Discussion The audit has shown that the addition of HSV swabs and treatment into the guideline had a positive effect, with more cases of HSV proctitis being diagnosed and treated. Our guidelines were also modified to include LGV treatment, but given the low prevalence this may be rationalised. Ongoing work around coding is also planned as many were coded as proctitis without rectal microscopy.

P109 ROUTINE HEPATITIS C ANTIBODY TESTING IN MSM – ARE WE OVERTESTING?

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Introduction The hepatitis C virus (HCV) is rarely transmitted sexually. MSM with HIV are at increased transmission risk. Debate exists regarding sexual transmissibility of HCV in those without HIV or additional risk factors beyond receptive anal intercourse. Following outbreaks of HCV in Europe and London in MSM, Oxfordshire Sexual Health Services introduced annual unselected HCV antibody testing as a screening minimum for all MSM. Evidence now suggests this may not be necessary. We set out to audit our HCV testing to assess this and identify potential policy modification.
Methods We reviewed all HCV antibody tests undertaken in a 12 month period. We identified all HCV positive patients to determine risk factors for infection in order to establish whether these patients were identified through annual screening or would have been identified using a selective basic risk analysis.
Results We found 13 positive results out of 1351 tests. 6 had previously known HCV, 4 were co-infected with HIV. 2 were heterosexual men with additional risk factors, one was an MSM with additional risk factors. No HIV negative MSM with HCV infection were identified through annual screening alone. Approximately 3.5% of tests undertaken were based on recognised risk factors for HCV, 96.5% were undertaken as part of annual screening. This equated to £1486 per new diagnosis, excluding service costs.
Discussion Routine annual screening of HIV negative MSM in this study did not pick up any new HCV diagnoses. Cost per diagnosis may be reduced with targeted testing. The annual screening policy needs modification.

P110 WORKING SMARTER BY INCORPORATING ONLINE TESTING: MAXIMISING SELF-MANAGEMENT OR OPENING AN ADDITIONAL CHANNEL? A TWELVE MONTH REVIEW

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Introduction We reviewed how the introduction of online access to sexually transmitted infection (STI) testing for a county wide sexual health service has affected face to face (F2F) attendances, and overall attendance numbers.
Methods As part of managing a large county wide integrated-sexual health service we have based our planned attendance numbers on actual activity data from previous years to forecast service activity. In April 2016 we introduced the option of online STI access alongside a complementing triage system. Using electronic record and online access data we compared actual to projected activity, and established the effect of the online service in terms of overall activity for 2016/17.
Results The introduction of an online channel together with a reviewed triage system appears to have directly reduced F2F attendances. The overall activity level including both F2F and online for the service did rise, but based on the cost of F2F attendance compared with theaverage cost of online tests, there are still estimated savings of over £500,000 and predicted reduction of around 10,000 F2F attendances.

Abstract P110 Table 1 F2F and Online testing

Service	Activity plan 2016–17	Activity actual 2016–17 (based on quarters 2 and 3 extrapolated)
F2F	59410	49398
Online access	4654	17118
Total	64064	66516

Discussion People have been satisfied with the online service and it appears to be an acceptable and popular alternative and not and addition to F2F. The reduction in F2F attendances (10,000) frees up clinical time enabling improved and increased resource for complex care and staff and service development.

P111 REACHING OUT – GUM IN THE GENERAL PRACTICE SETTING

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Introduction Providing accessible GU services in rural areas is difficult. Providing a service in General Practice (GP), close to patients' homes may increase access (particularly to those who might not otherwise test) and avoid the perceived stigma of attending a GUM clinic. A GUM service was set up in 2008 within a general practice setting (syndromic management), in an area of high need (HIV prevalence 2.58 PHE 2015).We aim to describe the outcomes of running a GU clinic within GP.
Methods Demographic, attendance and diagnoses data was collected and analysed from 2008–2016.
Results A total of 1081 patients were seen (1826 attendances) with a median of 200(186–221) per year. 604 diagnoses of infection were made (33.1%). 922(85%) lived in the town where the clinic was held. 53.8%(582) had never been seen in GU in our county before compared with 32.6% in the hubs. 440 (41%) were men of which 40(9%) were MSM. Mean age for attendees was 29 (28 at the main GU hub). Total number <20 year olds fell from 2007-2016 but those aged 21–35yrs and 45–60yrs increased. Table 1 shows the distribution of GUMCAD diagnoses. There were 426 DNAs (18.9%), 42% were follow-ups. Overall HIV testing was refused in 15.5% cases, (30% in 2007 but 7% in 2016).