be integrated with specialty care to provide optimal clinical management for people living with HIV.

Objective To examine the effectiveness of shared care models of HIV between primary care and specialty care and how primary care providers can assist in improving the care of people with HIV.

Methods Three databases, PubMed, Medline and EMBase were searched for relevant terms from studies published in the period from 1996 to 2011. Studies were included that integrated primary care in HIV management and included highly active antiretroviral therapy (HAART) as part of the treatment modality.

Results 11 studies that met the inclusion criteria were included in this review. Primary care was found to be at least as effective in HIV counselling, testing and treatment and, to a lesser degree, prevention, when compared to specialty care alone. Screening for HIV at a primary care level was cost-effective, especially in a high HIV prevalence and high-risk community. There were no significant adverse clinical outcomes reported in a primary care approach. Effectiveness of various interventions using a primary care approach were demonstrated in the review, including HAART adherence programmes, home care, the involvement of peer health workers and perinatal use of HAART.

Conclusions Primary care has an important role in the shared care of the diagnosis and management of people with HIV. Some improvements with current guidelines on the management in primary care of people with HIV in developing countries should be considered.

P115 LEARNING FROM PATIENTS TO REDESIGN AN HIV SERVICE

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Background/Aims Our HIV cohort more than doubled between 2004/11 with no increase in clinic capacity or staffing. Some of our service users have complex health needs—related to delayed HIV diagnosis, poor adherence to ART and co-morbidities—but an increasing number are stable on treatment and more than half have their medication delivered to their home. We are reviewing our service model to focus on the needs of our complex patients but at the same time providing a responsive, quality service to the stable patients. A key part of this review is to elicit our patients' views on the current service and how it might be improved.

Methods A self-administered questionnaire completed by HIV+ service users.

Results 50 people completed a questionnaire and 76% described their current health as good to excellent. 43% were attending appointments 3–4 monthly, with 39% attending more frequently. 72% wished to continue to be seen at the same frequency. Most (76%) reported that appointments were available at suitable times. Barriers to clinic attendance included poor car-parking (44%) and lack of transport links (13%). A majority (84%) have access to a personal computer and 53% have a webcam—of these 50% would value an online consultation. 32% would consider HIV monitoring by their GP and 33% would like to receive some of their care in this setting. Of the people currently receiving ART delivered to their home 35% would like monitoring to be performed by the individual delivering the medications.

Conclusions Most patients are satisfied with the current model of care and may be reluctant to be seen less often. However there is a softening in the reluctance to involve GPs in HIV care and a willingness to consider models using newer technologies and care at home. We have reviewed our clinic template increasing the number of early and late appointments and are actively developing pilots to explore new ways to deliver care to increase choice and flexibility for our patients.

P116 ASSESSING THE SEXUAL VIOLENCE SERVICES CURRENTLY PROVIDED IN GENITOURINARY MEDICINE CLINICS

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Background Many patients present to Genitourinary medicine (GUM) clinics following sexual violence (SV) occurring in circumstances including sexual assault (SA), domestic violence (DV), sex work (SW) and trafficking. BASHH has guidelines for SA but not for addressing SV in other situations. Are GUM clinics providing services for these needs?

Aims To assess services currently available in GUM for those disclosing SV.

Methods A cross sectional anonymous online survey of UK GUM clinics was performed. The survey was designed by the authors and piloted. Information was gathered on specific clinics for SV, how often they occur and which members of the multidisciplinary team are involved, and training available for SV. Links with other support services was ascertained. The data were analysed using Microsoft Excel.

Results The response rate was 66/178 (37%), with all regions and deaneries being represented. All responding clinics provide PEP, emergency contraception, STI screen, hepatitis prophylaxis and advice for those presenting after SA. 24% of clinics never use chain of evidence procedures. 80% have a local sexual assault referral centre (of these 87% were happy with this service). 80%, 77%, 50% and 38% have no dedicated clinic for female genital mutilation, sexual trafficking, DV and SW respectively and less than 50% have local training or procedures for these facets. 32% ask about non-consensual sex in all GUM consults, 53% ask this in special groups only. 47% routinely ask about SW.

Discussion There is a wide variation in the SV services available at GUM clinics. Sexual assault services meet guideline recommendations for GUM but SV occurring in other contexts may not be addressed. Sexual violence is increasingly reported and GUM clinics may be the first or only location of presentation. We recommend further training and guidelines to ensure clinics are equipped to meet this need.

P117 AUDIT ON UPTAKE OF HIV TEST IN SEXUAL HEALTH CLINIC, ANTENATAL AND TOP SERVICES IN DUMFRIES BETWEEN JANUARY AND JUNE 2011

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Background BASHH introduced "UK National Guideline for HIV testing 2008" recommending universal HIV testing in GUM or sexual health clinics, antenatal and termination of pregnancy services. Early identification HIV positive persons help to reduce further transmission of HIV infection to others and allow referring them to appropriate services for further treatment.

Aims and Objectives The audit was undertaken to identify compliance of local sexual health clinic, antenatal and TOP services with "UK National Guideline for HIV testing 2008". To establish uptake of HIV test by patients accessing Sexual Health Clinic, Antenatal and TOP services in Dumfries between 1st January and 30th June 2011 and give recommendations according to findings.

Methods Retrospective audit of electronic patients' records of all persons accessing the local sexual health clinic in relation to STI issues, pregnant women attending antenatal clinic, patients receiving TOP service care between 1st January and 30th June 2011.

Results From 844 episodes of care in sexual health clinic, HIV test performed in 400 (47%) episodes. 511 women attended antenatal

clinic and 507 (99.2%) of them had HIV test. From 42 patients having TOP, 6 (14.2%) women had HIV test.

