P191 PREVALENCE AND IMPACT OF MUSCULOSKELETAL PAIN AMONG STAFF WORKING IN A LARGE INTEGRATED SEXUAL HEALTH SERVICE IN UK

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Introduction Musculoskeletal pain (MSKP) is common and contributes to sickness absence among people of working age. Little is known about the occurrence of MSKP in staff working in Sexual Health (SH).

Methods SH staff working in a large integrated service completed a questionnaire exploring MSKP at several different anatomical sites, its severity and impact on work and personal life.

Results 39/80 (49%) questionnaires were completed. One staff member reporting pre-existing MSK problems was excluded. 92% respondents were female. 61% of doctors and 85% of nurses reported MSKP. Low back (LB) pain was more common in nurses (76%) than doctors (27%). However, involvement of single or multiple sites and overall impact were comparable for both groups. Those with/without pain were not significantly different in terms of age, median time working in SH or types of routine procedures. The most common site of pain was LB (54%). Pain intensity was on average moderately severe during the day (29%) and more severe at night (46%). Moderate to fairly severe impact was reported for work/daily routine (34%), social activities/hobbies (29%), sleep (29%), fatigue/low energy (26%) and emotional wellbeing (23%).

In terms of impact including seeking healthcare, using analgesia, missing work and interference with normal/recreational activities the most common sites implicated were LB, neck and hand pain in that order.

Discussion MSKP is very common among SH staff and causes significant impact professionally and personally. Reassuringly, symptoms were not markedly associated with any particular clinical procedure.

Public Health, Epidemiology and Partner Notification

P192 SYNDEMICS AMONG GAY, BISEXUAL AND OTHER MEN WHO HAVE SEX WITH MEN IN THE UNITED KINGDOM AND THE REPUBLIC OF IRELAND: EMPIRICAL EVIDENCE OF CLUSTERED HEALTH INEQUALITIES

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Introduction Gay men experience a multiple burden of ill health in relation to sexual health, mental health and substance use and there is growing recognition that these could cluster as *syndemic* health inequalities. Few studies (outside the USA) have addressed the co-occurrence of such negative health outcomes. We examine empirical evidence of syndemic health outcomes in an online cross-sectional survey of MSM.

Methods Self-report data on sexual, mental and physical health outcomes from the SMMASH2 survey of 3373 MSM in Scotland, England, Wales, Northern Ireland and the Republic of Ireland in 2016 were used to derive a measure of syndemic ill health.

Results Overall, 68.2% reported at least one sexual health outcome, 60.4% reported at least one mental health outcome, and 61.0% reported at least one physical health outcome. There was significant co-occurrence of outcomes, with 67.0% reporting multiple health outcomes; 42.0% reporting two, and 27.0% reporting all three. There was statistically significant clustering of the behaviours at all levels. When examining all three outcomes concurrently, all were clustered with greater prevalence than expected if the outcomes where independent (O/E Ratio=1.07; 95% Confidence Interval 1.004 –1.14).

Discussion Clustering of poor sexual, mental and physical health provides evidence of syndemic health inequalities in communities of gay, bisexual and other MSM surveyed online (at levels significantly higher than the nationally estimated prevalence of 8.4%). Current health improvement efforts are often characterised by disjointed services, which should be reconfigured to ensure a holistic approach to addressing the complex, multi-faceted, interrelated issues affecting these communities.

P193 MAKING ONLINE CONTACT COUNT: ADDRESSING HEALTH NEEDS IN UNDER 18S ATTENDING SRH

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Introduction The Five Year Forward Review calls for an upgrade in prevention and public health and Making Every Contact Count suggests utilisation of provider encounters to enable positive behavioural change. The London Sexual Health Transformation Programme will be implemented in April 2017 and it is proposed that asymptomatic patients will access services online rather than attending a clinic.

Methods In the financial year 2015 – 16 there were 1975 attendances of 998 individuals <18 at a sexual & reproductive health service. A risk assessment proforma was used in 98.82% (n=505/511) of those 16 or under and 72.9% (n=355/487) of those aged 17. These were analysed using an electronic report.

Results Current mental health problems, smoking, drug and alcohol use was recorded in 837 (97%), 694 (81%) and 818 (95%) records respectively.

Abstract P193 Table 1 Under 18s attending SRH

	Under 16 n=205	Age 16 n=300	Age 17 n=355
Mental health difficulties	47 (23%)	63 (21%)	93 (26%)
Smoking	70 (34%)	85 (28%)	122 (34%)
Alcohol use alone	67 (32.7%)	124 (41.3%)	128 (36%)
Drug use alone	5 (2.4%)	12 (4%)	10 (2.8%)
Drug + alcohol use	14 (6.8%)	18 (6%)	31 (8.7%)

Discussion Mental health difficulties, smoking, drug and alcohol use are common across all ages. Assessment enables health promotion through brief interventions and is important to

identify young people at risk; commissioners should ensure that opportunities are not lost with online access. We suggest commissioning of a one stop shop model for under 18s or robust online screening protocols to ensure opportunities for intervention are not lost.

