Methods We performed a retrospective review of all PEP requests from June-December 2016, following the introduction of this proforma. We investigated exposure types, reported use of condoms, alcohol, drugs, and partners STI status. We assessed appropriateness of PEP decisions in accordance with national guidelines, and compared risk profiles to published findings from 56 Dean Street.
Results 116 PEP assessments occurred in this time, with the specific proforma. All were evaluated as appropriate for PEP. GMHS attendees had same median age (31 years) as those of Dean Street. However, GMHS attendees reported significantly elevated risks of no condoms used (73 vs 54%; p <0.0001), more recreational drugs (30 vs 20%; p = 0.01), with an additional 13% using both drugs and alcohol. GMHS attendees reported more IAI, and significantly less group sex activity (3.5 vs 11%; p =0.02). Partner's viral or bacterial STI status was rarely known.
Discussion PEP is appropriately assessed and provided for GMHS attendees. High risk sexual behaviours are common, requiring comprehensive HIV prevention strategies for the continuing epidemic.

P065 THE GMI COMMUNITY COACHING MODEL – COACHING HIV SELF-TESTING AND SELF-SAMPLING WITHIN HIGH RISK MSM

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Introduction In light of moves towards online provision of HIV services, e.g. self-testing, or online self-sampling, the GMI Partnership wanted to understand whether there was a way in which community based organisations could support and incorporate trends towards online provision of services, as well as understand the knowledge of at risk communities in light of changes, through the provision of community coaching on self-testing and self-sampling. The GMI Partnership provides sexual health promotion and HIV prevention services to 76,000 high risk MSM across London each year, as well as in-depth interviews with at least 4,000 MSM each year.
Methods 2888 online surveys identified existing literacy re-HIV self-testing and self-sampling in MSM (targeted via dating apps.) Recognising that literacy was limited, GMI provided community coaching on self-testing with MSM in high risk venues, to identify whether the intervention was more likely to engender comfort with new technologies (200 quantitative interviews).
Results HIV literate MSM do not understand the difference between self-testing and self-sampling.

The community coaching model ensures high levels of confidence and acceptability in self-testing technologies.
Discussion Community testing models can complement self-testing and self-sampling.

There will always be clients for whom online provision of new technologies will not work.

Scalability of the model within African groups (community based intervention).

P066 RISK REDUCTION' REFERRALS TO A SPECIALIST LONDON HIV AND SEXUAL HEALTH PSYCHOLOGY SERVICE

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Introduction Considering the low number of referrals of 'risk reduction' patients to the HIV and Sexual Health Psychology service in comparison to number of patients presenting with sexual risk taking at referring sexual health clinics, we implemented a 'sexual wellbeing' service development initiative in 2016.

We aimed to compare all the 'risk reduction' referrals in 2014 to 2016 in order to reflect on the impact of the service developments implemented in 2016.
Methods A retrospective case note review was conducted to identify referral rates to psychology over a 1-year period in 2014 and 2016. Age at referral, referral outcome and number of sessions were included.
Results The number of referral increased fivefold from 2014–2016. In 2014, 23 patients were referred. The mean age at referral was 32. 16 patients opted in to the service, 13 engaged in assessment/therapy. The mean number of sessions attended was 5. In 2016, 115 patients were referred. The mean age at referral was 36. 72 patients opted in and 48 patients engaged in assessment/therapy. The mean number of sessions was 3.

40 patients are still engaged with the service and will complete an intervention.
Discussion The service development initiative has resulted in a significant increase in the number of referrals to psychology. Further service initiatives are ongoing to address the continuing low number of patients opting in and engaging with psychological interventions.

P067 ALL BETTER NOW?: COMPLETING THE AUDIT CYCLE FOR PEPSE IN THE EDINBURGH GUM SERVICE

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Introduction Over 2014-2015 in the GUM clinic in Edinburgh we audited PEPSE (post exposure prophylaxis for sexual exposure) as per 2011 BHIVA guidelines. The initial audit results showed that we fell short of the BHIVA auditable standards, most noticeably for proportion of prescriptions within recommended criteria, completion of PEPSE course and STI testing. Based on the results of the audit and the updated 2015 BHIVA guidelines, changes were incorporated into a new local PEPSE pathway. Changes included more detailed patient discussion about whether PEPSE is recommended, providing full 28 day course at first visit if indicated and STI screening at initial visit. We have re-audited PEPSE prospectively August 2016 onwards to see if there was improvement in the standards after the new local guideline was implemented.
Method The following and demographics were documented on Excel Spreadsheet for patients who were prescribed PEPSE and compared with the results of the original audit.

