

P148 "FAST-TRACK" STD SERVICES IN AN URBAN STD CLINIC: INCREASED CLINICAL CAPACITY, BUT REDUCED OPPORTUNITIES FOR SAME-DAY TREATMENT

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Background Public health sexually transmitted disease (STD) clinics in the US continue to face service cutbacks due to financial pressures. "Fast-track" services (urine-based screening without a physical examination) allow for greater patient throughput, but may impede provision of same-day STD treatment.

Objectives (1) to demonstrate the extent to which fast-track implementation leads to increased service capacity; and (2) to document the percentage of fast-track cases with STD requiring further treatment.

Methods Demographic, behavioural, and clinical data analysis from fast-track service delivery in St. Louis County STD Clinic (urban St. Louis, Missouri, USA) from January 2009 to August 2011.

Results Implementation of fast-track services resulted in an increase in clinic throughput of 34.8 patients per month, and a decrease in patients turned away without care (5.6%). Most fast-track patients were male (65.9%), reflecting general clinic demographic trends. Infection rates among fast-track patients were 9.6% for *Chlamydia trachomatis* and 0.7% for *Neisseria gonorrhoeae*; these patients were contacted by telephone and instructed to return to clinic for treatment. Effective treatment was documented for 67.0% of infected patients.

Conclusion Implementation of fast-track services resulted in increased clinic capacity. However, substantial staff time and effort were required to ensure adequate treatment for those testing positive for STD. Enhanced risk assessment prior to fast-track screening may help identify those patients who will benefit from full STD clinical examination and same-day treatment.

P149 EVOLUTION OF THE NCSP: INTEGRATING CHLAMYDIA SCREENING INTO COMMUNITY HEALTH SERVICES; POLICY AND PRACTICE DEVELOPMENTS IN ENGLAND

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Background The National Chlamydia Screening Programme is a major component of sexual health provision in England. Over 1.4 million tests were performed on asymptomatic under 25-year olds in 2010/2011, and over 87 000 diagnoses made. The expansion of chlamydia testing services in the NHS has occurred predominantly outside of GUM utilising both traditional health services and introducing alternative approaches for young people to access testing. Coverage of screening has been higher in deprived areas and among young people at increased risk of infection.

Discussion The NCSP is evolving from a stand-alone programme to one that is integrated in primary care and sexual health services, with outreach screening being restricted to hard to reach groups. This integration is occurring both in terms of the way chlamydia screening is commissioned and provided, and in terms of data collection, removing the requirement for chlamydia-specific services. This process is expected to substantially improve value for money and maximise synergies between chlamydia prevention and other services. Clinical research and modelling, comparison with other programmes around the world and the major organisational changes

in the NHS and public health system continue to shape the commissioning and delivery of screening. Clinical practice, from distribution of test kits to partner notification and treatment, is increasingly dependent upon electronic resources. Key discussion points include: How can we continue to develop flexible, responsive community sexual health services that include chlamydia screening as a core component? Will evaluation criteria for quality assurance and for clinical effectiveness currently applied to a stand-alone NCSP be valid in the integrated models?

P150 FEMALES UNDER 16 ATTENDING GUM

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Background The government set out a number of sexual health targets in the white paper "Choosing Health" 2004 and include. A reduction in the under 18 conception rate, An increase in the percentage of people aged 15–24 accepting chlamydia screening. Young people need to be able to easily access sexual health services in order to prevent, diagnose and treat sexually transmitted infections (STIs) and gain advice and contraception to protect against unintended pregnancy. A significant proportion of patients under the age of 16 are seen, who may have child protection concerns or be vulnerable. We wanted to examine the reasons for their attendance.

Aims In female patients under the age of 16 attending the integrated sexual health clinic, to identify. The reasons for attendance. STI diagnosis and treatment. Contraceptive use and provision. The degree of sexual risk-taking in under 16s, including sexual history, condom use, requests for post coital contraception and pregnancy testing, and the number of pregnancies. Other child protection concerns, including age at first intercourse and age of sexual partner, and parental awareness of their sexual activity. Other factors that contribute to vulnerability and risk-taking in, including alcohol and drug use, mental health issues, low self esteem, homelessness and chaotic life style.

Methodology Service provision was reviewed in comparison to the DoH standards. 50 sets of records were analysed.

Results Reasons for attendance Contraception 80% PCC 60% Pregnancy Test 20% Sexual Screening 42% Recommendation: (1) development of integrated sexual health clinics, (2) PCT commissions a local, accessible abortion service, (3) develop links with other drug alcohol services, (4) combine sexual history sheet with the under 16s proforma, (5) Improve education about LARC in schools to promote uptake, (6) encourage a self-taken chlamydia swab or urine sample in those who decline full STI screening.

P151 HOW EFFECTIVE IS TARGETED OUTREACH?

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Background The national sexual health strategy recommends that services should meet the needs of local communities and identifies where service developments are needed most. The financial pressures of the health service and the operational pressures of trying to meet a 48-h target make it difficult to establish targeted outreach projects to reduce the burden of STIs and the uptake of STI/HIV screening and testing in hard to reach groups.

Methods A needs assessment was carried out with relevant partner organisations and an outreach project with sexual health advisors

was developed. The needs assessment identified three areas for targeted outreach: brothel services for heterosexual men, sauna for MSM and youth offender services. A health advisor outreach clinic was established and staffed 1–4 times a month. Outcome data from the clinics are presented.