P194 ROLLING OUT THE UK'S FIRST REGIONAL MSM HPV VACCINATION PROGRAMME: EARLY EVALUATION AND PRACTICAL CONSIDERATIONS

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Introduction The four countries in the UK had different interpretations of the JCVI HPV vaccination recommendations. We aim to describe our experience to date of the full vaccination programme that commenced in our region in October 2016.
Methods We conducted a retrospective review of our opportunistically-offered vaccination programme, using both electronic and paper records.
Results From October 2016 until end January 2017, 827 vaccines were administered to 609 patients. The records of 274 vaccinees were analysed. 59% were HIV negative, 41% positive. 99% were MSM, aged 18 – 67, 12% were over 45, 43% were diagnosed with an STI or had PEP in the preceding 6 months, 74% had no documented history of genital warts. 11% attended solely for the HPV vaccine at their second visit. 91% of HIV positive patients re-attended for their second vaccine at their usual HIV clinic appointment. An estimated completion rate, calculated using those who re-attended as planned at one month and received a second vaccination, was 83%. For the HIV positive cohort, this was higher still at 95%.
Discussion We found that opportunistically vaccinating this cohort resulted in only 11% of all second attendances being solely for a HPV vaccine, and only 6.5% in the HIV positive cohort. Our completion rate, calculated using data at one month, was high. We aim to present a full six months of data.

P195 HOW PREPARED ARE GUM AND HIV CLINICS IN LONDON TO RESPOND TO THE HEPATITIS A OUTBREAK? A SURVEY OF VACCINATION POLICY AND LOGISTICS

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Introduction From late 2016, Hepatitis A virus (HAV) infection in MSM increased in incidence in the UK and has reached outbreak status. By February 2017, 42 confirmed or suspected cases had been reported in London. An outbreak committee was convened by Public Health England and as part of this work data was gathered to ascertain current levels of vaccination and future needs in MSM attending GUM/HIV clinics.
Methods Clinical leads for GUM and HIV services in London were e-mailed a survey asking about past HAV vaccination policy, requirements for vaccine, logistics of vaccine provision, acute HAV infection reporting and contact tracing policy.
Results 14/17 (82%) NHS Trusts, representing 23 clinics responded to the survey.

Abstract P195 Table 1 HAV Vaccination Provision for MSM in GUM and HIV clinics in London

Never stopped in GUM	Stopped in GUM in last 2 years	Stopped in GUM in last 2–10 years	Stopped in GUM >10 years ago
3/23 (13%)	6/23 (26%)	7/23 (30%)	7/23 (30%)
Offered to all HIV+ patients		**Offered to selected HIV+ patients only**	
20/23 (87%)		3/23 (13%)	

4/23 (17%) GUM clinics restarted routine vaccination in 2017. Only 3 HIV clinics were able to estimate background HAV immunity in their MSM as being 70–90% immune/vaccinated. The barriers to roll out of vaccination were identified as cost/funding (17/23 74%); logistics of provision (11/23 48%) and vaccine supply difficulties (7/23 30%). All clinics would contact trace acute HAV cases internally, 6/23 (23%) would notify the Health Protection Team by phone and the rest would notify using the BASHH/PHE notification form.
Discussion The provision of HAV vaccination for MSM in London GUM clinics has been variable, leading to a significant proportion of MSM potentially remaining non-immune. The main barriers to vaccination have been funding, logistics and vaccine supply. If the outbreak is to be halted, these barriers need to be overcome.

P196 THE COST TO FIND ONE CASE OF SYPHILIS

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Introduction Cost effectiveness is an important consideration especially in the context of constrained budgets. For the National Chlamydia Screening Programme, doubling Partner Notification (PN) was modelled to reduce the cost per diagnosis by £60 and improves gender equity (Turner et al, BMJ. 2011; 342:c7250. doi: 10.1136/bmj.c7250); however, it is not known how PN impacts on a less common but growing Syphilis epidemic. We therefore looked at the impact of PN for patients with Syphilis using a new PN tool.
Methods The Syphilis diagnoses and testing for one year from February 2016-2017 were determined for two clinics, prices for testing and PN were derived from the integrated sexual health tariff (www.pathwayanalytics.com) and PN data was obtained from SXT (www.sxt.org.uk).
Results The Syphilis incidence was 257/30,641 and the cost of a full screen £75; consequently, the cost per Syphilis diagnosis was £8,941. Ten percent of patients coded as partners were found to be infected with Syphilis. The PN outcomes of 248 (96%) patients with early infectious Syphilis were known: 132 partners were verified as seen and tested (KPI=0.53), representing 13 new diagnoses. The cost to deliver PN was £4903 [248*(£17.33 tariff & £2.40 SXT)] and ten partners need to test at £750 [10*£75] to diagnose one case, making the