Aim(s)/objectives To audit occupational PEP/PEPSE related attendances in a sexual health clinic (SHC) in 2015 and compare to a previous audit (2011–2013).
Methods A retrospective case note review of patients attending in 2015 for PEP/PEPSE. Clinical records were unavailable for patients attending prior to April 2015 due to the SHC contract transferring to a new provider.
Results A total of 8 patients attended for PEPSE, two were initiated in A&E, 1 in a Sexual Assault Referral Centre (SARC) and 4 in the SHC. All patients attended after sexual exposure, with none attending after needle stick injury. All patients were started on PEPSE within 72 hours, had baseline HIV test and STI screen. All had PEPSE prescribed within the recommended indications compared to 88% previously. Fifty percent finished PEP course whilst 25% had a documented HIV test 4–6 weeks post PEP.
Discussion/conclusion Issues around clinical record ownership have been interpreted differently across trusts. Locally, when the provider for the SHC changed, minimal patient record information was transferred to the new trust. This limited access contributed to small audit numbers. Compared to previous audit smaller numbers of patients finished the PEP course and attended for follow up HIV test but clinicians have a greater understanding of recommended indications for PEPSE.

P045 SWITCHING FROM BOOSTED ATAZANAVIR (ATV) PLUS FTC/TDF TO A TAF-BASED SINGLE TABLET REGIMEN (STR): WEEK 48 DATA IN VIROLOGICALLY SUPPRESSED ADULTS

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Background/introduction Tenofovir alafenamide (TAF) is a tenofovir prodrug that contains elvitegravir 150mg/cobicistat 150mg/FTC 200mg/TAF 10mg (E/C/F/TAF).
Aim(s)/objectives This study assessed efficacy and possible bone and renal safety advantages in patients who switched from a TDF-based regimen to E/C/F/TAF.
Methods Virologically suppressed (HIV-1 RNA < 50 copies/ml) adults on a TDF-based regimen for at least 96 weeks were randomised 2:1 to switch to open label E/C/F/TAF or to continue their prior regimen. At baseline, the median CD4 count was 658 cells/uL, the median eGFR(Cockcroft-Gault) was 103.8 mL/min and 10.6% of patients had baseline proteinuria of at least 1+ on dipstick analysis.
Results At Week 48, 390/402 (97.0%) of those who switched to E/C/F/TAF and 183/199 (92.0%) of those continuing boosted ATV plus FTC/TDF had HIV-1 RNA < 50 c/mL (difference, 5.1%; 95% CI: 0.9% to 9.2%). No patients had virologic failure with resistance. In patients who switched, hip and spine bone mineral density (BMD) improved significantly, and proteinuria and specific tubular proteinuria also improved significantly Serum creatinine mean change (μmol/L) from baseline: E/C/F/TAF, +0.88; ATV+ FTC/TDF, +3.54 (p = 0.003). E/C/F/TAF patients had statistically higher changes from baseline in fasted lipid tests; the median change in total cholesterol: HDL ratio was: E/C/F/TAF, +0.2; boosted ATV+FTC/TDF, +0.0 (p = 0.001).
Discussion/conclusion At Week 48, patients who switched from a boosted ATV+FTC/TDF regimen to E/C/F/TAF had a significantly higher rate of virologic control, had significant improvements in hip BMD, spine BMD and in serum creatinine, and also had significantly less proteinuria than those continuing on their TDF-based regimen.

P046 A NEW APPROACH TO QUANTIFYING HEALTH ADVISER INPUT IN A RE-COMMISSIONED SEXUAL HEALTH SERVICE

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Background/introduction With sexual health services going out to tender, commissioning intentions have prioritised health promotion and prevention strategies. Whilst these activities are currently performed they have been difficult to quantify. Consequently, new codes have been devised to register face to face and telephone input for a) counselling/support/safeguarding issues face to face (HCSF) b) counselling/support/safeguarding via telephone interaction (HCST), c) Health education/health promotion or advice face to face (HEF) d) Health education/health promotion or advice via telephone interaction (HET) e) partner notification face to face (HPNF) and e) partner notification via telephone interaction(HPNT)
Aim(s)/objectives To ascertain whether the newly devised codes have been integrated into routine service
Methods Case notes were analysed over a 3 month period to ascertain, the frequency of use of such codes
Results 37 case notes had input as regards counselling/support/safeguarding face to face (HCSF). 14 had such input via telephone. 75 case notes had input as regards health education/health promotion (HET) face to face, 94 had such input via telephone. 66 case notes had input as regards partner notification face to face, 43 had this via telephone.
Discussion/conclusion It has been established that the codes have been easy to apply and have already given a quantitative view as regards health promotion/education/safeguarding, which has supported discussions with commissioners. It is envisaged that use of the codes will enable of health adviser interventions to be measured time wise. This work will also be presented.

