Background PID is a common condition seen at genitourinary clinics. BASHH published NICE approved guidelines in 2011. To improve consistency amongst clinicians we designed a simple *aide memoire* tick-box sticker. To improve health adviser (HA) contact and reduce "did-not-attend" (DNA) rates we established a HA staffed telephone follow-up clinic

Methods We regularly audit both management of PID and follow-up and so were able to compare data (2011–2015) to demonstrate improvements in practice with these changes

Outcome Partner notification rates improved from 50% to 67% helped mainly by the telephone clinic as HA documented in all cases whether partners had been screened/treated. 82% had a recording of symptom change, previously 77%. For those followed-up using the telephone clinic proforma this was 100%. Results for the number of named male contacts screened for infection and/or treated have improved (2011 = 0.21; 2014 = 0.38; 2015 = 0.48) and we now achieve above the BASHH target (0.4 – large city centre clinic). Over the past five years introducing these measures into clinic has improved all outcomes except DNA rate which remains stubborn (33% vs 27%). For a large city centre clinic the reasons behind this are complex and varied

Conclusions Innovative yet simple measures can be easily introduced which have a positive impact on guideline adherence and also make audit an easier task. With the advent of EPR in many clinics these initiatives should be transferable and aid standardising management across the GU network particularly during this time of change and service integration

P051 AN AUDIT OF BLOODBORNE VIRUS SCREENING AND SAFER SEX ADVICE FOR SEX WORKERS

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Background/introduction Commercial Sex Workers (CSW) are at increased risk of STIs including Hepatitis B virus (HBV) and, for some, Hepatitis C virus (HCV) and sexual assault. These risks can be reduced by vaccination, post-exposure prophylaxis (PEP) awareness and condoms.

Aim(s)/objectives To audit management against clinic policy with respect to documentation of: HBV status; offering vaccination (vacc.) to HBV negative; HCV test; HIV test; PEP information/awareness and offer of condoms. Additional data was collected on new/prior STIs, recreational drugs, and same sex contact.

Methods Casenotes of all attenders between 01/01/12 and 30/09/15 with a SW code were reviewed and additional data collected regarding vaccine uptake.

Results 56 (7 males (12.5%), 49 females (87.5%)) individuals with a total of 243 episodes, with a median of 3 (1–17) visits, were identified. Median age of 30 (range 18–63) with 51 (91%) of white British ethnicity. 38 (67.9%) reported an STI diagnosis prior to the period audited and 13 (23.2%) had $\geq$1 new STI during this period, median 1 (1–3). 21 (37.5%) reported current/recent use of recreational drugs and 31/54 (57.4%) documented same sex contact, (including MSM contact for females). PEPSE was issued at 2/243 (0.8%) of episodes.

Discussion/conclusion The main limitation of the audit was dependence on SW code. Performance was good (>95%) for HBV documentation at first/subsequent visits, offer of HIV test, whilst HCV testing and documentation re. condoms and PEPSE awareness were suboptimal (45–80%). None were IVDU, and policy re. HCV testing in CSW will be reviewed given the low positivity rate.

Abstract P051 Table 1 Blood borne viruses in sex workers

	Test offered	Test accepted	Tested positive
HBV at first visit (*n* = 56)	55 (98.2%)	55 (98.2%)	1 (eAb + sAg)
HCV test (episode, *n* = 243)	193 (79.4%)	176 (91%)	0
HIV test (episode, *n* = 243)	239 (98.4%)	222 (92.9%)	0
	Documented	**HBV status at first visit (*n* = 56)**	**Outcome of those with unknown status at first visit (*n* = 33)**
HBV status (episode, 243)	239 (98.4%)	1 past infection (1.8%)	4 immune (12.1%)
		1 chronic HBV (1.8%)	7 undergoing vacc. (21.2%)
		20 immune post vac (35.7%)	10 vacc. at first visit (30.3%)
		1 not tested (1.8%)	7 vacc. at later visit (21.2%)
		33 status unknown (58.9%)	3 declined vacc, (9.1%)
			2 did not attend vacc. (6.1%)
	Documented	**Not documented**	
PEPSE info/awareness (episode, 243)	111 (45.7%)	132 (54.3%)	
Offered condoms (episode, 243)	174 (71.6%)	69 (28.4%)	

P052 MEN WHO HAVE SEX WITH MEN (MSM) PRESENTING WITH REPEAT BACTERIAL SEXUALLY TRANSMITTED INFECTIONS (STI) REPORT HIGH USE OF ALCOHOL AND PARTY DRUGS

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Background/introduction Bacterial sexually transmitted infections (Chlamydia, Gonorrhoea and Syphilis) are increasing in men who have sex with men in the UK. The reasons for this include alcohol and recreational drug use, availability of PrEP and awareness of HIV treatment as prevention, and social media.

