P142 RECREATIONAL DRUG USE IN HETEROSEXUAL MEN IN A SEXUAL HEALTH CLINIC IN EAST LONDON: THE FORGOTTEN MAJORITY?

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Introduction Recreational drug use is widely reported in the MSM population, however its use in the male heterosexual population is less well-described. We undertook a short survey to determine the prevalence of chemsex use in all men.

Methods Self-directed questionnaires were given to all male attendees at a GUM clinic for three weeks in December 2016. Data on demographics, level of education, sexual risk and drug use (including 'chemsex' drugs and other recreational drugs).

Results 268 questionnaires were returned. 70% (182/260) were heterosexual and 63% (155/246) were of white ethnicity. 41% of both the heterosexual and MSM groups had ever tried one drug. Prevalence of recent use (less than 1 year) was 27% (40/149) in heterosexuals and 35% (24/68) in MSM. There was much less use of 'chemsex' drugs in heterosexuals versus MSM (20% versus 9%, p=0.03). Use of crystal methamphetamine and GHB were much lower in the heterosexual population. The highest prevalence of any previous drug use was found in white men vs non-white men (73/133 (55%) versus 11/65 (17%), p <0.05) a pattern was seen in both heterosexual and MSM groups.

Discussion There were surprisingly high levels of recreational drug use in heterosexual men, especially those of white ethnicity. 'Chemsex' drugs still seem to be much more common among MSM, especially crystal methamphetamine and GHB, but the difference in mephedrone use is much less marked. These data highlight the necessity of asking all patients that attend GUM clinics about their drug use, and not only MSM.

Abstract P142 Table 1 Recreational drug use in Heterosexual and MSM.

	Ever Used			
	MSM n (%)		Heterosexual men n (%)	
All	29/70	(41)	59/144	(41)
Cocaine	21/66	(32)	47/139	(34)
MDMA	23/67	(34)	42/134	(31)
GHB	11/65	(17)	3/131	(2)
Ketamine	9/63	(14)	15/130	(12)
Mephedrone	9/65	(14)	11/131	(8)
Crystal methamphetamine	5/64	(8)	2/130	(2)
Legal	1/61	(2)	9/128	(7)
Steroids	0	-	3/130	(2)
Other	4/62	(6)	12/124	(10)

P143 ESTABLISHING A REGIONAL MANAGEMENT PATHWAY FOR PERI-ANAL AND ANAL CANCERS AND PRE-CANCERS IN A MODERATE PREVALENCE HIV SETTING

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Introduction There is a rising incidence of anal cancer and pre-cancer among people living with HIV (PLWH), largely thought to be driven by sexual transmission of the Human Papilloma virus. However, a wide difference in screening methods exists. BHIVA guidelines state centres should incorporate a pathway of managing suspected peri-anal and anal cancers and pre-cancers.

Methods Our aim was to collate data on current screening and referral methods for peri-anal and anal lesions within our region to guide establishing a regional management pathway.

An online survey was sent to specialists involved in managing PLWH. This included trainees and Consultants in Infectious Disease and Genito-urinary medicine. They were asked the methods used, if any, in routine clinics for identifying PLWH with anal and peri-anal cancers and pre-cancers, and whether there was a local established management pathway.

Results 33% of respondents stated that they regularly screened PLWH for peri-anal and anal lesions; the majority by enquiring about symptoms or carrying out proctoscopy examination, largely in men who have sex with men and PLWH with known anogenital warts. Only one Infectious Diseases specialist felt comfortable in using a proctoscope, and 67% of clinicians did not feel that they could be involved in the annual surveillance of peri-anal and anal intra-epithelial neoplasia.

Discussion The results have supported the need for the implementation of a peri-anal and anal cancer and pre-cancer management pathway within our HIV regional network, alongside further education and streamlining of screening within the region.

P144 OPTIMISING CHLAMYDIA SCREENING – A CITY AND COUNTYWIDE APPROACH IN NOTTINGHAMSHIRE

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Introduction The Public Health Outcomes Framework detection rate indicator (DRI) sets a target of ≥2,300 chlamydia diagnoses per 100,000 15 to 24 year-olds. The 2014 DRI in Nottingham City and Nottinghamshire County was 2,807 and 1,900, respectively.

We used the National Chlamydia Screening Programme's Chlamydia Care Pathway (CCP) approach to review 2014 data and identify opportunities to improve the quality of screening and increase the DRI.

Methods Routine surveillance data from GUMCAD and CTAD was used to populate the CCP for the region. Findings were discussed at the local strategic sexual health group and actions agreed.

Results Issues identified were around unknown test offer-rate, low coverage in some districts and low retesting rates following treatment. In response: existing GUMCAD codes were used to infer the offer of a test; health promotion activities focused on raising awareness of testing among key populations, primary care and providers of other young person services; re-testing pathways were audited and a text reminder system for re-screening at 3months was implemented in one of the units.

