for attendance. In addition a questionnaire survey was administered prospectively to 172 rebook patients as regards reasons for re-attendance.
Results In the retrospective study, 106/150 (71%) were female, the average age of males was 30.4, the average age of female was 23.9. 56% (84/150) of patients attended three times or more related to genital warts, genital herpes, pelvic pain, contraception or recurrent bacterial vaginosis. In the prospective survey. 24% stated that they had re-attended because of genital warts, recurrent genital soreness or pelvic pain. 73/172(42%) were asymptomatic. Between 48–63% stated they preferred to attend because of the expertise, friendliness and confidentiality of the clinic.
Discussion/conclusion In one study, 56% of attendees had attended with recurrent issues not related to recurrent bacterial STIs. Between 48–63% had attended related to friendliness, expertise and confidentiality of the clinic inferring that quality of care and confidentiality are important factors in reasons for re-attendance.

P103 HOW AND WHY DO WE DO TESTICULAR ULTRASOUNDS? A NATIONAL CLINICAL DEVELOPMENT GROUP SURVEY OF GENITOURINARY MEDICINE CLINICS

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Background/introduction There is a paucity of guidelines for when testicular ultrasound (USS) should be performed and how easily GUM clinics should be able to access scans.
Aim(s)/objectives To establish what pathways are in place for USS requests and clinical prompts to order a scan.
Methods A 10 question survey was designed using Survey Monkey. This was approved by the BASHH Clinical Development Group, and disseminated within the network via the regional representatives.
Results The link was sent to 139 leads and completed by 111 clinics (79%). The majority of respondents (92.79%) had USS located in hospital. 72.97% services had no guidelines and 48.18% had no pathway for urgent scans. 77.48% requested between 1–6/ USS month. No service had to wait > 2 weeks for urgent requests, with 23.85% services having same day access. Ranking for symptoms and signs showed 62% services would often/ always scan for a mass present >14 days, and 92.79% always scan a hard, painless testicular mass.
Discussion/conclusion The majority of services have access to timely USS, although half do not have established pathways for urgent scans. The most concerning clinical features are the persistence of swelling and mass consistency, but for other features, such as pain, respondents felt that further information is required. In general, patients are relying on clinical judgment of experienced clinicians to decide the need for requesting scans. With integration of practitioners with different skills, there is need for a more standardised approach for how, when and why we perform testicular ultrasounds.

P104 PATIENT STORIES: WHAT CAN WE LEARN FROM LISTENING TO HEALTHCARE WORKERS WITH HIV

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Background/introduction Issues faced by healthcare-workers (HCW) with HIV are complex. HIV positive individuals continue to experience unacceptable levels of health related stigma. National HIV testing week offers a perfect platform to raise the profile of HIV within our hospital Trust.
Methods HIV positive healthcare workers were approached and asked to write an account of their experiences of testing, living and working with HIV and whether they had chosen to disclose their status to colleagues and the outcome of that experience. Key themes were extracted from the stories.
Results Six healthcare workers living with HIV, on treatment, in care, agreed to share their stories. Key themes from the stories were: missed opportunities for HIV testing pre-diagnosis, misdiagnosis and misunderstanding of HIV from HCW, feeling judged and experiencing prejudice from HCW, loss of professional confidence due to negative attitudes towards HIV/AIDS from HCW, delayed or non-disclosure of HIV status due to experiencing negative comments or behaviours towards HIV in clinical settings: however HCW who disclosed their status at work experienced significant support and empowerment, including a desire to teach and train HCW. Patient stories were used in HIV testing week to promote testing as part of a larger HIV-awareness campaign.
Discussion/conclusion Engaging HIV positive healthcare workers as part of a strategy to increase awareness of HIV in healthcare settings is empowering for patients and a powerful message to colleagues.

