cocaine (6%). 3.7% of service users reported using at least one of the three main drugs typically associated with chemsex.
Discussion/conclusion Our study identified that substance misuse is common in MSM attending sexual health clinics in Greater Manchester. It highlights the need for the robust collection of data during consultation in order to better understand service user requirements.

P139 SCREENING FOR CHILD EXPLOITATION IN ONLINE SEXUAL HEALTH SERVICES: AN EXPLORATORY STUDY OF EXPERT VIEWS

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Background/introduction Sexual health services routinely screen for child sexual exploitation. Although, sexual health services are increasingly provided online there has been no research on translation of the safeguarding function to online services. We studied expert views on safeguarding in this context.
Aim(s)/objectives To explore expert views on safeguarding within online sexual health services and their implications for service development.
Methods We conducted semi-structured interviews with local, regional and national experts purposively sampled to represent a wide range of organisations that have direct influence over CSE protocols, child protection policies and sexual health services. Interviews were analysed by three researchers using a matrix based analytic method.
Results Our respondents described two different approaches to safeguarding. The 'information providing' approach considers that young people, at risk of CSE, will ask for help, when they are ready from someone they trust. The primary function of the service is to provide information, generate trust and respond reliably to disclosure. The approach values online services as an anonymous space to test out disclosure without commitment. The 'information gathering' approach considers that young people may withhold information about exploitation. Services should therefore seek out information to assess risk and initiate disclosure. This approach values face-to-face opportunities for individualised questioning and immediate referral.
Discussion/conclusion The 'information providing' approach is associated with confidential telephone support lines and the 'information gathering' approach with clinical services. The approach adopted online will depend on ethos and the range of services provided. Effective transition from online to clinic services after disclosure is an essential element of this process and further research is needed to understand and support this transition.

P140 THE USE OF PELVIC ULTRASOUND IN AN INTEGRATED SEXUAL HEALTH SERVICE

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Background Clients presenting to integrated sexual health services may have gynaecological and contraceptive problems requiring ultrasound assessment. This would usually need referral to radiology causing delays in diagnosis and engendering patient worry and anxiety. To address this we have developed an in-house ultrasound service.
Aim To analyse if the use of pelvic ultrasound improves the patient journey, avoids referrals to radiology and saves time and potentially money.
Methods Over a 6-month period, 180 transvaginal pelvic ultrasounds were performed. So far we have reviewed 50 case notes. Information collated includes the indication for the scan, the findings and diagnosis. Further analysis of the rest is on going.
Results Preliminary results show that 96% of patients had their ultrasound on the day of initial presentation. Some of the indications for scanning included pelvic pain (36%), confirmation of position of IUC (30%) and abnormal bleeding (10%). 88% of patients were managed within the sexual health service and did not require onward referral. The majority of these had normal scans. Abnormal findings on scanning included fibroids, partial uterine perforation, adenomysosis and polycystic ovaries. 6 patients required referrals; one for a urological problem and 5 for appropriate gynaecological problems such as endometriosis and pelvic congestion syndrome. No radiology departmental ultrasound scans were required.
Conclusion Use of ultrasound in an integrated sexual health service provides patients with a streamlined experience, effectively providing a 'one stop shop' for most sexual health presentations. In the long run it could provide a value-based local service.

P141 A SERVICE EVALUATION FOR AND ON BEHALF OF THE EUROPEAN CLINICAL COLLABORATIVE GROUP (ECCG) - THE MANAGEMENT OF GONORRHOEA ACROSS EUROPE

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Background/introduction Gonorrhoea (GC) cases appear to be rising as well as increasing problems with resistance to many antibiotic groups. With open boundaries and free movement of populations and doctors, a consistent standard of care is important across Europe. Regular evaluation is crucial in controlling the emergent spread of resistant GC.
Aim(s)/objectives To evaluate current clinical practice amongst sexual health physicians across Europe against the current European guidelines. Also, key areas of controversy will be explored with to help inform further guideline development.
Methods The ECCG is a network of 120 sexual health specialists across 38 countries, who conduct questionnaire-based research across the European region. An expert panel consisting of six ECCG members was established then interviewed to help identify areas of controversy. Subsequently, a clinical scenario based questionnaire was developed then disseminated to all ECCG members.
Results Provisional results demonstrate variation in clinical practice across Europe. This is discernable from the choice of treatment for a patient with a history of anaphylaxis to penicillin and

treatment for confirmed pharyngeal infection. In addition, data showed a lack of consensus to guidelines regarding choices of look back period for sexual contacts.
Discussion/conclusion Management of GC varies across Europe and is not always in line with current European guidelines. Although there are minor variations between guidelines, there are vast discrepancies amongst European clinicians regarding clinical practice. There is a need for on-going Europe wide education to ensure that patients are receiving safe evidence based care.

