Results There were 408 (98 Gonorrhoea, 310 Chlamydia) detected infections in the 2012 period and 404 (121 Gonorrhoea, 283 Chlamydia) in 2014. Between 2012 and 2014, the rate of detected extra-genital Chlamydia/Gonorrhoea infections increased 4-fold from 18/408, 4.4% to 77/404 19% ($P < 0.0001$). The rise was seen in both pharyngeal (10/408, 2.45% vs 48/404, 11.8% $P < 0.0001$) and rectal infections (8/408, 2% vs 40/404, 9.9%, $P < 0.0001$). Significant rises were seen in MSM in rectal (5/408, 1.2% vs 28/404, 6.9% $P < 0.0001$) and pharyngeal infection (10/408, 2.5% vs 21/404, 5.2%, $P = 0.02$) and for women in rectal (3/408, 0.7% vs 12/404, 3% $P < 0.02$) and pharyngeal infection (0/408, 0% vs 20/404, 5%, $P < 0.0001$). In these patients, rates of extra-genital self-swabbing rose from 0% (0/24) to 58.5% (141/241), $P < 0.0001$. In separate samples of consecutive un-infected patients having extra-genital swabs, self-swabbing rose from 0% (0/100) to 90% (90/100) $P < 0.0001$.
Conclusion The introduction of routine self -taken extra-genital swabs has led to a large rise in detected extra-genital Chlamydia and/or Gonorrhoea infection, especially for MSM and women. The rise in rates of extra-genital self-swabbing shows that this is acceptable and effective.

P134 CHAPERONES FOR INTIMATE EXAMINATIONS IN A GENITOURINARY MEDICINE CLINIC: AUDIT OF DOCUMENTATION

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10.1136/sextrans-2015-052126.177

Introduction BASHH, GMC, RCP and FSRH provide guidance stating that a chaperone should be offered for intimate examinations and the name of the chaperone should be documented. Record keeping is often found to be suboptimal in litigation. Our proformas have prompts for both offer and name of chaperone.
Aim/objectives To audit our documentation of chaperone offer (including name) for intimate examinations.
Methods 20% case notes for new episodes seen by doctors May–July 2014 were randomly selected and reviewed. Gender of doctor and patient were recorded.
Results 208 case notes were examined. 114 patients were examined (61 not examined; 33 inadequate documentation). 96/114 (84.2%) had the offer of a chaperone documented; 18 (15.8%) did not. Of the 96 where the chaperone was documented as offered, 89 (93%) had the chaperone's name documented; 7 (7%) did not. In 64 cases, doctor and patient were the same gender, and in 50 cases they were opposite gender – chaperone offer was documented in 87.5% and 80% respectively ($p = 0.278$, student's 2 tailed t-test).
Discussion Chaperones for intimate examinations reassure and protect both doctors and patients. With the GMC dealing with just under 30 allegations in 2014 recording of this is potentially pivotal. Despite prompts, only 78% had both offer and name documented. It was concerning that in 33 cases it was not clear as to whether or not an examination had occurred. The results ran counter to expectations with offer of a chaperone higher when patient and doctor were the same gender although this was non-significant.

P135 A MULTI-DISCIPLINARY APPROACH TO FGM REPORTING AND SAFEGUARDING ASSESSMENTS IN THE GUM CLINIC

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10.1136/sextrans-2015-052126.178

Background/introduction Around 103,000 women aged 15–49 in England and Wales are living with the consequences of female genital mutilation (FGM), which has no clinical benefits and is illegal in the UK. Despite this, girls in some communities in the UK continue to have this procedure performed. Mandatory national reporting of FGM cases was introduced in September 2014 and support and safeguarding assessments are required.
Aim(s)/objectives To produce a clinic policy for appropriate assessment of women with FGM.
Methods GUM clinic staff worked with our trust FGM lead, local social services, community paediatric colleagues and support organisations to develop a policy for women with FGM. This incorporates both the mandatory reporting and safeguarding assessment.
Results A clinic proforma for assessing women with FGM was developed to enable clinic staff to follow the new policy. This was introduced following training in November 2014 and we have piloted it since then. To date this has been used to assess 6 women who had undergone FGM; all were black African and one was unaware that she had "been cut". Three women had had type 3 FGM performed, two type 2 and one type 1. Four women reported symptoms as a result of FGM and five stated that they were "against" the procedure. No safeguarding issues were identified.
Discussion/conclusion Whilst implementing the mandatory reporting required for women who have been subjected to FGM, we have successfully developed and implemented a new policy to ensure that appropriate safeguarding assessments are made within the clinic.

P136 SERVICE EVALUATION OF CARE NEEDS OF YOUNG PEOPLE AGED UNDER 25 LIVING WITH HIV: ARE THEY CONSISTENT?

