treated, and 27% (33) were biological false positives. Those with untreated STS—median age 30 (IQR 26–35); ethnicity: 45% (20) black African, 23% (10) black Caribbean, 18% (8) white other, 9% (4) Asian, 2% (1) black British, 2% (1) white British. All women attended the GU clinic for treatment and follow-up; with one exception who remained untreated (late latent STS) and was repatriated prior to delivery to Uganda in 2004. GU screens identified Chlamydia (3), TV (2), warts (2), herpes (1), BV (6), thrush (5) and hepatitis B (4) in those with untreated STS.

Discussion Our innovative MDT approach where each positive antenatal STS result is managed by our GU team has resulted in prompt treatment of untreated cases, identification of untreated STIs, and no reported cases of congenital STS. Our effective robust pathway includes standardised communication with all relevant teams and we encourage its use nationally.

P127 AN AUDIT OF THE MANAGEMENT OF COMPLAINANTS OF SEXUAL ASSAULT COMPARED WITH THE BRITISH ASSOCIATION FOR SEXUAL HEALTH AND HIV (BASHH) 2011 GUIDELINES

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Background The revised BASHH guidelines for the management of sexual assault were published in 2011. Introduction of a new electronic patient record (EPR) at a sexual health clinic provided an opportunity to audit the management of sexual assault.

Aims To review the clinical care of complainants of sexual assault against the auditable outcome measures identified in the guidelines.

Methods The EPR of patients attending between 1 August 2010 and 31 July 2011 was searched using the term "assault." Cases reporting a sexual assault for the first time were included and reviewed against the auditable outcome measures. Demographic data and sexually transmitted infection (STI) test results were recorded.

Results 236 records were identified but 99 cases fulfilled the inclusion criteria. Of the 14 auditable outcomes, only HIV risk assessment reached the 100% standard and seven achieved above 60% concordance (offer and provision of HIV post-exposure prophylaxis, emergency contraception, follow-up tests, forensic medical examination, hepatitis B vaccine and detailed history of assault). Child protection assessment was documented in 57% of under-19s. 28% had the recommended STI tests and 16% were offered STI prophylaxis. There were no self-harm risk assessments documented. STI prevalence was: Gonorrhoea 8%, Chlamydia 9%, HIV 2%, Hepatitis C Virus and Trichomonas 1%.

Conclusion Low STI testing rates overall are explained by Hepatitis B and C testing not previously being a requirement unless there was a specific risk identified. The clinic conducts an automatic risk assessment for under-16s but not for under 19s. STI prevalence was high. A sexual assault pro-forma will be recommended and improved documentation is required.

P128 THE ACCEPTABILITY OF USING SOCCER CLUBS AS VENUES FOR CHLAMYDIA SCREENING IN YOUNG MEN: RESULTS FROM A QUALITATIVE STUDY

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Background Many non-clinical, including sports, settings have been used in an attempt to screen more men for Chlamydia. While feasible there is very little research exploring their acceptability among users of these settings.

Objective We explored the acceptability of, and the best way to deliver, Chlamydia screening in soccer clubs among young men who play amateur soccer.

Methods 18 semi-structured, face-to-face interviews with men aged between 18 and 35 who play soccer in London-based non-professional leagues. Interviews were carried out from October to December 2011 and analysed using a framework approach.

Results Soccer clubs are acceptable venues to access Chlamydia screening because they offer several potential benefits over screening in traditional settings. Importantly they are discreet testing venues and allow screening to take place within the context of normal daily routines. Having testing kits handed out to all team members by a senior member of the club (captain/coach/manager) or a visiting health care professional (HCP) meant that no one would feel singled out for testing and overcome barriers to asking for, or collecting a kit from central collection points. While some men preferred to use the test kit there and then and return samples to a collection point at the club, others preferred to use kits at home and return samples to the laboratory by post. However, concerns about confidentiality and test tampering meant that some men favoured a visiting HCP to coordinate testing rather than a member of the club.

