P198 DOES GUM SPECIALITY TRAINING PREPARE NEW CONSULTANTS TO MANAGE SEXUAL DYSFUNCTION?

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Background/introduction Service provision for patients with sexual dysfunction (SD) in the UK varies according to locality and available expertise. Speciality training in SD may be variable and poorly standardised.

The 2010 GUM curriculum is due for review in 2015. The opinion of senior trainees and new consultants will help inform these curriculum developments.

Aim(s)/objectives We aim to establish

- whether new consultants feel adequately equipped to manage patients with SD
- what additional training is currently being undertaken
- whether additional training opportunities would be welcome

Methods An electronic survey was distributed to 51 trainees within 24 months of CCT and 19 new consultants.

Results The response rate was 39% (27/70) from 9 deaneries. 92% (24/26) felt that having training in SD as a GUM physician was important (46%) or very important (46%). Most trainees had had some exposure to informal teaching 89% (24/27) or departmental teaching 63% (17/27) but very few had formal training. Only 8% (2/26) of respondents felt their training had adequately equipped them to manage SD. 46% (12/26) felt equipped to some extent but 31% (8/26) did not feel adequately equipped to manage SD. 88% (23/26) felt they would benefit from further training.

Discussion/conclusion Many senior trainees and new consultants do not feel equipped to manage SD. The ability to recognise and appropriately refer patients with SD is essential for any GUM clinician. The 2015 curriculum review will help standardise core training in SD, as well as providing opportunities for those who wish to deliver specialised services in future.

P199 CHANGING TEENAGERS' PERSPECTIVES ON THEIR SEXUAL HEALTH: RESULTS FROM AN INNOVATIVE EDUCATIONAL PROGRAMME IN UK SECONDARY SCHOOLS

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Background/introduction UK schools are not obliged to provide comprehensive sex and relationships education (SRE). SRE is frequently outdated, taught by non-specialists, and covers only the technicalities of heterosexual sex and sexually-transmitted diseases.

Aim(s)/objectives We aimed to deliver a peer-led programme of age-appropriate sessions covering sexual, physical, and psychological health, inclusive of non-heterosexual and non-cisgender identities. Sessions were designed to empower young people aged 11–18 to discuss these topics in a non-judgemental environment.

Methods 50-minute sessions encompassed body image, drugs and alcohol, sex and sexual risk taking, or contraception. Trained university student volunteers employed games, small group discussions, quizzes, and visual media. Volunteer to pupil ratio averaged 1:8. Pupils were encouraged to ask questions and reflect throughout. Anonymous written feedback assessed pupils' enjoyment of the sessions, volunteers' teaching ability, and impact of the sessions on their self-perception.

Results 876 feedback forms were completed. 91.8% of pupils enjoyed the sessions and 93.0% rated them as well taught. 61.9% of pupils reported the session to have changed the way they felt about themselves or their health. Free text comments from the remaining 38.1% indicated prior comfort with navigating health issues. Forms also showed high levels of satisfaction with the opportunity to receive non-judgemental, comprehensive responses from relatable peer-educators.

Discussion/conclusion Comprehensive SRE delivered by knowledgeable peer-educators allows teenagers to freely discuss issues surrounding their sexual and mental health, empowering them to make informed decisions and potentially affecting their risk-taking behaviours. This programme demonstrates an innovative but easily replicable means of providing this education.

P200 A FACILITY TO ENABLE HIGH-QUALITY, TIME-EFFICIENT EVALUATIONS OF DIAGNOSTICS FOR STIs

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Background/introduction Control of STIs is challenged by inadequate access to prompt diagnosis and treatment for patients and partners. Novel point-of-care diagnostics have real potential to address some of these challenges but their robust evaluation, and hence utility, is hampered by the ethics and regulatory landscape that confronts industry and academia.

Aim(s)/objectives To develop a diagnostics and clinical facility to deliver high-quality, time-efficient diagnostic evaluations for STIs.

Methods A multi-institutional and disciplinary group (*e*STI[2]) including clinical, public health and social scientists, microbiologists, clinicians, trial coordinators, and North American and European regulatory expertise was established. An 'overarching' ethics, favourable costing, and regulatory framework was carefully developed and put in place to enable any new diagnostic evaluation involving residual and/or additional-to-routine patient-consented samples to start promptly without requiring lengthy ethics applications. Strong working relationships with *multiple* GUM clinics were developed to overcome the potential for clinic fatigue, and Good Clinical Laboratory Practice Standard Operating Procedures were enabled.

Results Since February 2012, the network has conducted several evaluations with both academia and industry, spanning initial 'proof of concept' projects using residual samples, multi-site diagnostic evaluations involving >800 additional-to-routine patient samples completed in four months, and service evaluations of CE-marked assays. A diagnostic evaluation to support an application for regulatory approval will be taking place in 2015.

Discussion/conclusion The development of a diagnostic facility for STIs that fast-tracks high quality diagnostic evaluations is

feasible and has potential for supporting promising diagnostic technologies towards NHS adoption.