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10.1136/sextrans-2015-052126.179

Background/introduction CHIVA standards recommend all adolescents and young people living with HIV have an individualised care plan to transition them to adult services over time, as is appropriate to their age, developmental stage and social circumstances. Within the UK, adolescents living with HIV acquire the infection either via vertical transmission or sexual acquisition. These 2 groups differ in terms of medical, social and psychological needs, with the former group historically doing less well in terms of adherence and prognosis compared to the latter group.
Aim(s)/objectives To understand and characterise patients under the age of 25 attending for HIV care in a provincial UK adult HIV clinic, and identify care needs.
Methods Case note review of all HIV positive patients attending care under the age of 25.

Results Of 39 patients (29 male, 10 female), mode of transmission was 27(69%) sexual, 11(28%) vertical, and 1 unknown. The vertically-acquired cohort have lower CD4 counts (64% vs 93% CD4 >350), more resistance mutations (including triple class resistance) and lower rates of viral suppression (45% vs 90%) compared to the sexually-acquired cohort. Retention in care is also lower, (72% vs 92% attending in the last year). STI rates are high overall but higher in the sexual transmission cohort, 75% vs 55%.
Discussion/conclusion The under 25 HIV clinic cohort comprises 2 distinct groups: a vertically -acquired cohort with poorer outcomes, who consistently require more support and motivation to remain engaged in care; and a sexually-acquired cohort who adhere to HAART, but have higher rates of STIs and would benefit from support involving motivational interviewing and health promotion.

P137 TACKLING HIV RELATED STIGMA AND DISCRIMINATION WITHIN NHSGGC SERVICES

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10.1136/sextrans-2015-052126.180

Background/introduction Individuals with HIV report experiencing stigma and discrimination. Outcome 5 of the Scottish Government Sexual Health and BBV Strategy (2011–15) aims to address this issue. Locally a system was established to record and collate events on a 'third party' basis, which revealed that most incidents occurred within NHS services.
Aim(s)/objectives In collaboration with the HIV Patient Forum, we examined HIV stigma among NHSGGC staff by:

- Assessing knowledge of HIV
- Measuring HIV attitudes and beliefs
- Capturing staff experiences of HIV stigma

Based on the findings, we are developing an appropriate staff CPD programme.
Methods Between 8–23 July 2013, an anonymous self-complete questionnaire was sent to all 38,000 NHSGGC employees. This was circulated by email from the Director of Public Health with reminders issued via internal staff bulletins.
Results A 10% completion rate was achieved (n = 3,971 responses). Staff

- had variable knowledge of HIV which was much poorer in relation to treatment advances and routes of transmission.
- held mixed attitudes with less favourable attitudes correlated to poor knowledge
- reported practice which could be perceived as discriminating against patients
- expressed a strong desire for greater knowledge and access to training

Discussion/conclusion This survey from the largest UK NHS employer provides evidence that poor knowledge and attitudes are based on outdated information and assumptions which in turn leads to poor patient experiences. This has provided a platform to develop pro-active anti-stigma approaches ranging from a staff-facing campaign, refreshed HIV training and development of a patient empowerment toolkit.

P138 CASH DIRECT: INCREASING PATIENT CHOICE AND ACCESS TO LARC

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10.1136/sextrans-2015-052126.181

Background/introduction Busy lifestyles and women's continued need and desire for reliable methods of contraception, has led to the development of 'CaSH Direct' which offers LARC assessments and procedures at times that are convenient to women but without the need for multiple visits to.
Aim(s)/objectives CaSH Direct aims to:

- Increase women's access to LARC
- Reduce demand on clinics
- Increase women's choices of times and location of procedure
- Reduce the time women spend in clinic
- Make more efficient use of staff time

Methods Women attending clinic and requesting a LARC are offered a telephone consultation at a time that is convenient to them (day or evening) meaning women do not need to take time away from work or family to access the service avoiding the need to wait in clinic to be assessed. Clients are then contacted by a sexual health practitioner who completes an assessment over the phone allowing the woman to take the call in an environment that is familiar to her and without the cost or time implication of attending clinic. A suitable appointment time is made at the end of the assessment for the client to attend an agreed clinic for the procedure to be carried out.
Results Client feedback has proved to be favourable for the service with 70% rating the service as excellent, pressure in walk-in clinics has been eased and appointment times are being utilised more effectively.
Discussion/conclusion CaSH Direct has made a positive impact on service provision and client choice through innovative and effective use of skills within the service.

P139 TO ATTEND OR NOT TO ATTEND – "WHY" IS THE QUESTION?

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10.1136/sextrans-2015-052126.182

Background/introduction Documents such as "10 high impact changes for genitourinary medicine 48 h access" produced by the Department of Health (DH) in 2006 have helped reduce waiting times and increase capacity. Our service experienced a significant increase in the rate of non-attendance of appointments following a change in service base in February 2014. In response we decided to ascertain whether adopting some or all of the DH's high impact changes would improve the poor attendance.
Aim(s)/objectives On review we were already employing most of the recommended changes. One omission was high impact change 5: "Review current access system and make it easier for patients to access the service", therefore we asked patients their preferred means of attendance (appointment or drop in) and times of attendance.
Methods 105 services users were questioned over a 4 week period from the 1st until the 31st August 2014.