to be successful, both need to work in collaboration to provide accessible and acceptable services.

UG6 PLEASE DON'T TELL MY GP: PATIENTS' CONCERNS ABOUT THE SHARING OF INFORMATION BETWEEN SEXUAL HEALTH CLINICS AND GENERAL PRACTITIONERS (GPS)

[1]Qiang Lu*, [2]Emily Clarke, [1,3]Raj Patel, [1]Harriet Eatwell, [1]Rohilla Maarij. *[1]School of Medicine, University of Southampton, Southampton, UK; [2]Department of Sexual Health, Solent NHS Trust, St Mary's Community Health Campus, Portsmouth, UK; [3]Department of Sexual Health, Solent NHS Trust, Royal South Hants Hospital, Southampton, UK*

10.1136/sextrans-2016-052718.55

Background/introduction At sexual health clinics, patients are asked for permission to contact them by a variety of methods. When patients who have opted-out of GP contact are found to have a sexually transmitted infection (STI) and cannot be contacted despite multiple attempts, a case-by-case decision is often made, regarding breaching the patient's permissions and contacting their GP.
Aim(s)/objectives To determine why some patients decline GP contact, and to assess their views on GP contact against their expressed wishes, in order to treat an STI, when a patient is unable to be contacted by other means.
Methods This was a prospective, qualitative, NRES-approved study involving 10 semi-structured interviews with patients attending a level 3 UK sexual health clinic who had declined GP contact.
Results Three key areas of concern were identified: potential negative implications of permanently recording sexual health problems on GP records, including the effect on future life insurance and job applications; concerns about receptionists in GP surgeries breaking confidentiality in the reception area and being judgmental; and patients' close relationship with their GP. However, 8/10 of those interviewed supported a breach of permissions by contacting their GP in order to treat an STI.
Conclusion With the increased involvement of GPs in delivering sexual health services in the UK, it is essential that action is taken to improve patients' confidence in confidentiality protections at their GP. Sexual health clinics should ensure they explain why GP contact may be required in order to potentially increase patients' willingness for this to occur.

Section 5 Poster presentations

P001 IN 2015, MSM ACCESSING PEPSE IS SIGNIFICANTLY MORE ASSOCIATED WITH CLUB DRUG USE THAN 2013/2014

[1]Zoe Ottaway*, [2]Daniel Richardson. *[1]Maidstone and Tunbridge Wells NHS Trust, Maidstone, Kent, UK; [2]Brighton and Sussex University Hospitals NHS Trust, Brighton, Sussex, UK*

10.1136/sextrans-2016-052718.56

Background/introduction Recreational drug (RD) use is increasing in men who have sex with men (MSM) and increases sexual risk taking behaviour and possibly increasing attendances for PEPSE.
Aim(s)/objectives To identify Club drug use during PEPSE attendances in MSM in 2013/4 compared to 2015.
Methods Review PEPSE (MSM) attendance during two 4-month periods: November 2013 to February 2014 and March 2015 to June 2015.
Results 152 MSM attended for PEPSE: 51 in 2013/4 and 101 in 2015. The median age was 31 (18–79) years. Documentation of Club drug use during PEPSE episode increased significantly from 27/51 (53%) in 2013/14 to 100/101 (99%) during 2015 ($p < 0.001$). Club drug use during PEPSE episode increased significantly from 9/51 (18%) in 2013/4 to 41/101 (41%) in 2015 (OR 3.19, $p < 0.005$). There were no significant changes in the Club drugs being used: *gamma*-Butyrolactone(GBL), Mephedrone and Crystal Meth being the most frequent reported.
Discussion/conclusion Episodes of unsafe sex leading to access of PEPSE appear to be more associated with club drug use in 2015 than in 2013/4 and our documentation of this has improved. Identification of club drug use in MSM is an important harm intervention.

P002 IS ENQUIRY REGARDING ALCOHOL CONSUMPTION AND ALCOHOL REDUCTION ADVICE ACCEPTABLE TO SEXUAL HEALTH SERVICE USERS? A CROSS-SECTIONAL STUDY OF CLINIC ATTENDEES

[1,2]Martyn Wood. *[1]Mid-Cheshire Hospitals NHS foundation Trust, Cheshire, UK; [2]Royal Liverpool University Hospital, Liverpool, UK*

10.1136/sextrans-2016-052718.57

Background/introduction Problem alcohol consumption is a major health problem in the UK. Alcohol assessment and behavioural advice or "brief interventions" are effective in decreasing alcohol intake in primary and secondary care but not in sexual health clinics.
Aim(s)/objectives We assessed sexual health service user views towards alcohol screening using a prospective cross-sectional survey to identify any themes, which limit acceptability of these methods.
Methods Age, gender, alcohol consumption measured by AUDIT-C score, and opinion towards 10 statements on alcohol screening within a sexual health clinic were assessed.
Results 462 surveys were returned. Respondents were 64% female, 36% male. Most, 53.7%, were aged $\geq$25 years, the highest number of responses was received from those aged 20–24 (32.2%), median age category was 25–29 years. The majority of respondents, 61.6% had hazardous alcohol consumption. Males had more positive AUDIT-C scores (indicating hazardous alcohol consumption) compared to females (75% vs 54%, $p < 0.001$). Those aged <30 had more positive AUDIT-C scores (67.9% vs 32.1%, $p < 0.001$). Attitudes to alcohol assessment performed by sexual health practitioners were positive (range 91.1%–74.5% favourable), responses were less favourable, becoming negative towards the appropriateness of the sexual health clinic as a screening venue (range 56.7%-33.6% favourable). Responses to 4 out of 10 opinion statements were related (multivariate regression model) to age or AUDIT-C score.
Discussion/conclusion Different strategies need to be explored within sexual health for alcohol consumption reduction

interventions as clinic users are younger, have higher rates of hazardous alcohol consumption and are potentially more resistant to standard brief interventions.