P047 HEALTH CARE NEEDS OF WOMEN AGED 40 AND OVER ATTENDING AN INNER CITY INTEGRATED SEXUAL HEALTH CLINIC

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Background/introduction Sexual health policy is targeted towards younger adults, with national screening programmes and research studies excluding individuals over the age of 44. UK surveillance data demonstrated that rates of sexually

transmitted infections (STIs) doubled in older people between 1996 and 2003, the fastest rise in all age groups.
Aim(s)/objectives To assess the health care needs of women aged 40 and over attending an integrated sexual health clinic in South London.
Methods Retrospective case notes review of 200 randomly selected female patients aged 40 and over attending between 2nd June 2014 and 30th May 2015.
Results 1728 out of 5039 women (34%) who attended the sexual health clinic were aged 40 and over. In the sample of 200, mean age was 46.6 years (range: 40–73 years). Ethnicity: Black 111 (55%), White 57 (29%), Other 32 (16%). 110 women (55%) attended for STI-related reasons (symptoms/partner notification/possible exposure/treatment). 41% attended for contraception and 10.5% for asymptomatic screen. Of 150 tested, 29 (19.3%) had STIs. STIs were: genital herpes 8 (5.3%), trichomoniasis 7 (4.7%), genital warts 5 (3.3%), chlamydia 2 (1.3%) and gonorrhoea 1 (0.7%). Overall condom use was 22.9%.
Discussion/conclusion A significant proportion of women accessing sexual health services were aged 40 and over. 1 in 5 women were diagnosed with an STI. Under a quarter of women used condoms, indicating sexual risk taking behaviour. The sexual health needs of older people will continue to increase, given our rapidly ageing population. There is therefore a need to develop age-specific health promotion strategies and to challenge assumptions regarding sexuality in older age.

P048 WHAT FACTORS CAUSE DELAY IN TERMINATION OF PREGNANCY? A LITERATURE REVIEW OF THE EVIDENCE

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Background/introduction Although abortions performed at earlier gestations are relatively medically safer and less costly, nonetheless in many settings there exists a small minority of women who receive abortions in the second trimester. The difficult circumstances faced by women seeking later abortions have been highlighted, but it is not always clear what factors lead to abortions being performed later in pregnancy.
Aim(s)/objectives To identify the causative factors of later (second trimester) abortion, analyse the impact of service provision on timing of abortion and highlight other factors relevant to delay in seeking or obtaining abortion.
Methods A literature search was conducted using Medline and Embase databases, and results were limited to English language studies from the last 20 years in settings where termination of pregnancy was legally available.
Results Most delays tended to act on one or more of three periods: identification of pregnancy, decision-making, and obtaining an abortion having made a decision. Delays in suspecting or confirming the pregnancy were key drivers in later termination and were particularly pronounced in young people; service-related delays were common, though small, and were often compounded by logistical factors such as financial difficulties.
Discussion/conclusion The causes of later abortion are many and complex, and very commonly overlap; more research is needed to analyse how these factors interact to cause delay. The association of low socioeconomic status with increased abortion delay suggests more must be done to ensure the accessibility of abortion services.

Abstract P049 Table 1 HIV+ MSM

ASPECT OF ASSESSMENT	Number (%) n = 85
Sexual history taken	77 (91)
If sexual history taken, Sexually active in past 12 months	60 (78)
Of those who are sexually active, STI screen offered	58 (97)
Of those with screen offered, STI screen done	53 (91)
STI detected:	10 (19)
1. Chlamydia trachomatis	1 (10)
2. Neisseria gonorrheae	8 (80)
3. Syphilis	1 (10)
4. Warts	2 (20)
5. Acute Hepatitis C	2 (20)
Recreational drug history	63 (74)
If recreational drug history taken, recreational drugs use disclosed	17 (27)
If recreational drug history taken, chemsex specifically disclosed	3 (5)

P049 AUDIT: RATES OF SEXUAL HISTORY TAKING AND SCREENING IN HIV POSITIVE MEN WHO HAVE SEX WITH MEN (MSM)

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Background/introduction Increased rates of STIs in MSM may in part be due to the emergence of 'chemsex'; use of recreational drugs in the context of high-risk sex. BASHH has set a target of 97% of MSM attending for a new episode being offered a screen (80% acceptance). BASHH/BHIVA guidance recommends HIV-positive patients have 6 monthly sexual histories and annual STI screens.
Aim(s)/objectives To evaluate whether HIV positive MSM patients were asked about recreational drug use, including chemsex and assessed and screened for STIs during consultations.
Methods The notes of 142 HIV positive men seen in 2015 were available, of whom 85 were MSM. Information was collected regarding sexual history, recreational drug use documentation, STI screen offer and test results.
Results 77 (91%) of the MSM had a sexual history documented, of whom 60 (78%) were sexually active. STI screens were offered to 58/60 (97%) of those who were sexually active and accepted by 53 (91%) 10 (19%) of these had an STI. A recreational drug history was taken in 63 (74%) with 17 (27%) admitting to use and 3 (5%) to chemsex (Table 1).
Discussion/conclusion Sexual history documentation was below recommended levels. 19% men tested had an STI highlighting that frequent screening in this group is essential. A quarter of patients admitted to recreational drug use, although how many were explicitly asked about chemsex is unclear. Given the increasing concern around this practice, questions about chemsex should be incorporated into the sexual history proforma.

P050 IMPROVING MANAGEMENT AND PARTNER NOTIFICATION OUTCOMES OF WOMEN TREATED FOR PELVIC INFLAMMATORY DISEASE (PID) BY INNOVATIVE YET SIMPLE BESPOKE MEASURES

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