Abstract O6 Table 1 Rates of chlamydia and gonorrhoea infections in relation to practitioner group

Grade of staff	Band six nurses	FY1	ST2	GP	SAS	Registrar	Consultant	Whole cohort
No of staff	7	6	4	2	1	9	6	41
No of consultations	442	140	207	252	486	996	930	3453
No of PID diagnoses	17	8	9	14	21	50	47	166
% Of cohort diagnosed with PID	3.8	5.7	4.3	5.6	4.3	5	5.1	4.8
Chlamydia prevalence (%)	10.1	9.3	6.3	12.3	8.6	10.9	11.4	10.4
Gonorrhoea prevalence (%)	2	0.7	1.4	3.6	1.6	2.7	3.1	2.5
% Of PID patients chlamydia positive	5.9	12.5	11.1	28.5	23.8	24	31.9	23.5
% Of PID patients gonorrhoea positive	5.9	0	0	28.5	0	12	6.4	8.4
% Chlamydia positive patients diagnosed with PID	2.2	7.7	7.7	12.9	11.9	11	14.2	10.9

hypothesised that clinicians with less training and experience may tend to err on the side of caution and be more likely to diagnose PID than more senior colleagues.

Objectives To ascertain whether the rates of PID diagnoses differ by grade of clinician.

Methods Women attending our service as new or rebook patients between March 2009 and January 2010 were seen by eight different grades of clinician. Of these, all but Band five nurses saw symptomatic patients. Data were analysed by grade of staff conducting the consultation.

Results Chlamydia (CT) prevalence was broadly similar across all staff groups. The rates of PID diagnoses were also similar. However, the proportion of PID patients with CT differed significantly between staff groups. In the cases of PID diagnosed by more experienced staff, CT was found in 24% to 32% of patients. This is broadly consistent with the current understanding of PID aetiology. PID diagnosed by nurses and more junior doctors was less likely to have a confirmed STI aetiology. The rate ratio of diagnosis of CT positive to CT negative PID by consultants vs Band six nurses is 5.43 (95% CI 0.77 to 38.01) p=0.089 The rate ratio of diagnosis of CT positive to CT negative PID by experienced doctors (GP, SAS, Registrar, Consultant) vs nurses, FY1 and ST2 doctors is 3.09 (95% CI 1.01 to 9.43) p=0.048 (see abstract O6 table 1).

Conclusions Significant differences were found in the proportion of patients with chlamydia positive PID between experienced doctors and other clinicians. The broader experience of senior doctors may help them in differentiating PID from other causes of lower abdominal pain thus improving the specificity of their diagnosis.

Session title: Testing, service delivery and maintaining good practice

Session date: Wednesday 27 June 2012; 1.45 pm–3.15 pm

07 THE DIAGNOSIS AND TREATMENT OF CHLAMYDIA AND GONORRHOEA IN GENERAL PRACTICE IN ENGLAND: ANALYSIS OF ELECTRONIC HEALTH RECORDS AND SURVEILLANCE DATA

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[1]S Wetten,* [1]M Yung, [2]C Mercer, [3]J Cassell, [1]G Hughes. *[1]Health Protection Agency; [2]University College Hospital; [3]Brighton and Sussex Medical School, Brighton, UK*

Background Primary care has become increasingly important in STI management in England but data on diagnosis and treatment in this setting are not routinely analysed.

Aims To investigate and assess the diagnosis and treatment of bacterial STIs in general practice (GP).

Methods We calculated age and gender standardised estimates of the incidence of diagnoses of chlamydia and gonorrhoea in GP using data from the GP Research Database and national population statistics for the years 2003–2008. Since diagnoses made and treated elsewhere can be recorded in primary care notes, we estimated cases treated in primary care using an algorithm to identify appropriate prescriptions within defined window periods, accounting for other possible treatment indications. We estimated the proportion of all cases reported in England which were treated in GP, relative to other providers of sexual health services.

Results An estimated 21 423 diagnoses of chlamydia (42.3/100 000 registered population) and 1494 diagnoses of gonorrhoea (2.96/100 000) were made in GP in England/annum between 2003 and 2008. 35% of chlamydia diagnoses were in those over 25 years. 70% of chlamydia and 36% of gonorrhoea diagnoses recorded in GP were treated, comprising respectively 12% and 3% of all cases diagnosed in England. Doxycycline and azithromycin were most commonly prescribed drugs for chlamydia. Despite revision of gonorrhoea treatment guidelines in 2005, quinolones remained most commonly prescribed for gonorrhoea (42% in 2006–2008), although the proportion treated with cephalosporins rose gradually over the study period (29% in 2006–2008). The algorithm identified 12% and 30% more treated cases of chlamydia and gonorrhoea compared with including same-day prescriptions only.