Results For the initial audit in 2014–2015 n= 100, for the re-audit in 2016 at the time of submission n=80.

Abstract P067 Table 1 PEPSE Audit

Percentage of patients with (%)	2014–2015	2016	BHIVA guidance recommendation (2011/2015)
Baseline HIV test	81	90	100
Prescriptions that fit recommended indications	55	71	90
Prescriptions administered within 72 hours of exposure	83	100	90
Prescriptions within 24 hours of exposure	36	44	90
Completion of 4-week course of PEPSE	47	49 completed, 19 ongoing, 32 unknown or incomplete	75
STI screen	51	80	90

Discussion The results suggest marked improvement, though we still fall short of the auditable standards.

P068 PREP FOR IRELAND? AN NGO POLICY PAPER TO INFORM DISCUSSION ON LEGALISING THE AVAILABILITY OF PREP IN IRELAND

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Introduction PrEP is illegal in Ireland and the issue of the introduction of PrEP has not been adequately researched within an Irish context. This paper, due for completion in April 2017, examines the question, 'Should PrEP be introduced to Ireland?'

Methods A comprehensive literature review on PrEP has been completed, to be followed by key informant interviews with national and international stakeholders to ensure coherence with national policy, to capture multiple perspectives and priorities, highlight implementation and operational difficulties, and off-set unintended consequences.

Results The results of this paper will focus on PrEP within five key areas – Public Health Effectiveness, Adherence, Feasibility/Knowledge/Willingness to take PrEP, Risk/Risk Compensation, and Cost/Cost Effectiveness. The findings will contextualise PrEP within key populations of MSM, PWID, as well as Sex Workers and will inform Irish policy makers' decision making by providing input to debates on the pros and cons of introducing PrEP to Ireland.

Discussion It is argued that PrEP adds to the package of proven HIV prevention options already available and is recommended by UNAIDS for use in conjunction with other prevention methods. However PrEP is frequently not seen in value-neutral public health terms and is a contested intervention along economic, ethical, and rights-based axes. This paper examines PrEP in detail in order to inform discussion on its potential introduction within Ireland.

P069 POST EXPOSURE PROPHYLAXIS AFTER SEXUAL EXPOSURE: MANAGEMENT IN ED AND GUM

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Introduction Post-exposure prophylaxis following sexual exposure (PEPSE) is a method of preventing HIV infection. 2015 BASHH guidelines identify criteria for when PEPSE should and could be offered. Our aim was to review patients prescribed PEPSE either at our local Emergency Department (ED) or via GUM between 1st July – 31st Dec 2016 to establish if we are following the BASHH guidelines.

Methods This retrospective study identified patients that were prescribed PEPSE through the ED or GUM using electronic records and paper notes to audit criteria.

Results 176 PEP recipients were identified. Twenty-two of these were not associated with sexual exposure. Two were extending a current course of PEPSE due to new exposure; prescribed according to guidelines. 14 patients received PEP according to the ED register but no documentation was available. 7 patients received PEP in ED with documented exposure risk consistent with the BASHH guidelines but were lost to follow up. 131 PEP patients were seen in GUM. 6 patients presented to GUM after PEP was initiated at a different ED, all these were provided PEP according to guidelines. 35 presented after PEP was started in ED and the rest presented directly. 98% were prescribed PEP according to guidelines. There were 2 that were started on PEP in ED that was discontinued in GUM.

Discussion The majority of patients with available documentation were prescribed PEP according to guidelines. We intend to support our ED service in better documentation of patients presenting for, and prescribe, PEPSE.

P070 A RETROSPECTIVE AUDIT OF THE PROVISION OF PEPSE IN A COMMUNITY SEXUAL HEALTH CLINIC

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Introduction When setting up a specialist GUM clinic within a community sexual and reproductive health service we started offering Post Exposure Prophylaxis (PEPSE) to eligible patients. The patient pathway was to start PEPSE in our service, then attend the HIV clinic in the hospital for all related follow-up appointments.

Aims To audit our practice against the 2011 BHIVA guidelines for the use of PEPSE.

Methods Our electronic record was interrogated for consultations coded as PEPSE between January 2013 and July 2015.