Methods Retrospective review of 45 randomly selected MSM attending routine HIV care (HIV+ group) OR receiving PEP (PEP group) at each of 2 London clinics during 2014/15.
Results

Abstract P198 Table 1 RDU use in HIV+ and HIV negative MSM

	HIV+ group (*n* = 90)	PEP group (*n* = 81)
Aged <45	29 (32%)	67 (83%)
Offered SHS	47 (52%)	73 (90%)
Accepted SHS	33 (70%)	68 (93%)
Positive for STI	8 (24%)	25 (37%)
Asked about RDU	40 (44%)	78 (96%)
Ever used RDU	18 (45%)	38 (48%)
Used RDU in last 6 months	8 (44%)	37 (97%)
RDU considered problematic	2 (25%)	14 (37%)

The most commonly used drug was mephedrone (81% in PEP group vs 38% in HIV+ group) followed by crystal methamphetamine (54% vs 12.5%). 2/81 (2.4%) in the PEP group tested HIV positive within 3 months of follow up.

Discussion High levels of STIs and RDU were seen in both groups but most significantly in the PEP group. This highlights the importance of identifying RDU/chemsex in PEP patients, which may be an opportunity for intervention to reduce risk of acquisition of HIV through risky sex.

P199 ANALYSIS OF TRAINING NEEDS IN A NEWLY INTEGRATED SEXUAL HEALTH SERVICE (SHS)

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Background The Integrated Sexual Health Services: National Service Specification 2013, includes; Patients to receive their care in a "one stop shop." Staff training should include accredited courses facilitated by BASHH and the FRSH. Key Performance Indicators that relate to the number of staff who are dual qualified.
Method Nurses were identified by their nursing role, band, original speciality and their training needs. The Band 6 (B6) nurses are the initial first training focus. Training for B6 nurses was considered as Essential; (that required to meet service specification) and Non Essential (that required in order to deliver a truly "one stop" holistic care package, or provide training to others).
Aim To identify the training needs of a newly integrated service in order to formulate a strategy which meets the training requirements of the team, whilst retaining high quality service delivery.
Conclusion Integration causes a significant training burden on SHS from a financial, organisational and workforce perspective. Meeting integration training demands is likely to cause disruption to services and staff; resulting in additional stress, increasing sickness and staff turnover rates. Training approach is based upon "quick wins" first targeting those B6 nurses with contraception and Level 2 sexual health experience. B6 Nurses were targeted first as most of their time is spent in clinic; thus improving access, and useful in upskilling others. B6 nurses considered "early adopters" were selected, as likely to have a positive effect on others.

P200 EARLY DETECTION OF SEXUALLY TRANSMITTED INFECTIONS - WERE THERE MISSED OPPORTUNITIES? A QUALITATIVE STUDY IN THE UK

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Background/introduction The early recognition and investigation of outbreaks of sexually transmitted infections (STIs) is vital for preventing onward transmission.
Aim(s)/objectives We sought to understand the facilitators and barriers to outbreak recognition in order to improve early detection. To review the recognition and management of a series of recent outbreaks of sexually transmitted infections in the United Kingdom (UK). To formulate guidance that will enable early recognition of outbreaks.
Methods We interviewed clinicians and public health professionals who had been recently involved in identifying and managing STI outbreaks in the UK. Interviews were audio-recorded and transcribed verbatim. Transcripts were analysed using thematic analysis.
Results Ten STI outbreaks were reviewed, generally by interviewing both a clinician and public health professional. Health advisers and sexual health consultants often noticed increases in cases with smaller clinics often identifying outbreaks more quickly than larger centres through "soft" signals such as increased partner notification, contacts named multiple times or cases with similar geographical location. Sometimes changing demographics first alerted staff. In two centres, increased ceftriaxone use prompted data review. Public Health England (PHE) regional teams identified two outbreaks: one through analysis of the national dataset (GUMCAD); and one via the formal Infectious Diseases Notifications process.
Discussion/conclusion "Soft" signals, picked up in smaller clinics were less readily noticed in larger services. Although quarterly retrospective collation of electronic data by PHE currently limits their role, electronic records should be better exploited locally within services.

P201 EVALUATION OF *CHLAMYDIA TRACHOMATIS* (CT) AND *NEISSERIA GONORRHOEAE* (GC) INFECTIONS IN FEMALE SEX WORKERS (FSW) ATTENDING A DEDICATED SEX WORKER CLINIC

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Background/introduction Previous research shows that female sex workers (FSW) are at high risk of certain sexually transmitted infections (STIs), and that migrant FSW appear to be at even higher risk.
Aim(s)/objectives To evaluate the characteristics of FSW managed by our dedicated sex worker clinics who tested positive for either CT or GC, including information about sexual partners outside of work.
Methods Retrospective case note review of patients identified by the Sexual Health and HIV Activity Property Type (SHHAPT) code 'SW' who also had either CT or GC in 2012–2014.