Conclusions General practice makes an important contribution to the diagnosis and treatment of bacterial STIs. Efforts to ensure GPs are aware of and use recommended treatment guidelines are needed.

08 THE AUSTRALIAN CHLAMYDIA CONTROL EFFECTIVENESS PILOT (ACCEPT): FIRST RESULTS FROM A RANDOMISED TRIAL OF ANNUAL CHLAMYDIA SCREENING IN GENERAL PRACTICE

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[1]J S Hocking, [1]S Spark, [2]R Guy, [1]M Temple-Smith, [1]C K Fairley, [2]J Kaldor, [2]B Donovan, [2]M Law, [1]J Gunn, [3]N Low,* [1]ACCEPt Consortium. *[1]University of Melbourne, Melbourne, Australia; [2]University of New South Wales, New South Wales, Australia; [3]University of Bern, Bern, Switzerland*

Background ACCEPt is a cluster randomised controlled trial to evaluate annual opportunistic chlamydia screening for 16–29-year-old men and women in general practice (GP).

Objective To report enrolment and baseline results.

Methods The unit of randomisation is a town; all GP clinics are enrolled and towns are randomised using a minimisation design. In intervention towns a multifaceted approach to increase chlamydia testing includes: an education package, a computer prompt; incentive payments; a recall system for annual testing; partner notification; and regular feedback on testing rates. The intervention will be in place for up to 4 years. Control towns will continue usual practice. The primary outcome is change in chlamydia prevalence estimated from samples of 80–100 consecutive GP patients in each town (total 4000) at the beginning and end of the trial.

Results From July 2010 to December 2011, we enrolled 603 GPs from 154 clinics (clinic response rate >80%) in 52 geographically

diverse towns in four Australian states (total population 72 000 16–29-year-olds). To date, 27 towns have been randomised (13 intervention, 14 control). Intervention and control towns are similar: baseline chlamydia prevalence (5.8%, 95% CI 4.4 to 7.5% vs 5%, 95% CI 3.9 to 6.3%, individual response rate 63%); past chlamydia testing rate in 16–29-year-olds (6.1%, 95% CI 5.8 to 6.4% vs 5.8%, 5.6 to 6%). After 3 months of the intervention in the first two towns the chlamydia testing rate was 10.9% (95% CI 10.1% to 11.7%; 691 people tested), a 160% increase compared with the testing rate (4.1%) in the year before the intervention.

Conclusions Our high recruitment rate shows that Australian GPs are willing to test for chlamydia. The baseline data show a high prevalence of chlamydia among young adults in the study towns. While testing rates are increasing, ongoing work is needed to get coverage up to levels that might reduce prevalence in intervention towns.

09 IS HIV AND BLOOD BORNE VIRUS TESTING ACCEPTABLE AND INDICATED IN PSYCHIATRIC SETTINGS?

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[1]C Sanger,* [1]J Hayward, [1]G Patel, [2]A Poots, [2]C Howe, [1]J Green. *[1]Central North West London NHS FT, London, UK; [2]NIHR CLAHRC for Northwest London, London, UK*

Objective Studies in North America and Europe indicate that the prevalence of blood borne viruses (BBVs) are elevated in individuals with severe mental illness. No comparable data exists for the UK. We introduced the routine offer of testing for HIV, Hepatitis B and C into an inpatient psychiatric unit, where the local diagnosed HIV prevalence is 7.29/1000.

Method Psychiatric inpatients were approached at one central London hospital site, between April 2011 and February 2012 and offered routine BBV testing.

Results Of the first 100 patients offered a test 83% of patients approached were assessed to have mental capacity to provide informed consent for testing. 69% of patients offered BBV testing, accepted. The prevalence of HIV was found to be 3%. One individual was newly diagnosed with HIV and transferred to specialist care. Overall, 18% of patients tested were found to have a newly diagnosed or previous infection with a BBV.

Conclusion It is acceptable to patients to be offered routine BBV screening in a psychiatric setting and the majority have capacity to consent; uptake rate is comparable to that seen in GUM clinics. HIV prevalence rate was found to be over four times higher than that of the local population. Given the elevated prevalence rates in psychiatric patients, there is a strong case for the wider introduction of routine testing in mental health settings. There is a need to systematically ascertain rates of infection in mental health patients across a range of geographical areas since the prevalence of BBVs appears to be higher than that in the local population.

