvement in confidence scores in sexual history taking.

Discussion/conclusion Students often find terminology used in sexual history taking unfamiliar or uncomfortable. They come from a variety of social, ethnic and religious backgrounds and may carry judgmental attitudes. Some may have had negative sexual experiences. Providing a psychologically and physically safe environment for them to develop this important skill is of