Conclusion Soccer clubs appear to be acceptable venues for young men who play soccer to access self-collected testing kits for Chlamydia. Processes for accessing, using and returning test kits should be discreet, easy and quick. We will be developing testing pathways in soccer clubs to pilot in six London clubs during the 2012–2013 season.

P129 IMPROVING CLINICAL STANDARDS IN GU MEDICINE: A RETROSPECTIVE AUDIT OF *NEISSERIA GONORRHOEAE*

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Objectives This was a retrospective analysis of clinic performance in the management and treatment of *Neisseria gonorrhoeae* (GC) according to BASHH guidelines.

Methods All cases of GC diagnosed at our clinic between 1 January and 30 June 2011 were identified. The case notes were reviewed and assessed against current BASHH criteria. This was compared to data collected in the same clinic from 1 January to 30 June in 2007, 2008 and 2009. The number of cases identified for 2007, 2008, 2009 and 2011 was 41, 61, 78 and 75 respectively.

Results

Criterion	2007 (%)	2008 (%)	2009 (%)	2011 (%)
CR1 >95% of genital GC cases should be cured by first line therapy	77	96	100	97
CR2 100% patients with GC should be screened for *Chlamydia trachomatis* or receive presumptive treatment	100	100	100	98.6
CR3 100% patients should have at least one documented interview with a partner notification trained health professional	82	95	92	92
CR4 100% patients identified should receive written information about STI's and their prevention	32	64	81	61
CR5 100% treated patients should have a test of cure (TOC)	–	–	–	36
CR6 For each case at least 0.6 sexual partners should be verified as having been satisfactorily managed within 4 weeks	0.41	0.33	0.36	0.5

Discussion The number of cases cured by first line therapy improved by 20% between 2007 and 2011, but had decreased by 3% from 2009 to 2011 (CR1). The percentage of patients seeing a health advisor remains the same as in 2009 at 92% (CR3). Supply of written documentation dropped by 20% since 2009 (CR4). Chlamydia screening or treatment decreased by 1.4% from 2009 due to one case (CR2). TOC was poor at 36% but this was due to the guidelines during the data collection time period not requiring a TOC (CR5). Sexual partner notification was still below the expected 0.6 (CR6).

Conclusions Current BASHH targets were missed in all six criterion. In criterion 1, first line treatment was not prescribed with explanatory documentation in two cases. However in both these two cases the culture proved to be sensitive to the antibiotics used. In criterion 2, one case resulted in the target being missed. This patient had refused all tests, but presumptive treatment was not prescribed. Poor written documentation accounts for the failings in criteria 3 and 4. This may have been due to the recent introduction of electronic patient records. It is hoped that recent improvements to the system may improve these figures. Future audits should show an improvement in TOC as the new guidelines are adopted. Finally although criterion 6 has not met the BASHH target this year, it is a significant improvement on previous years results.

P130 ANTIBIOTIC RESISTANCE PROFILES OF *NEISSERIA GONORRHOEAE* (GC): A COMPARISON OF DATA 2007–2011

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Objectives This was a retrospective analysis of antibiotic use and resistance profiles of GC at a UK GU clinic.

Methods All GC cases at our clinic between 1 January to 1 June in 2007, 2009, and 2011 were identified. The case notes were assessed for antibiotic resistance. The number of cases identified was 41, 78 and 75 for these respective years. Data on diagnostic method was also collected last two cohorts.

Results 63%, 56%, and 69% of patients diagnosed with GC were male in 2007, 2009, 2011 respectively. In 2011 the mean age of patients was 26, and the median 23. 19.5%, 8% and 12% were men who have sex with men (MSM) in 2007, 2009, 2011 respectively. First line antibiotics each year were as per BASHH guidelines (see abstract P130 table 1).

