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