P142 CHALLENGES AND OPPORTUNITIES OF A 'LOOK BACK' EXERCISE ON CHILD TESTING

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Background/introduction The consensus document 'Don't forget the children' 2009 recommends that all HIV units perform a 'look back' exercise to establish the HIV status of children whose HIV positive parents attend that service, as a standard of care.
Aim(s)/objectives To perform a 'look back' to identify children born to HIV positive females in our unit. Determine their HIV testing status and establish a robust pathway for testing and recording outcome.
Methods A retrospective notes review of all HIV positive women registered with the Sexual Health Clinic.
Results 76 women identified, 66 had 149 children. Ethnicity was predominantly African (38/76). 48/76 women acquired infection abroad. Children at risk of vertical HIV transmission recognised in 53/66 women. Child testing identified and documented in 29/53 women (65 children); 8 were HIV positive. 10/53 had children resident abroad (23 children). Parental discussions on-going in 6/53 women. A further 3/53 women declined testing. In 3/53 records were incomplete and 2/53 testing in progress.
Discussion/conclusion Challenges of retrospectively identifying children at risk of undiagnosed HIV highlighted particularly in parents that have not disclosed their status to children. We identified a reliance on verbally reported documentation as evidence of child testing, the challenges of testing older children and the need for robust reporting between paediatric and adult services. Clinicians should continue to ask about children abroad who subsequently join parents in the UK to avoid missed opportunities for testing.

P143 AN AUDIT OF THE MANAGEMENT OF CHLAMYDIA TRACHOMATIS

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Background/introduction Chlamydia trachomatis (CT) is the most commonly reported bacterial STI in the UK.
Aim(s)/objectives We aimed to evaluate our overall management of CT.
Methods All patients with a positive CT NAATs result over a 2month period (August–September 2014) were identified from our electronic patient records; clinical data was collated and analysed using an Excel spreadsheet
Results 180 patients were identified; 54% female, 72.6% aged <25 years, 41.6% of Black Afro-Caribbean/UK ethnicity. 96.6% were heterosexual. 97 infections were from LVS and 1 urine (females); males 82 urine and 2 rectal swabs. Both rectal swabs were negative for LGV. 39% (70/180) were symptomatic; 19 males and 24 females had microscopy performed. 25.5% (46/180) had co-infections. 69% (125/180) had an HIV test; all negative. All contactable patients (174/180) were treated for CT and any co-infections. Three patients were treated elsewhere, and three were uncontactable. The median time from result to treatment was 2 (IQ (0–6) weeks. 36% (65/180) attended for a test of cure. One patient tested positive for CT due to re-infection. 8 patients had HIV tests repeated at their follow up attendance, all negative.
Discussion/conclusion Our centre meets the BASHH 2015 standards. Areas for improvement are HIV testing and performing microscopy in all symptomatic men to enable earlier treatment. We now offer repeat testing at three months only to patients aged <25 years and all MSM via a recall text reminder. This will enable better use of clinic resources through targeting higher risk patients and detecting re-infections as well as treatment failure.

P144 STAFF ENGAGEMENT SURVEY PRE- AND 6-MONTHS POST INTRODUCTION OF ROUTINE DOMESTIC ABUSE ENQUIRY

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Background/introduction In July 2015, routine domestic abuse (DA) enquiry was introduced in a busy, walk-in, inner-London, genitourinary medicine (GUM) clinic. Guidelines, proforma and management pathway were devised. Tiered training was/is provided (basic level for all staff, in-depth for Sexual Health Information Protection team and DA champions). A separate audit demonstrated 91% of walk-in GUM patients were asked about DA, following routine enquiry introduction.
Aim(s)/objectives To assess staff engagement with routine DA enquiry.
Methods On-line survey disseminated to GUM healthcare professionals, two weeks prior to, and 6 months post-introduction of, routine DA enquiry.
Results 27 vs 20 staff completed the surveys. The majority were female [70 vs 90%]. Respondents were doctors [48.1% vs 42.1%], nurses [44.4% vs 57.9%] and healthcare assistants [7.4% vs 0%]. 3.7% vs 20% had worked in GUM < 1 year. 87.5% vs 89.5% had received training, 85.0% vs 100% of these respectively had rated this good-excellent. 4.8% vs 66.7% of respondents reported having managed patients disclosing DA at least once/week. 14.3% pre-introduction vs 0% post-introduction respondents had never managed a patient disclosing DA. Respondents reported feeling 'very confident' asking about DA [16.7% vs 63.2%] and managing disclosures [8.3% vs 26.3%]. 45.8% vs 63.2% thought 'Routine DA enquiry was a great idea…why hadn't we introduced earlier?' 8.3% pre-introduction respondents had some reservations vs 0% post-introduction.
Discussion/conclusion Staff engagement in routine DA enquiry was high from the outset and improved over 6 months. Levels