Discussion Not all patients might have been offered the HIV test in sexual health clinic. TOP service does not offer the HIV test routinely.

Recommendations Sexual health clinic should offer HIV test to all patients accessing their service and document in patients' medical records that the HIV test was offered. When patients decline the HIV test, reasons for declining have to be documented. TOP service should update their local TOP guideline instructing their nurses, midwives and doctors to offer HIV test to all patients accessing their services. To present findings of the audit to medical staff at local, regional and national levels. To conduct re-audit in 3–6 months once changes have been implemented.

P118

RAPE IN YOUNG ADOLESCENTS: RISK FACTORS FOR ATTENDING A SEXUAL ASSAULT REFERRAL CENTRE AND ENSURING ADEQUATE SEXUAL HEALTH FOLLOW-UP

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Background We are an urban sexual assault referral centre (SARC) also covering a large rural area. We see men and women over the age of 13 who have been sexually assaulted in the last 7 days. In 2011 we saw 53 attendances from adolescents between 13 and 15 years (13% of all SARC attendances).

Aims (1) To review the profile of young victims of rape and sexual assault. (2) Retrospectively review the sexual and emotional health follow-up received by this client group post sexual assault. Method 2 data sets were reviewed. The SARC database were used to identify all clients attending in 2011 aged between 13 and 15 and to collect information including demographics/details of the assault/particular vulnerabilities including alcohol use and whether looked after and accommodated (LAAC) or known to social work. The National Sexual Health electronic patient record (NASH) was then used to review whether these clients attended for any sexual/emotional health follow from their local sexual health services to which they are routinely referred post assault. (A few clients requested referral to their GP.)

Results 32/53 (60%) of clients had been drinking alcohol prior to the assault. 14/53 (26%) of clients were LAAC and a further 12/53 (23%) were known to social work. 5/53 clients had previously attended the SARC and were attending after a second sexual assault and all five clients were LAAC. 36/53 (67%) had specialist sexual health input post assault with five clients due to attend in the next few weeks. Four clients were referred to their GP. Eight clients failed to attend any follow-up and social work were informed.

Conclusion A significant proportion of young adolescents attending our SARC have one or more markers for vulnerability. Health services need to be aware of the increased risk of sexual violence for these clients. Successful follow-up is possible with close liaison between health and social care workers.

P119

INTEGRATED CARE IN SEXUAL HEALTH: A NOVEL TRAINING PROGRAMME TO ENGENDER CULTURE CHANGE FOR TRAINEES IN PRIMARY AND SECONDARY CARE SPECIALTIES

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Background Changes in the NHS dictate that staff in general practice (GP), public health (PH), SRH and GUM work closely together.

This integration cannot be achieved by processes and structures alone. It requires a substantial change in attitude and understanding between the protagonists.

Aim To develop a training programme to increase trainees' understanding of the philosophy and ways of working of other disciplines involved in delivering sexual health care, so as to facilitate collaboration and integrated working.

Methods The day-long programme, first held in February 2011, was delivered to 21 specialist trainees reaching the end of their training in GUM, SRH, PH and GP. The London Deanery funded the innovation and invited participants from among its trainees. Each day was structured to cover: understanding population health; an update on the future of the NHS; workforce planning; involving patients and public; developing services, financial considerations and examining patient pathways. There was humorous stereotyping of specialties followed by group work to dispel misconceptions and understand each other's viewpoint. Speakers represented all invited disciplines and included a senior manager, a third sector leader and a member of the government's Listening Forum. A detailed evaluation of the day included an interval questionnaire after 4–8 months.

Results Two training days have now taken place; a third is over-subscribed for February 2012. Trainees said it was excellent, they found it inspiring and thought provoking. They requested more workshops which have been incorporated. Interval evaluations showed trainees had undertaken joint working and used their learning to prepare for consultant interviews. The model has now been used by London Deanery in related generic training programmes for other professionals and other disciplines.

Conclusion This model programme delivers effective training in leadership and culture change.

P120

CORRELATION OF PATIENT COMPLETED TRIAGE TOOLS WITH PATIENT SYMPTOMS IN AN INTEGRATED SEXUAL HEALTH SERVICE

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Background Triage tools (TT) were introduced in an integrated sexual health service to enable patients to be streamed to the most appropriate healthcare professional. The tool used is a patient completed questionnaire to ascertain reasons for attendance and any presenting symptoms.

Aim To determine whether the TT is a good indicator of patient symptoms and predictor of the skill mix required for the service.

Method A retrospective analysis of case notes reviewed gender, reported symptoms stated on TT and whether these symptoms correlated with the history taken from the patient.

Results 360 notes were analysed (178 females, 182 males), 125/178 (70%) of females were symptomatic according to TT. In 17/178 (9%) the correlation between TT and history taking was deficient. In 8/17 of these cases, issues related to contraception or referral for termination of pregnancy. 53/178 (30%) were asymptomatic according to TT. In 13/53 cases, symptoms were later disclosed on history taking (dyspareunia, vulval discomfort, disclosure of assault or contraception issues). In males, 82/182 (45%) were symptomatic and 7/182 (4%) of cases demonstrated a correlation deficit (eg, disclosure of assault). 100/182 (54%) of cases were asymptomatic on TT of which 24/100 were not on history taking.

Conclusion In 61/360 (17%) of patients the correlation of symptoms was incomplete on history taking compared to the TT. This indicates that although the tool remains a useful guide to patient presentation, clinics require a broad skill mix, including those with experience in dealing all aspects of integrated sexual health.