Discussion In 2011 the antibiotic sensitivity was unknown in 41%, it was 35% of cases in 2009. In 2011 27% of all cases were culture negative despite positive NAAT test. In 15% of all cases no culture was performed. Those without positive culture were diagnosed by NAAT, and in one case microscopy. Of those positive by NAAT alone 52% were female, compared to 75% in 2009. In 2011 54% with positive NAAT alone had co-current *Chlamydia trachomatis* infection, compared with 40% of all GC patients. 100% of females with GC in 2011 were NAAT positive, compared with 69% in 2009. 83% of males with GC in 2011 were NAAT positive compared with 80% in 2009.

Conclusions This data suggests that the levels of resistant gonorrhoea within our clinic reduced between 2007 and 2009, but has since risen in the last 2 years. This would indicate the need for the recent change in first line antibiotics. This could be a reflection of the changing percentages of MSM in the cohorts, which have altered in line with our antibiotic sensitivity. A large number of patients diagnosed with GC are culture negative. This may reflect the high sensitivity of NAAT or a high rate of false positive NAAT. It is interesting that a large proportion of those positive by NAAT alone are co-infected.

Abstract P130 Table1

Antibiotic resistance profiles	2007 (%)	2009 (%)	2011 (%)
Percentage of GC fully sensitive to antibiotic testing panel	46	67	59
Percentage of GC fully sensitive to antibiotic testing panel	27	15	20
Reduced susceptibility to two antibiotic groups	15	10	16
Reduced susceptibility to three or more antibiotic groups	12	2	5

P131 SEXUAL HEALTH FOR THE BRITISH FORCES IN GERMANY [BFG]—A NURSE-LED SERVICE

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Background Before 2008 GUM provision in BFG comprised one central and two satellite GUM clinics. Run by a F/T consultant and 3 or 4 nurses, it covered an area the size of Scotland with little primary care input. Since 2008 Guy's and St. Thomas' [GSTT] and SSAFA Forces Help have held the contract to provide GUM services to the BFG population. The contract was for a nurse-led service with consultant cover provided remotely and through monthly visits from the UK.

Aim To increase provision of screening and management of STIs across BFG by the new [reduced] staff.

Objectives To modernise the GUM service; to develop the 15 primary care medical centres across the region to provide level 1 and 2 GUM service, and to offer out-reach screening to soldiers and school children.

Methods The labs replaced routine cultures and chlamydia PCR with dual NAATs making it cost neutral. We modernised the GUM service and encouraged testing, especially for HIV. Training for primary care providers included STIF courses. Once trained, GPs supported their nurses to deliver screens. The GUM nurses visited medical centres to encourage and support provision. We also instituted young peoples' services for schools and targeted screening to soldiers at Health Fairs.

Results 60 multi-professionals have attended our STIF courses, mean evaluation score is 4.4/5. We used figures from the lab servicing the majority of BFG. Despite a steep decline in the community [soldiers, their dependants and contractors] from 46k in 2008 to 36k in 2011, there has been a marked improvement in all measures of SH provision. The GUM workload has also risen and HIV tests have doubled.

Conclusions We describe a successful, innovative, cost effective model for a nurse-led GUM service which could be used elsewhere. There is now a vastly increased availability of STI screening for our scattered, high-risk population. We will present data for 2008–2011 by age and gender (see abstract P131 table 1).

Abstract P131 Table 1 Characteristics of GUM service of British Forces in Germany

Changes in GUM service outcomes from 2007 to 2011	2007	2011	Comment
Total population of BFG	48k	36k	25% decline
New/rebook attenders	2427	2154	11.2% decline
Follow-up patients	1162	377	67.6% decline
Total chlamydia tests in GUM*	2149	1916	10.8% decline
Chlamydia positivity rate	16.8%	11.6%	30.1% decline in incidence
Gonorrhoea diagnoses	33	24	27.3% decline in incidence
Tests at Health Fairs*	0	239	7.5% chlamydia positive
GP Chlamydia tests*	787	1415	79.8% increase
Chlamydia positivity rate	7.4%	6.1%	17.6% decline

*These tests were dual NAATs [chlamydia and gonorrhoea] from 2009.