P201 TENDERING OF SEXUAL HEALTH SERVICES: A REGIONAL STAFF SURVEY OF IMPACT ON CLINICS AND INDIVIDUALS

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Background The Health and Social Care Act was implemented in April 2013 and has led to tendering of Sexual Health (SH) services in England. By 2014 all of the services in our region had experienced tendering.
Aim To assess the impact of tendering on staff.
Methods Clinical leads within the region were asked to circulate an online survey to all clinical staff within the service. Details on job role, timing of tendering, results of tendering and how strongly individuals agreed or disagreed with statements about tendering were asked for.
Results There were 54 responses from individuals working within 7 services. 9 (17%) agreed with the statement "my physical health has been adversely affected". 34 (63%) disagreed with the statement "the process of tendering has not affected my psychological wellbeing". 39(73%) agreed with "the process of tendering has affected my enjoyment of my work". 25(47%) had considered leaving sexual health as a result of the tender. 24 (45%) agreed with the statement that they knew colleagues who had left SH as a direct result of tendering. 31(57%) agreed with the statement that their colleagues had seen less patients as result of tendering. 25(47%) disagreed with the statement "the tender has impacted negatively on how easily patients can be seen in our service".
Conclusion This is the first survey of staff experiencing tendering and demonstrates the physical and psychological impact on them. It is important to note the potential consequences of tendering on the stability of services as trained staff seek employment elsewhere.

P202 EVALUATION OF INTERFERING SUBSTANCES COMMON TO SWAB AND URINE SPECIMEN USING THE BD MAX™ CT/GC AND CT/GC/TV ASSAYS, A NEW AUTOMATED MOLECULAR ASSAY

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Background/introduction The BD MAX™ CT/GC and CT/GC/TV assays performed on the BD MAX™ System are qualitative multiplex assays designed for the detection of *Chlamydia trachomatis* (CT), Neisseria gonorrhoeae (GC), and Trichomonas vaginalis (TV) DNA in female urine, endocervical, and vaginal specimens, or CT and GC DNA in male urine specimens.
Aim(s)/objectives This study evaluated the performance of the BD MAX™ CT/GC and CT/GC/TV assays in the presence of interfering substances commonly found in vaginal swab and urine specimen.
Methods Vaginal and Urine specimen pool suspensions prepared in BD MAX™ UVE Sample Buffer were inoculated with (44) different biological, chemical, and bacterial substances at a concentration that may be found in urogenital specimens. Suspensions containing interfering substances were subsequently triple-spiked with quantitated cultures of CT, GC, and TV at 2X the Limit of Detection (LOD) for positive specimen. Negative specimens were not spiked with organism. All pools were inoculated into BD MAX™ UVE Sample Buffer Tubes, heated on the BD MAX™ Pre-warm Heater and tested on the BD MAX™ System.

Interference was determined as non-conforming positive or negative test results.
Results Interference was not identified with any of the 31 substances tested for urine. No interference was observed in vaginal swab specimens with the exception of contraceptive foams and gels (>25 μL/mL), metronidazole cream (>2.5 μL/mL) and whole blood (>0.66 μL/mL).
Discussion/conclusion These results demonstrate that the BD MAX™CT/GC and CT/GC/TV assays detect the presence of Neisseria gonorrhoea, *Trichomonas vaginalis*, and *Chlamydia trachomatis* in in the presence of interfering substances common in urine and vaginal swab specimen.

P203 CURRICULUM COMPETENCES-BASED EVALUATION OF GENITOURINARY MEDICINE HIGHER SPECIALIST TRAINING IN A LARGE TEACHING HOSPITAL

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Background/introduction Award of a certificate of completion of training is dependent on registrars attaining 44 competences described in the 2010 Genitourinary Medicine Higher Specialty Training curriculum.
Aim(s)/objectives This study evaluates clinical opportunities of a 4-year modular training programme in a large teaching hospital to determine:

1. Whether opportunity cost of training to service delivery is justifiable.
2. Competences that are inadequately addressed by direct clinical opportunities alone.

Methods Curriculum competences-based evaluation was undertaken with local faculty and trainees quantitatively assessing the 'usefulness' of the modular programme to meet each curriculum competence.

A Quality-Cost Justification matrix determined whether opportunity costs to service provision could be justified for individual clinical opportunities. This considered whether the opportunity is a mandatory curriculum requirement as well as the quality of training determined by triangulating quantitative 'usefulness' ratings of the faculty with qualitative findings of the trainee survey.
Results While 100% (n = 6) of registrars were either satisfied or very satisfied with existing clinical opportunities, these were only sufficiently useful for attaining 23/44 competences. Additional formalised training by way of an academic programme, opportunities to design teaching programmes and research and management experience were required to meet 10/20 GUM, 5/18 HIV, 6/6 management competences.

For all sexual health and 2/6 HIV clinical opportunities, the high quality of training justified the opportunity cost to service provision.