Discussion/conclusion Use of the proforma has increased identification of mental health issues, highlighted concerns regarding age differences and provided details of drug/alcohol use, social circumstances and sexual exploitation. The data suggests that use of the proforma allows a more detailed risk assessment thereby increasing the likelihood of identifying safeguarding issues. We initially used the proforma routinely in all under 16 year olds and have since expanded this to all under 18 year olds.

P143 IMPLEMENTATION OF AN ASYMPTOMATIC PATHWAY SIGNIFICANTLY REDUCES CLINIC VISIT DURATION

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Background/introduction Our sexual health clinic in a busy city-centre is experiencing increasing patient demand. The challenge is to provide time-efficient, quality patient-care. Developing a structured screening pathway for asymptomatic patients to be seen by nursing assistants (NAs) could reduce time spent within clinic.

Aim(s)/objectives

1. To successfully and safely introduce a pathway enabling NAs to screen asymptomatic, heterosexual patients.
2. To assess the pathway's impact on patient-care including:
   - Time spent within clinic
   - Screening tests offered/accepted (following BASHH guidance)

Methods

- Baseline data was recorded for two weeks prior to pathway introduction.
- The asymptomatic pathway was implemented, including self-completed symptom questionnaire and patient assessment/testing tool.
- A competency package for NAs was introduced.
- Comparison of patient-care to baseline was made.

Results Eighty asymptomatic patients were identified during the initial two-week period. Following introduction, thirty-three patients followed the pathway. Four subsequently disclosed symptoms and were excluded.

Abstract P143 Table 1 Asymptomatic pathway

	Pre Asymptomatic Pathway (80 patients)	Post Asymptomatic Pathway (29 patients)	p Value
Mean Time in clinic (minutes)	67	44	0.00001
HIV Testing Offered	79 (98.7%)	29 (100%)	0.55
HIV Testing Accepted	66 (83.5%)	25 (86%)	0.65
Chlamydia positive NAATs	2 (2.5%)	0 (0%)	0.39

Discussion/conclusion Early results show significant reductions in clinic visit duration. This improves patient experience, increases patient numbers and allows trained staff to manage complex patients. HIV test offer and uptake increased. More data are needed for future analyses. NAs will continue to be supported in pathway provision. Further elements will be introduced to assess and manage risk-taking behaviour.

P144 VALIDATION OF THE DENVER HIV RISK SCORE FOR TARGETING HIV SCREENING IN VANCOUVER, BRITISH COLUMBIA

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Background/introduction The Denver HIV risk score (DHRS) is a prediction rule developed for targeting HIV testing and validated in U.S. clinical settings (PMID: 22431561). The final model of the DHRS included age, gender, race/ethnicity, sex with a male, vaginal intercourse, receptive anal intercourse, injection drug use, and past HIV testing.

Aim(s)/objectives We aimed to validate the DHRS in patients attending two publicly funded STI clinics in Vancouver, British Columbia.

Methods We validated the model using electronic records (2000–2012) from 47,175 clinic visits. Each visit was scored based on variables included in the DHRS. Visits were stratified into 5 risk groups according to their score: very low (<20), low (20–29), moderate (30–39), high (40–49), and very high (≥50). The model's discrimination and calibration for predicting an HIV diagnosis were examined by AUC and the Hosmer-Lemeshow (H-L) statistic. We examined the sensitivity and proportion of patients that would need to be screened at different cutoffs of the risk score.

Results The prevalence of HIV infection was 0.46%. Validation demonstrated good performance: the AUC was 0.80 (95% CI: 0.79–0.81) and the H-L $\chi^2 = 8.8$, 8 df, $p = 0.36$. HIV prevalence within each risk groups was: 0%, 0.05%, 0.25%, 0.86%, and 1.23%, respectively. HIV testing is recommended for scores of ≥40. The DHRS identified cases with a sensitivity of 96% and a fraction screened of 41%.

Discussion/conclusion The DHRS performed well in these STI clinic settings in Vancouver, accurately identifying individuals at increased HIV risk, and may be useful for providing individualised estimates of risk as part of routine HIV screening.

P145 INTRODUCTION AND TRIAL OF A "CHEMSEX" SUPPORT SERVICE IN A SOUTH WEST LONDON GU CLINIC

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Background/introduction Since 2013 our centre has recognised a problem of recreational use drug associated with sex amongst MSM.

Aim(s)/objectives A joint survey with the local commissioners was set up to establish the extent of the problem in the borough and to identify a need for further services.

Methods 100 HIV negative MSM and 50 HIV positive MSM completed a patient survey with questions regarding recreational drug use related to "chemsex".