Results 129 episodes of infection were seen in 114 women. Age range 18–56; 76% (87/114) were ≤30 yrs. 103/114 (90%) were born outside of the UK; 77/103 (75%) were from Eastern Europe. 83/129 (64%) were vaginal infections (CT, GC or both); 40/120 (31%) pharyngeal and 26/129 (20%) rectal. 21/114 (18%) reported unprotected vaginal sex (UPVI) with clients. Where recorded 71/93 (76%) had a partner outside of work; of these 77% reported UPVI. 86/114 (75%) were HIV negative; 16% had never tested. 58/114 (51%) were deemed to have at least one vulnerability.

Abstract P201 Table 1

	2012	2013	2014
Total number FSW seen	560	538	517
*Number of CT infections	16	28	47
*Number of GC infections	8	18	22
Prevalence CT (%)	2.8	5.2	9.1
Prevalence GC (%)	1.4	3.3	4.2

*10 patients had both CT and GC

Discussion/conclusion Prevalence of both CT and GC is high and increasing in FSW, highlighting the importance outreach and testing in this vulnerable patient group.

P202 THE ACCEPTABILITY OF SELF-SAMPLING AT HOME FOR *CHLAMYDIA TRACHOMATIS* AND *NEISSERIA GONORRHOEAE* IN MEN AND WOMEN; RESULTS FROM THE FEASIBILITY STUDY TO DETERMINE THE TIME TAKEN FOR NAATS TESTS TO BECOME NEGATIVE FOLLOWING TREATMENT FOR *CHLAMYDIA TRACHOMATIS* AND *NEISSERIA GONORRHOEAE* IN MEN AND WOMEN

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Background/introduction Self-sampling with nucleic acid amplification tests(NAATs) for detection of chlamydia(CT) and gonorrhoea(NG) is increasingly being used in clinics, with much success. There is some data to suggest that it is acceptable to patients.
Aim(s)/objectives To assess symptoms, sexual behaviour and the acceptability of self-taken swabs for CT and NG, among participants in the 'Time to test of cure study for CT and NG'.
Methods Individuals who had a positive NAAT test for CT and/or NG were eligible. Self-taken specimens from the site of infection were collected at home. Data about sexual behaviour, symptoms and acceptability of home testing with self-taken samples was collected from questionnaires.
Results 102 men (87 MSM) and 52 women were recruited to the study, 84 had NG infection and 71 had CT infection. The median age was 28 years. Unprotected sexual intercourse in the last month was reported by 68% of MSM, 56% of heterosexual men and 51% of women. Symptoms were reported by 25% of MSMs, 50% of heterosexual men and 51% of women. 86% of participants found the information clear and easily understandable. 85% felt confident taking their own samples. 58% found the samples easy to take, 75% were happy to take their own swabs and 78% were happy to take samples at home.
Discussion/conclusion This data highlights the need for screening of asymptomatic patients and provides data to support that self-taken sampling is acceptable to patients. It also provides evidence to support home testing for CT and NG. Therefore allowing for greater access to testing and treatment and reducing the burden of infection in the community.

P203 HIV-TESTING AFRICAN SERVICE USERS WITHIN A NEWLY INTEGRATED SEXUAL HEALTH SERVICE - OUR EXPERIENCE

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Background/introduction HIV testing is recommended for all sexual health clinic attendees, and in generic health services for high risk groups including BME communities, especially in areas of high HIV prevalence such as Leeds (2.51/1000).
Aim(s)/objectives In July 2015 an integrated contraception and STI service, Leeds Sexual Health, began following commissioning by Leeds local Authority wherein the routine offer of HIV testing was extended to all attending service sites across the city, 4 out of 5 of which had previously seen patients for contraception and sexual health (CASH) services only.
Methods We prospectively examined data in those of African ethnicity regarding offer and uptake of HIV testing in these new settings.
Results Interim data indicates a much higher number of African patients accessing the integrated service but with a lower overall uptake of HIV testing, a significant disparity in HIV testing uptake between men and women, with significant numbers of patients choosing not to disclose their known HIV status at a community setting where they are accustomed to only sharing contraception information.
Discussion/conclusion Staff used to achieving HIV testing rates of over 80% in a GUM clinic setting have found patients reluctant to test when they have come expecting the previous service. We are therefore trying to assess genuine missed opportunities for testing and considering reframing HIV testing as a positive and routine intervention e.g. along with postpartum contraception, when trying to embed HIV testing as part of a standard, integrated sexual health care offer.

P204 IDENTIFYING PROBLEM DRUG USE IN MSM ATTENDING A DEDICATED SEXUAL HEALTH CLINIC

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Background/introduction There has been increasing recognition of the sexualised use of drugs (Chemsex) by MSM in recent years. Associations with sexual risk behaviour, HIV and other STIs are well described.
Aim(s)/objectives Our objective was to evaluate self-reported problem drug use in MSM attending a dedicated clinic.
Methods Patients attending the dedicated MSM clinic were given a simple questionnaire at registration, asking about: I) recent