definitions, to manage ongoing care for patients including partner notification.
Aim(s)/objectives Analyse virtual management undertaken with patients following new attendance for episodes of STI care. To ascertain and categorise the number of virtual contacts that prevented a face to face follow up attendance.
Methods Thematic analysis was performed on a randomised sample of telephone consultations definitions between 04/15 and 01/16
Results 82,994 calls were made to automated results systems. 13,373 calls were transferred from the automated system.

Abstract P215 Table 1 Telephone consultations

calls were analysed	2719
No follow up required	969 (35.6%)
Information, support or reassurance only	640 (23.5%)
Previously undiagnosed infections requiring follow up	1054 (38.8%)
Initiation or verification of PN	1150 (42.9%)
Referral to Level 1/2 or other services	68 (2.5%)

Discussion/Conclusion The automated system manages 82% of calls without patients opting to speak with clinicians. Significant numbers of patients opted for telephone consultation upon notification of an infection, giving opportunity for initiation of PN alongside management of further testing and treatment. Approaching ¼ of consultations analysed, showed no additional testing or treatment was indicated, but advice and reassurance was the primary reason for speaking with staff. Virtual consultations can provide a high quality alternative to face to face follow-up visits.

P216 COMMUNITY PHARMACY-DELIVERED CHLAMYDIA TESTING AND MANAGEMENT IN THE UK - A COMPREHENSIVE REVIEW

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Background/introduction Provision of sexual health services in community pharmacies is perceived to be a desirable strategy for increasing access to STI testing and care.
Aim(s)/objectives To comprehensively review the literature on chlamydia services in community pharmacies in the UK
Methods Eight electronic databases (Medline, AMED, BNI, CINAHL, EMBASE, HBE, HMC, PsychInfo) were searched by two researchers independently, until 4.3.16. Search terms were: (1) chlamydia, AND (2) pharmac*. Studies with qualitative or quantitative evidence on community pharmacy-based chlamydia care including screening, testing, treatment, partner notification and training were included.
Results 8 studies, published 2007–2015, met inclusion criteria. They were disparate in terms of subjects: (4 focused on pharmacy staff, 2 on clients), methodology: (2 surveys, 1 qualitative, 1 mixed methods, 1 RCT, 2 cross-sectional and 1 cost-consequence study). Focus varied: treatment 7, screening/testing 5, partner notification 4, training 1, studies respectively. Main findings: pharmacists appear willing to offer chlamydia services if appropriately trained and supported. Barriers to offering opportunistic screening were highlighted. Two studies reported acceptability of screening/treatment but uptake by men in one study was very low (6%). The largest study (1131 people tested positive through pharmacy) reported 47% treated in pharmacy. Preliminary feasibility and acceptability of accelerated partner therapy and expedited partner therapy were shown (2 studies).
Discussion/conclusion Despite considerable policy appetite and pharmacist support for pharmacy-delivered chlamydia care, very little robust evaluation of any element of chlamydia testing and/or management has occurred. Well implemented studies of clinical efficacy, assessing quality of care and cost-effectiveness are warranted.

P217 THE DEMAND AND PROVISION OF INTERPRETATION SERVICES IN AN INNER CITY LONDON INTEGRATED SEXUAL HEALTH CENTRE

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Background/introduction Our centre serves a typical linguistically diverse inner city area. The General Medical Council (GMC) states we must provide our patients with information in a way they understand and, where possible, make arrangements to meet language needs. The trust has its own policy, in line with NHS England, relying exclusively on commercial medical interpretation services.
Aim(s)/objectives To ensure we are responding to the communication and language needs of our clients in line with GMC guidance and trust policy.
Methods A retrospective case note review of patients attending between January 2014 and August 2015 coded as requiring an interpreter. A systematic sample of 100 out of 604 cases was taken.
Results 88 notes were identified as appropriately coded. Place of birth comprised 23 countries with the most common being Ecuador (15, 17%), Spain (15, 17%) and Colombia (11, 12.5%). The most common language recorded was Spanish (32, 36%). The type of interpreter used was documented in 76 (85%) cases with 48% of episodes using telephone Language Line. Other sources of interpretation included friend (9%), family (3.3%), partner (5.5%), clinician (4.4%) and Google Translate (11%) with, at times, multiple sources. Average consultation time was increased by 12.7 minutes. The majority of results (80.3%) were delivered by text in English.
Discussion/conclusion Although the trust recommends exclusive use of commercial interpretation services we are using this in only 48% of episodes. Other sources are utilised but these are not recommended by the trust. It may be that clarified departmental protocol will change practice.