P003 USING TRADITIONAL SEXUALITY DESCRIPTORS: ARE THEY USEFUL ANYMORE?

[2]Katie Coates, [1]Matthew Phillips*. [1]*Stockport NHS Foundation Trust, Stockport, UK*; [2]*University of Manchester, Manchester, UK*

10.1136/sextrans-2016-052718.58

Introduction Sexuality is a complex topic in sociology and healthcare. It is multifactorial; combining gender, sex, sexual orientation and erotic desires. Three sexuality descriptors are commonly used: heterosexual, bisexual and homosexual. Women who have sex with women (WSW) and men who have sex with men (MSM) are classified as homosexual. These three descriptors are sometimes used in sexual health clinics in the UK as part of the coding to understand the demographics of service users.
Aims We wished to review if these descriptors matched patients' described behaviours in an integrated sexual health clinic.
Methods We reviewed 300 patients presenting to a UK sexual health clinic between April 2013 and September 2013. 100 patients were randomly chosen based on their sexuality descriptor, which had been self-selected when booking in. Electronic patient records were used to access patient histories. Stated sexuality and sexual behaviour were compared.
Results Out of the 300 patients selected, 88 were excluded, leaving 212 for analysis. 18.1% of patients described behaviour outside of the stated sexuality descriptor. 50.1% of the bisexual cohort, 1.8% of the heterosexual cohort and 3.5% of the homosexual cohort described behaviour different from the descriptor.
Conclusion Our findings suggest that the current classifications of sexuality are inadequate to fully capture behaviours, although due to full sexual history taking clinical care is not compromised by this. Personal identity and choice of sexuality descriptors may bias epidemiological understanding of sexual behaviours if relying on these three traditional descriptors.

P004 REGIONAL AUDIT OF THE MANAGEMENT OF SYPHILIS

[1]Sumit Bhaduri*, [2]Lisa Goodall, [2]Kieran Fernando. [1]*Worcestershire Health and Care Trust, Worcestershire, UK*; [2]*Staffordshire and Stoke on Trent Partnership NHS Trust, Stoke, UK*

10.1136/sextrans-2016-052718.59

Background/introduction BASHH guidelines for syphilis management were revised in 2015 and are awaiting publication.
Aim(s)/objectives To review regional clinics' syphilis management and adherence to provisional BASHH audit standards.
Methods Regional sexual health clinics were asked to review cases of syphilis diagnosed the previous year with respect to gender, sexuality, HIV status, pregnancy, screening for other sexually transmitted infections, disease stage, whether non treponemal titres were measured, follow up, treatments given, discussion of the Jarisch Herxheimer (JH) reaction and partner notification (PN).
Results 13/15 (86%) clinics participated. 161 case notes were reviewed. 81% were male, 54% were classified as men having sex with men. 34/161 (21%) were HIV positive. 13/161 (19%) were pregnant (in 84% written communication had been made to obstetric/neonatal teams). 138/161 (86%) were screened for other STIs, 24% cases having concomitant STIs. 63% were early presentations. In 97% an RPR/VDRL was performed at commencement of therapy. 142/161 (88%) were treated with parenteral penicillin. The JH reaction was discussed in 49% of early STS cases. In 75% a four-fold reduction of titres in RPRs was achieved. In 37% the patient attended for follow up for 12 months (16% had no follow up). In 86% of cases PN was performed with 87/161 (54%) of contacts being verified as having attended clinics for screening and treatment.
Discussion/conclusion Areas for improvement regionally include discussion of JH reaction, demonstration of success of treatment, patient follow up and partner notification. A reaudit is planned in the future.

P005 HEPATITIS C SCREENING BY COUNTRY OF BIRTH IN A GENITOURINARY MEDICINE CLINIC- HOW MUCH ARE WE MISSING?

Jennifer Murira*, Eric Monteiro. *Leeds Teaching Hospitals Trust, Leeds, UK*

10.1136/sextrans-2016-052718.60

Background/introduction Screening for Hepatitis C at GUM clinics is recommended by NICE (PH43) in high risk populations. One of these risk groups are people born/brought up in a country with a prevalence >2% of chronic hepatitis C.
Aim(s)/objectives To determine the rate of screening by country of birth in GUM clinic attendees before and after the introduction of a clinic specific guideline for Hep C screening.
Methods All GUM attendees who were seen between October 2013 and October 2014 and were born in a country of Hep C prevalence of >2% were included. This data was linked to whether a hepatitis C serology test had been performed with the results server. The rate of screening before and after the introduction of guidelines in April 2014 was compared. All HIV positive individuals were excluded.
Results During the audit time frame, 2,664 patients were identified as being born in a country with high Hep C prevalence. 1299 attended in the 6 months pre guidelines, 1365 attended 6 months after. Introducing clinic guidelines led to a 2.88 times increase in screening (4.7% vs 13.6%). During this period we diagnosed 3 cases of hepatitis C in people born in a high prevalence country.
Discussion/conclusion Introduction of guidelines improved screening in our clinic however the rate of screening remained low. Assuming 2% prevalence we 'missed' 50 cases of Hep C. Major factors identified were clinician knowledge of the countries that should be screened and asking the patient their country of birth within the sexual history.

P006 WORKING WITH MARGINALISED GROUPS: HOMELESS ADULTS AND STREET BASED COMMERCIAL SEX WORKERS

Sian Warren*, Nicola Lomax. Dept Sexual Health, Cardiff Royal Infirmary, UK Cardiff,.

10.1136/sextrans-2016-052718.61