Results 452 patients were included. Age ranged from 14–65 years. 31,18 and 8 patients had positive NAAT, microscopy and AO respectively. Considering NAAT as the gold standard; sensitivity, specificity, PPV and NPV of microscopy and AO was 48%, 100%, 100%, 95% and 28%, 100%, 100%, 94% respectively. 51.6% of the cases would have been missed if only the microscopy was used to diagnose TV.
Discussion Overall prevalence of TV positivity in our study population was 7.52%.Microscopy provided the advantage of rapid result but failed to identify half the positives.TV NAAT testing in carefully selected symptomatic women will be of value to provide better patient care.

P115 SIX YEARS OF OUTREACH TESTING- DOES IT WORK?

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10.1136/sextrans-2017-053232.159

Introduction We have been running an outreach program since January 2009 in order to target high-risk MSM using sex on premise venues.
Methods Monthly outreach sessions to high-risk venues, inc annual pride events, run in conjunction with a LGBT organisation. Patients offered serological testing for HIV, syphilis, hepatitis B and C, triple site testing for Chlamydia/Gonorrhoea PCR and vaccination for hepatitis A and B.
Results Over 6years, 79 outreach sessions held, with 1305 assessments. 226 patients have attended more than once. 424 (68%) patients had never previously attended GUM and 391 (62%) had never had HIV testing. Testing found 13 HIV, 61 untreated syphilis (46 early), 4 chronic active hepatitis B, 63 Chlamydia (21 UR, 36 rec, 6 Th), 48 gonorrhoea (3 UR,18 rec, 27 Th). All patients attended for follow up at GUM clinic. HIV never testers decreased from 34% 2009 to 14% 2014. Vaccines given 160 in 2009, 40 in 2014.
Discussion The outreach program is a very important initiative, reaching high risk men who very often would not have been tested (34% in 2009). There was a high rate of infection diagnosed. Over time less vaccines required, percentage of HIV 'never testers' dropped 34–14% and 6mthly testing increased 13–45%. The outreach has increased access and raised the profile of the health services offered by GUM.

P116 OUR NEW STATUTORY OBLIGATIONS UNDER THE AMENDED FEMALE GENITAL MUTILATION ACT 2003 (SECTIONS 70–75 OF THE SERIOUS CRIME ACT 2015); ONE YEAR ON

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10.1136/sextrans-2017-053232.160

Introduction The UN estimates 200 million women and girls worldwide are living with the effects of female genital mutilation (FGM), with 137,000 victims in England and Wales. Following the introduction of the amended FGM Act 2003 in October 2015, I reported that 1385 new cases were identified in England in the quarter before the new law and 1316 in the quarter following. In keeping with my aim, I have reviewed the data from the year following the new legislation, to determine its effect.
Methods Using hscic and NHS digital data, combined with reports from UN and WHO, I analysed the 12 months following the legislation change. I also searched Ministry of Justice reports to study how many FGM protection orders (FGMPOs) and convictions have been made.
Results Data revealed similar numbers of new cases of FGM reported in each 3-month period since October 2015 (1242, 1293 and 1204 respectively). However, there are large gaps in the data. Since July 2015, there have been 97 applications for FGMPOs and 79 orders. There have still been no FGM related convictions in the UK, despite 32 cases being reported to have happened in the UK between January and September 2016.
Discussion The results are disappointing and we are yet to see substantial change. £4million has been spent and 22,000 FGM training sessions have been delivered but we are still failing to report properly and prosecute offenders. To achieve 2015's Sustainable Development Goals, the UK must play its part to help end FGM.

P117 A REVIEW OF SEXUAL HEALTH PROVISION AT COASTLINE HOMELESS DAY CENTRE

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Introduction
Homelessness goes beyond rooflessness It is isolating and destructive. The government recognises the homeless are more vulnerable to sexual health risks and need targeted interventions. Cornwall's sexual health outreach is limited.
Methods A fortnightly afternoon drop-in sexual health clinic, run by a senior nurse and healthcare assistant, was established in a Health-for-the-Homeless (HFH) General Practice service in a socially deprived area of Cornwall. Shared-care with the HFH service whereby patients gave permission for results to be copied to the GP service.
Results Between September 2013 and January 2017, there were 498 clinic attendances, with 109 (22%) females, and 389 (78%) male clients. Of all attendances, 181 (36%) accepted sexual health screening. Of these, 17 (9.4%) were diagnosed with a sexual infection and/or hepatitis C, including 7 (3.9%) of chlamydia; 4 (2.2%) of new hepatitis C infection; 3 (1.6%) of genital warts; and 1 (0.6%) of: gonorrhoea, herpes and molluscum contagiosum. All infections were treated. 5 (5%) females had cervical cytological assessment. A 140-strong sample of notes were scrutinised to ascertain examination uptake. Of 82 indicated examinations, 26 (32%) accepted, 56 (68%) clients declined. Poor uptake may account for the low rate of skin conditions diagnosed. 20 (4%) attendances culminated in vaccination. The clinic managed 3 (0.6%) recent sexual assault cases.
Discussion Client feedback suggests that medical help would not have been sought elsewhere. Meeting in a safe environment, we believe we have broken down barriers. An increasing number of returning clients we hope reflects trust in the service. Service costing will be discussed to develop contraception provision.