P218 A FULL STOP : PROVIDING A FULLY INTEGRATED SEXUAL HEALTH SERVICE FOR WOMEN ATTENDING TERMINATION SERVICES

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Background/introduction Traditionally Pregnancy Advice Services (PAS) stood apart from Family Planning and Genito-Urinary

Medicine services. Since 2011 Abertawe Bro Morgannwg Health Board deliver an Integrated Sexual Health service.
Aim(s)/objectives To demonstrate the benefits of integrated an service
Methods A case note review of all women attending PAS from 1st to 29th February 2016.
Results 145 case notes of women accessing PAS were reviewed; median age was 25 years (16–43). 137/145 (94%) had a termination procedure, 1 found not be pregnant, 1 miscarried, 3 transferred to BPAS as >18 weeks pregnant, 3 decided to continue pregnancy. At time of initial consultation, 89/145 (61%) had no form of contraception, 30/145 (21%) used condoms only, 20/145 (14%) were using the Combined Oral Contraception (COC) and 6/145 (4%) the Progesterone Only Pill (POP). At the time of discharge, 77/139 (55%) started a new method of Long Acting Reversible Contraception (LARC). 16/139 (11.5%) were prescribed COC, 25/139 (18%) POP and 1/139 (0.5%), contraceptive patch. 5/139 (4%) declined contraception, 15/139 (11%) wanted to access their GP for future contraception. 144/145 (99%) were offered Sexually Transmitted Infections (STIs) screening, 133/144 (92%) accepted dual Nucleic Amplification Assay Tests (NAATs), 7/133 (5%) had chlamydia, 1/133 (0.8%) had gonorrhoea. All 74/144 (51%) tested negative for syphilis and HIV.
Discussion/conclusion This holistic model of care provides women a more immediate opportunity to address their future contraceptive and sexual health needs, with a 55% increase in uptake of LARC and >5% identification of untreated STIs.

P219 RESPONDING TO THE LGV EPIDEMIC: ARE THE RIGHT PATIENTS BEING TESTED FOR LGV?

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Background UK national guidelines will recommend that samples from all *Chlamydia trachomatis* (CT)-positive men who have sex with men (MSM) with proctitis and all asymptomatic CT-positive MSM with HIV should be tested for Lymphogranuloma venereum (LGV).
Aim To investigate case characteristics and test outcomes of samples referred to the Sexually Transmitted Bacterial Reference Unit (STBRU) for LGV testing.
Methods STBRU and GUMCADv2 data for 2014 in England were matched. Test numbers and outcomes for patients in different risk categories were compared to understand targeting of LGV testing.
Results In 2014, 3,782 CT samples were tested for LGV, and 2,426 (64%) were matched to GUMCADv2. MSM accounted for 77% (1876/2426), heterosexual men 7% (178/2426) and women 11% (277/2426) of LGV tests (Table 1). Overall, LGV prevalence was 15% (366/2426), and was highest among HIV-positive MSM (33%; 230/692) and lowest in women (0.4%; 1/277). MSM accounted for 93% (342/366) of all positive samples, and 67% (230/342) of MSM with LGV were HIV-positive. In 2014, there were 3,434 CT diagnoses reported by GUM clinics in HIV-positive MSM, but we found only 692 HIV positive MSM had a CT sample tested for LGV, while 1,639 CT samples were from MSM without HIV, heterosexual men, or women, suggesting inadequate testing of CT samples from HIV-positive MSM.
Conclusion Although miscoding in GUMCADv2 may partially explain some LGV testing in heterosexual men and women and HIV negative MSM, these data still suggest that LGV testing might be targeted more effectively to conserve resources and maximise identification of LGV.

Abstract Table 1 The distribution of LGV tests and test outcomes by sexual orientation and HIV status for patients whose CT samples were referred for LGV testing in England in 2014

	LGV Positive	LGV Negative	Total	% of all LGV tests done in group	% of all positive LGV test results in group	LGV prevalence in group (%)
Total	366	2060	2426	100	100	15.1
MSM	**342**	**1534**	**1876**	**77.3**	**93.4**	**18.2**
HIV positive	230	462	692	28.5	62.8	33.2
HIV negative	112	1,072	1,184	48.8	30.4	9.5
Heterosexual	**14**	**164**	**178**	**7.3**	**3.8**	**7.9**
men	7	29	36	1.5	1.9	19.4
HIV positive	7	135	142	5.8	1.9	4.9
HIV negative						
Women	**1**	**276**	**277**	**11.4**	**<0.1**	**0.4**
HIV positive	0	1	1	<0.1	0	0
HIV negative	1	275	276	11.4	<0.1	0.4
Unknown	**9**	**86**	**95**	**3.9**	**2.5**	**9.5**
HIV positive	6	19	25	1.0	1.6	24.0
HIV negative	3	67	70	2.9	0.8	4.3

P220 THE UPTAKE OF HIV SCREENING AMONG PREGNANT WOMEN AT A GRENADIAN CLINIC

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Background/introduction In Grenada, almost 70% of patients diagnosed with HIV are of reproductive age, however this group is often the least educated about the disease. To prevent vertical transmission, access to testing and treatment is free. Screening for HIV occurs at booking and at 32 weeks gestation. Awareness of HIV status is not only important for the mother and child but also for healthcare professionals involved in her care. Despite this, women continue to opt out of HIV screening. This audit will seek to determine the uptake of HIV screening among pregnant women at a Grenadian clinic and discuss potential barriers to screening.
Aim(s)/objectives Determine the uptake of HIV screening among pregnant women. Explore possible barriers to screening.
Methods Optimal adherence to the screening programme was set at 100%. Retrospective data from women attending the antenatal clinic between 01/06/14 and 01/06/15 were included. Screening status was obtained from the visiting book. Data was then analysed against the set standard.
Results 140 women attended the clinic. 110/140 had opted in for HIV screening giving a screening rate of 79%. Reasons why women opted out of screening were discussed and included: Denial, Ignorance to susceptibility, Fear of discrimination, Confidentiality concerns, Screening at separate location and being unable to breastfeed with HIV-positive status.