Results The youth offender service clinic was the most successful outreach with 32 patients seen over 17 sessions (23 males and nine females). There were 15 males tested in the sauna over 18 sessions and four female sex workers tested in two clinic sessions. STIs were identified in 20% of all patients seen (two cases of Gonorrhoea, six cases of Chlamydia, two cases of syphilis). The mean percentage of patients seen in the outreach clinics who had never been to the GUM clinic was 71% (75% in brothel, 84% in YOS, 34% from sauna).

Discussion The targeted outreach has revealed a high level of STIs (20%) in the target group as assumed. The targeted outreach service should reduce the rate of STIs by appropriate treatment, partner notification and counselling. Recording of testing has missed out on the recording of educational activities and other health promotion carried out at sessions. Targeted outreach will help to improve access to those who don't normally attend, improve patient care and help reduce STIs in the community.

P152 IS IT FEASIBLE TO OFFER A CHLAMYDIA TEST OF CURE AT THE SAME TIME AS ROUTINE GONORRHOEA TEST OF CURE IN PATIENTS WITH BOTH INFECTIONS?

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Background BASHH guidelines recommend routine test of cure (TOC) for gonorrhoea by nucleic acid amplification technique (NAAT) 2 weeks after treatment if asymptomatic, while it is advised to defer chlamydia TOC until 6 weeks after treatment initiation. Chlamydia TOC is recommended only during pregnancy or if there is clinical suspicion of ongoing or re-infection, although there have been recent concerns about the efficacy of single dose azithromycin therapy. Many patients are co-infected with gonorrhoea and chlamydia, and with dual-platform NAATs it is simple and cost-effective to obtain chlamydia and gonorrhoea results from the same sample.

Aim To identify whether it is feasible to perform chlamydia and gonorrhoea NAAT TOCs simultaneously within 42 days of treatment in dual-infected patients.

Methods 38 patients with chlamydia who had repeat NAAT tests within 42 days of initiation of treatment were identified using clinical coding and pathology results. Demographic details, treatment type and time elapsed from initiation of treatment to TOC were obtained from patient notes.

Results 36/38 (94.7%) of chlamydia TOCs taken 41 days or less since the initiation of treatment were negative, including 8/8 (100%) of tests taken 14 days or less since chlamydia treatment. One positive test was from a male, the other from a female, 21 and 17 days after treatment respectively. Both were treated with azithromycin. The male patient denied sexual contact since treatment, and it was unclear whether the female patient was at risk of re-infection.

Conclusions 95% of patients in a clinical setting tested negative for chlamydia within 42 days of treatment. Performing a NAAT TOC for chlamydia and gonorrhoea simultaneously in dual-infected patients is therefore feasible, and is a cost-effective and convenient way to reassure patients that both infections have been eradicated. More work is needed to establish the cause of ongoing chlamydia positivity within 42 days of treatment.

P153 FEMALE GENITAL MUTILATION (FGM)—PROVIDING A HOLISTIC APPROACH AND CHALLENGING TABOOS IN A SEXUAL HEALTH SETTING

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Background In England and Wales nearly 66 000 women are living with FGM and a potential 22 000 girls are at risk each year. Due to increasing demand, a dedicated FGM service within the sexual health setting was initiated in partnership with a dynamic Somali facilitator and a voluntary community organisation.

Aims To analyse the attendances of women with FGM to our dedicated clinic.

Methods Retrospective analysis of all attendees to the FGM clinic between 1 December 2010 and 31 December 2011.

Results Of 197 attendees, 96% were from Somalia (190); mean age was 38 (14–72 years) with 52% living locally. Of those in whom we had documented information, FGM was mainly undertaken for cultural reasons (83/105, 79%), the majority (50/68, 73%) being cut in groups at their home (66/113, 58%). Mothers were the main instigators (58/81, 71%). Nearly half (84/173, 49%) had female children and seven women reported having their daughters cut abroad. The majority were against the practice (112/114, 98%). Reasons for attendance included chronic pelvic pain (57%), dyspareunia (44%) and sub fertility (24%). There was a high uptake of sexual health screening, with almost all patients (191, 97%) having serology for HIV and syphilis. Interestingly, no HIV was detected but 7% (13/185) were hepatitis B surface antigen positive and 31% (58/185) had cleared hepatitis B. There were six diagnoses of late latent syphilis and two of chlamydia.

Conclusions Our Somali facilitator has played a key role in challenging the taboo of sexual health issues within FGM-practising communities, providing a service that is culturally and linguistically appropriate. The rate of blood-borne viruses in this vulnerable group proves the importance of engaging them with sexual health services. Fast track referrals to on-site gynaecology and hepatitis clinic have facilitated re-engagement of some patients with medical care.

P154 WHO IS MOST AFFECTED BY STIGMA OF AN INTEGRATED SERVICE?

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Background Stigma of sexual health services creates barriers to access to care but it is not known if it affects all groups service users equally. Targeted stigma reduction requires this information.

Objective To determine which user groups of a level 3 One Stop Shop (OSS) sexual health services perceives the service as stigmatised.

Method Application of a validated quantitative tool to assess stigma among 200 unselected patients attending a OSS in outer London. We defined that the service was perceived as stigmatised if at least one moderately positive response indicating stigma was given.

Results The service was perceived as stigmatised by 55% (111/200) of patients surveyed. Stigma of the service was more felt by men (25/39 64%) than by women (84/160; 53%) and or those who classified themselves UK black (29/46; 63%) rather than UK white (19/66; 57%). Young men (age <26 years) (12/20; 60%) perceived the service as less stigmatised than older men (13/19; 68%) while