010 SHOULD SEXUAL HEALTH SERVICES PARTICIPATE IN THE HPV VACCINATION PROGRAMME? A NATIONAL SURVEY ASSESSING HPV VACCINATION UPTAKE IN YOUNG GUM ATTENDEES

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[1]R Sacks,* [2]A Robinson, [1]D Wilkinson. *[1]Imperial College Healthcare NHS Trust, London, UK; [2]Central and North West London NHS Foundation Trust, London, UK, On behalf of the BASHH Adolescent Special Interest Group*

Background In 2008, a schools-based HPV vaccination programme was introduced for girls aged 12–13, with an accelerated catch up programme for those aged 14–18. A significant impact on cervical cancer rates requires 80% uptake of three vaccinations, however in England the completion rate was 58% in 2009/10.

Aim To compare HPV vaccination outcomes and prevalence of risk factors, associated with HPV acquisition and cervical cancer development, in young women attending GUM clinics with national data.

Method An anonymous questionnaire was given to 13–19 y/old women attending 19 participating GUM clinics from March to August 2011. Data were analysed using multivariate linear regression in SPSS.

Results 2247 questionnaires were completed (median respondent age 17). Compared to national data, respondents were more likely to be smokers (48% vs 12% of 15 y/olds), have had coitarche aged <16 (52% vs 26%), have had an STI previously (29% vs 13% for <16 coitarche) or not be in education, employment or training (NEET) (8% vs 2% of 16 y/olds). Of the 74% offered the vaccination, 81% accepted. Of those accepting the vaccination, 81% had all three injections. Of those who had <3 doses, 65% reported no active recall. Overall, 47% of all respondents had received all three vaccine doses. Completion rates were lower in London, non-white ethnicities, 17–19 y/olds, NEETs, smokers and those with previous Chlamydia (all $p<0.0001$).

Discussion The study population exhibited lower HPV vaccination completion rates than the national average, demonstrating that GUM attendees are a harder-to-reach group through current PCT delivery programmes. This population also exhibited higher rates of risk factors for HPV acquisition, highlighting GUM attendees as a priority target group for HPV vaccination. This data demonstrates the potential role of GUM clinics as supplementary HPV vaccination delivery sites, in targeting at-risk young women with low uptake of the HPV vaccination.

011 HEALTH PROMOTIONAL MESSAGES IN SHORT MESSAGE SERVICE (SMS) FOLLOW-UP OF GU MEDICINE CLINIC DEFAULTERS; A TOOL TO IMPROVE SUBSEQUENT ATTENDANCE RATES?

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[1]E Rutland,* [2]H Roe, [3]A Weaver. *[1]Western Sussex Hospitals NHS Trust, Western Sussex, UK; [2]Southampton University Medical School, Southampton, UK; [3]Solent Community NHS Trust*

Background Patients who do not attend (DNA) booked GU medicine (GUM) clinics waste resources and may pose a public health risk through onward transmission of sexually transmitted infections. Short message services (SMS) appointment reminders improve attendance rates, however the impact of their use in patients who have already DNA'd is unknown. In addition, health promotional tools are frequently used to improve STI awareness however there is little evidence for their effect on GUM clinic attendance.

Aims To determine whether SMS follow-up of patients who DNA booked GUM appointments improves subsequent re-attendance rates and to assess the impact of inclusion of a health promotional message on re-attendance rates.

Methods This prospective randomised control study included all patients aged 16–30 yrs who DNA a booked GUM appointment during the 6 month study period. Subjects were randomised to: (1) no intervention; (2) SMS notification of the defaulted appointment and invitation to attend clinic; (3) as per arm 2 including a health promotional message about Chlamydia. All SMS were sent 1 week after the defaulted appointment. Patients re-booking or attending prior to this time were excluded. The proportion of patients who re-attend within 4 weeks of the defaulted appointment were compared using the Fisher's Exact test.

Results 252 patients were included. 4.5% (4/88) in the control group re-attended clinic compared to 8.2% (7/85) receiving a text reminder ($p=0.36$) and 15.2% (12/79) when a health promotional message ($p=0.032$). None of those re attending in the control group were diagnosed with an STI compared to 29% in group 2 (Gonorrhoea and Chlamydia) and 25% in group 3 (2 × Chlamydia and 1 Herpes).