Results Results indicated a high level of drug use with 60% (90/150) reporting any drug use and 21% (32/150) specifically using party drugs in the last 6 months. Clients were asked where they would like to have a specialist drug service and the

majority preferred the sexual health clinic as an acceptable venue 37% (56/150). A weekly "in-reach" service was set up with the local Drug Service to run alongside the MSM evening clinic. From August to December 2014, there were 15 clinics in total with 21 visits (max capacity 30 visits). 25% of those seen were from the local borough; the rest of the clients were from neighbouring boroughs.
Discussion/conclusion The service to date has been a clinical and operational success. A patient satisfaction questionnaire completed by 13 clients noted 92% were happy to be seen at this venue, 85% felt the provision of this service was worthwhile and 85% would recommend this service to others. Further work in this area with a targeted MSM history proforma, chemsex leaflet and needle exchange schemes are also being developed.

P146 ESTABLISHING A SEXUAL HEALTH RESEARCH PRACTICE NETWORK IN THE NORTH EAST

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Background/introduction There is a strong tradition of collaborative research and practice in sexual health in the North East of England.
Aim(s)/objectives The North East Sexual Health Research Practice Network brings together colleagues from academia, public health and clinical practice to share research findings and identify research questions based on local issues.
Methods A project group with representatives from local universities, Public Health England and local authorities developed a proposal for a regional sexual health research network to promote collaboration and share evidence of what works. A steering group was established to develop an initial work plan for the network.
Results The network has identified key outputs for its first year –including a website hosted by FUSE (the Centre for Translational Research in Public Health, a collaboration between the five North East universities), a mapping exercise of existing sexual health research in the region and an inaugural Research Practice event to share key findings and plan future projects.
Discussion/conclusion We have identified an enthusiasm for sexual health research in the region, and hope that the network will draw together colleagues working in different fields who may not be aware of the range of work being carried out across the region. We hope that by identifying research questions that are locally meaningful, and by offering support from colleagues with expertise in the field, we will generate research that will inform sexual health practice and commissioning, reduce duplication and ultimately improve the sexual health of people in the North East and beyond.

P147 A TRUST-WIDE AUDIT ON PELVIC INFLAMMATORY DISEASE MANAGEMENT IN A GENITOURINARY MEDICINE SETTING

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Background/introduction Diagnosis and management of pelvic inflammatory disease (PID) in the genitourinary medicine clinic can be challenging. Optimising management is essential in preventing potential sequelae. The national BASHH PID audit (2012) indicated that adherence to guidelines was inconsistent.
Aim(s)/objectives To audit PID management to help inform introduction of new trust guidelines.
Methods Retrospective case note review of all patients with a PID clinic code over six months at three clinics across the trust.
Results Of 184 cases identified, 99.5% of patients had either one or more of PID symptoms: lower abdominal pain, dyspareunia, abnormal bleeding, vaginal discharge. 92% and 97.8% of patients underwent microscopy and STI screening respectively. 16 tested positive for chlamydia, 4 for gonorrhoea, 5 for herpes simplex virus, 2 for trichomonas vaginalis, 47 for bacterial vaginosis (BV), 8 for urinary tract infection (UTI) and 10 for candida. 61% received a recommended treatment regimen, with up to 20 different treatment regimens prescribed. 44% of patients attended for follow-up after two weeks.
Discussion/conclusion In this cohort, there were relatively few STI diagnoses, with BV being the most likely microbiological diagnosis. There was wide variation in prescribing practice and adherence to local and national guidelines. Diagnostic criteria for PID were simplified and disseminated at a trust-wide meeting. New trust guidelines were introduced taking local resistance patterns and national guidance into account.

P148 LOST IN TRANSITION: USER VIEWS ON THE UPPER AGE LIMIT IN ACCESSING CONTRACEPTION AND SEXUAL HEALTH SERVICES

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Background/introduction In 2008 Integrated Contraception and Sexual Health (CASH) Services for those under 25s were launched at community and level-three sites. The age cap of 25 was linked to Chlamydia screening targets.
Aim(s)/objectives Staff highlighted concern regarding older clients and young people under 18 accessing services simultaneously. It was decided to consult user views before changes were made.
Methods Questionnaires were given to those under 25 attending CASH and level-three sites with choice regarding service access and age limit, 18, 20 or 25 and whether they had attended during a dedicated YP session.
Results 295 respondents; 41 male (13.9%). 2/14 <16s (14%), 9/57 <18s (16%), no 18–19 years olds and 10/156 >20s (6.4%) identified as attending during a dedicated YP clinic. 9/15 <16s (60%), 41/58 of <18s (71%), 52/66 18–19 years old (79%) and 125/156 of >20s (79%) preferred the age limit of 25.
Discussion/conclusion Surprisingly the majority of respondents from all age groups preferred 25 to be the maximum age for young people's CASH services. A small number of respondents were under 16 and further work with younger clients to address hidden concerns may be indicated. Older YP still preferred YP-orientated sessions however the majority of respondents attended out of dedicated young people session times highlighting the need for mainstream services to offer a young people friendly service during all sessions.