Aim(s)/objectives Our aim was to investigate the factors associated with recurrent bacterial STIs in MSM in Brighton, focusing specifically on drug and alcohol use.
Methods We reviewed MSM presenting to our service between September 2014-September 2015 who had had 3 or more repeat attendances with a bacterial STI. We included infectious Syphilis, pharyngeal, rectal and urethral Chlamydia and Gonorrhoea. We collected data on alcohol and recreational drug use.
Results An estimated 11,000 MSM attended during the study period. Of these, 46 MSM had 3 or more bacterial STIs. The median age was 34.5 years 21–57). 26/46 (57%) were HIV positive. 32/46 (70%) had 3 STIs; 10/46 (22%) had 4 STIs, 3/46 (7%) had 5 STIs and 1/46 (2%) had 6 STIs. 14/46 (30%) reported hazardous drinking, 31/46 (67%) reported use of party drugs (including Mephedrone, Crystal Meth, Ecstasy and GHB) and 7/46 (15%) reported 'slamming'.
Discussion/conclusion MSM attending multiple times with recurrent bacterial STIs also report high use of alcohol and recreational drug use including slamming. Public health interventions to reduce incidence of STIs should include focusing on drug and alcohol use in MSM.

P053 HIV SCREENING IN THE HIV NEGATIVE POPULATION – A REGIONAL HIV NETWORK AUDIT OF SCREENING OFFER, UPTAKE AND TURN-AROUND TIMES

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Background New BHIVA Standards of care for people living with HIV were published in 2013 for proportion of people newly attending sexual health services offered an HIV test in and time from HIV testing to lab reporting and sharing result with patient
Aims Baseline regional audit to assess HIV screening offer, uptake and turn-around times within sexual health services to feedback to commissioners.
Method Standards set from the 'Management of Sexually transmitted Infections' MEDFASH 2014. Retrospective audit of first 30 attendances between 01/09/14 and 30/11/14. Services reviewed notes coded as either HIV testing performed, inappropriate or declined. Information collected included documentation of offer, reason given for decline or deemed inappropriate. For those tested, times taken for lab reporting and sending patient result text was collected.
Results 8 services took part. 0.1% HIV positivity rate. 70% overall had documented reason for HIV test decline. 13% were coded as declined with no documented offer. Percentage of people with needs relating to STI's who had an HIV test at first attendance 97% offered (achieved in 84%, range 59 to 100%), 80% uptake (achieved in 70%, range 47 to 87%). 3/8 of services met both standards for turn-around times. Overall 92% of services received report from laboratory within 5 working days, range 1 to 20 days (standard 97%) and 90% of patients received their result within 10 working days, range 3 to 30 days (standard 95%).
Discussion Not all patients appropriate to be tested were offered HIV test, training as to when HIV testing is not appropriate in Sexual health was recommended. Patients in a long term relationship were most likely not to be offered screening, regardless of previous screening history. There was a large variation between processing times in both laboratories and sexual health services. Good practices for those meeting standards were shared with the network.

P054 PELVIC INFLAMMATORY DISEASE (PID) – IS TELEPHONE FOLLOW-UP FEASIBLE, SAFE AND EFFECTIVE?

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10.1136/sextrans-2016-052718.108

Background BASHH guidelines recommend follow up after PID treatment. A previous clinic audit highlighted high DNA rates for such appointments. In October 2013 we introduced a telephone follow-up protocol for PID to reduce unattended appointments without compromising patient safety and satisfaction. Patients diagnosed with PID were referred to the Health Advisor (HA) at the first consultation to commence the Partner Notification (PN) process. HA's then conducted a telephone follow-up appointment 2 weeks later to ensure treatment compliance and review symptoms.
Aim To audit the performance of the new PID telephone follow-up protocol and estimate number of appointments saved.
Method A 3 months retrospective electronic case note and PN record review of female patients diagnosed with C5A attending between 1/7/14 and 30/9/14.
Results 59 eligible case notes reviewed. Mean age = 25.8 years. 66% (39/59) patients received telephone follow-up. 71% (28/39) patients contacted on first attempt and all were happy to be telephoned. As per PID protocol 23% (14/59) patients with positive Chlamydia, gonorrhoea test or IUD in situ were advised to attend for doctor review. Of these 36% DNA'd their clinic follow up appointment. PN rates 0.8%.
Discussion PID follow up performed by HA telephone consultation is acceptable to patients and HCP's. We saved 39 doctors appointments over 3 months and there was no impact on PN rates or patient safety. Since this audit we now include patients with Chlamydia and IUD's in the telephone follow-up protocol, and men with Epididymo- orchitis. We estimate we could save 280 follow-up appointments a year.

P055 IMPROVING CLINICAL STANDARDS IN GU MEDICINE: A RETROSPECTIVE AUDIT OF NEISSERIA GONORRHOEA 2007 - 2015

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Background/introduction This was a retrospective analysis of clinic performance in the management and treatment of *Neisseria gonorrhoeae* (GC) according to the current British Association of Sexual Health and HIV (BASHH) guidelines.
Methods All cases of GC diagnosed in our clinic between 1st January and 30th June 2015 were identified. The case notes were reviewed and assessed against current BASHH criteria. This was compared to data collected at the same clinic for the