Discussion The CCP provided a strategic focus to increase understanding of screening at all stages of the pathway. It confirmed the need for an integrated screening approach across sexual health providers, primary care and broader health services who engage with young people. There was potential to achieve 'quick wins' by using the CCP to focus on each specific stage of the programme. 2017 data will be reviewed using the CCP to evaluate the impact of the plans which have been implemented.

P145 LONDON SEXUAL HEALTH TRANSFORMATION PROGRAMME

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Introduction The London Sexual Health Transformation Programme (LSHTP) is a partnership of 32 London Boroughs working to deliver a new collaborative commissioning model for open access sexual health services. The programme has facilitated cross London joint working to set up new services, agree new pricing mechanisms and ensure coordinated expert clinical specifications for all services, producing better outcomes for patients and better value for commissioners.
Methods To deliver this transformation the programme set up three distinct work streams: developing a new pan London e-services model for sexual health to better signpost patients to the right services and provide home testing kits where clinically justified; developing a new pricing mechanism that supports flexibility and planning; and supporting sub regional groups to re commission face to face services with a new agreed clinical specification to support overall system transformation objectives.
Results Transformed services; a new online offering, and a new London wide clinically agreed service specification. Improved resident access and experience. Patients will no longer need to attend a clinic if they don't wish to but will access expert advice, triage and testing in their home or safe space elsewhere. Saved approximately £30 – 40m through collaborative commissioning and patient channel shift away from expensive clinic attendance where it is not needed Built and maintained partnerships across London. It has been a major achievement to construct and sustain a collaborative of 32 London boroughs involved in this programme.
Discussion Is collaboration the way forward for effective commissioning?

P146 HAS THE ACCURACY OF SHHAPT CODING IMPROVED?

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Introduction An audit in 2013 suggested that only 69% of attendances and 64% of Sexual Health and HIV Activity Property Type (SHHAPT) codes were correctly assigned. SHHAPT coding supports the monitoring and reporting of STIs, facilitating robust assessment of service needs, enabling informed planning and better allocation of limited resources at all levels to reduce the level of Sexually Transmitted Infections (STIs). To achieve this coding requires accuracy and consistency and so the audit was repeated in 2016 to assess whether SHHAPT coding in this region had improved.
Methods Six new clinical scenarios were circulated to clinics in one UK region requesting that up to five individuals that regularly participate in completing the SHHAPT code assign an appointment type and the relevant SHHAPT code to each of them. The same scenarios were sent to Public Health England (PHE) and completed to provide the standard.
Results The percentage of correctly assigned attendances is 86% and SHHAPT codes are 75%, respectively.
Discussion Comparing the results from 2016 to 2013, recording of attendance type has improved to 86%, up by 17% and coding of the clinical scenarios to 78%, up by 14%.

Since 2013 new guidance and codes have been issued by PHE. To continue this improvement we suggest that at each regional meeting any new changes in the SHHAPT coding is highlighted and ask those clinicians attending to circulate to those within their department in a way that they belive to be most effective.

P147 AN AUDIT INTO THE OPTIMUM TIME FOR NEISSERIA GONORRHOEAE TEST OF CURE FOLLOWING TREATMENT IN SEXUAL HEALTH CENTRES

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Introduction *Neisseria gonorrhoeae* is the second most common bacterial sexually transmitted infection worldwide and has evolved resistance to several antibiotic classes. BASHH Guidelines 2011 currently recommend ceftriaxone 500mg IM plus azithromycin 1g stat as first line treatment and also recommend a test of cure (TOC) at 14 days. In our centre the time period between treatment and TOC was reduced to 14 days in July 2016. Anecdotal evidence suggests that this may be producing a higher false positive rate.
Methods Clinical notes for all positive gonorrhoea tests (pharyngeal, rectal, urethral, cervical) in a 3-month period were reviewed. Positive TOC were identified and reasons for these assessed (reinfection, treatment failure, false positive). Cycle threshold (CT) values were used to help identify false positives.
Results 7.5% of TOC results performed at 14 days were likely false positive (no risk of reinfection or treatment failure, high CT values), compared with 2.7% of TOC performed after 14 days. 8.3% of pharyngeal samples and 12.5% of urinary samples were false positive. There were no false positives found for rectal and vulvovaginal samples.
Discussion There is a significantly higher rate of false positives when a TOC is performed at 14 days and they are more prevalent in pharyngeal and urinary samples. This has a negative impact on both patient and health care provider time and can lead to unnecessary retreatment. Potential interventions could be to extend the TOC time period, include CT values for all TOC results or move to a less sensitive NAAT for TOC.