P105 SEXUAL HEALTHCARE PROFESSIONALS' ATTITUDES TOWARDS HPV VACCINATION FOR MEN IN THE UNITED KINGDOM

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Background/introduction Men who have sex with men (MSM) are at risk of HPV-associated genital warts and cancers but are unlikely to benefit from female-oriented HPV vaccination.
Aim To examine the attitudes of sexual healthcare professionals (SHCPs) towards HPV vaccination of men in the UK.
Methods An e-survey of SHCPs' views was conducted in July–August 2014. Members of UK-based professional sexual health associations were invited to participate by direct email and members' newsletters. Responses to 18 statements, with corresponding Likert scales, were used to examine their views on HPV vaccination.
Results Amongst 325 respondents (46% Doctors, 26% Nurses and 15% Health advisors), 14% are already vaccinating men against HPV and 83% would recommend gender-neutral HPV vaccination. While 64% would also recommend targeting MSM,

18% were against this strategy. Only 44% reported having sufficient knowledge about the use of HPV vaccine for MSM and 49% reported having skills to identify MSM likely to benefit from HPV vaccination. While 19% agreed that it is too late to offer HPV vaccine to sexually active MSM, 53% thought all MSM, regardless of their age, should be offered the vaccine.
Conclusion SHCPs perceived the need to vaccinate MSM against HPV. Despite insufficient knowledge, a gender-neutral HPV vaccination strategy was favoured over targeted HPV vaccination for MSM. Clear advice and guidelines for SHCPs on HPV vaccine use in men at sexual health clinics are required to ensure equitable opportunities for vaccination. If MSM-targeted HPV vaccination is recommended, SHCPs' attitudes need to be taken into account to achieve optimal uptake.

P106 HOW SHOULD PATIENTS BE CALLED FROM THE WAITING AREA WHEN ATTENDING FOR SEXUAL HEALTH SERVICES? A SERVICE EVALUATION

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Background/introduction The initial encounter between health professional and patient is fundamental to establishing rapport. It is important in a sexual health setting that patients feel at ease with however they are identified in the waiting area. Recent research suggested patients with HIV preferred to be identified by first name whereas most others preferred a number, and *all* patients in these categories should be called in these ways.
Aim(s)/objectives To determine the proportion of patients who expressed a preference to how they were called from the waiting room. And, to determine whether there was any association with reason for attendance, age, gender or HIV status.
Methods 167 patients who attended a drop-in clinic in October 2014 and 50 patients with HIV who had recently attended for HIV care were identified and included. Pearson's Chi-Squared Test was used to analyse the relationship between calling preference and sex, reason for attendance, and age (based on the median age of 26). When assumptions were not met, Fisher's exact test was used.
Results 60.8% (n = 132) of patients expressed no preference as to how they would like to be called from the waiting area. 36.4% requested their real details be used, 2.8% requested false details be used (n = 6). There was no statistical significance found between reason for attendance and preference (p = 0.406), age and sex did not significantly influence preference (p = 0.172, p = 0.288).
Discussion/conclusion The results suggest offering every patient the choice of how they wish to be addressed would be the most appropriate method used to call patients from the waiting area.

P107 SEXUAL HEALTH SERVICES FOR MEN WHO HAVE SEX WITH MEN (MSM): ARE THEY ACCEPTABLE?

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Background/introduction Locally, there is a large population of MSM. MSM have high and increasing rates of STIs and HIV: sexual health services should be accessible and MSM focussed.
Aim(s)/objectives The aims of this study were to assess patients' satisfaction with the current services, preferences on staff gender, preferences on self-taken rectal and throat swabs, and the need for a specialist MSM service.
Methods Patient satisfaction survey of MSM attending four MSM-services in our city (hospital-based STI clinic and HIV clinic, a local non-government organisation (Terence Higgins Trust) and a walk-in primary care centre). Data were analysed using SPSS.
Results 246 MSM completed surveys between January–March 2014. The median age was 35 years (18–79). Most MSM (92.3%) self-identified as gay, 7.3% as bisexual and 0.4% as other. 12.7% self-identified as HIV-positive, 61.1% HIV-negative, 20.0% unsure and 5.7% never tested. 206/246 (83.7%) did not have a staff gender preference, the male: female staff preference was 35:5/246 (14.2%:2.0%). 113/227 (49.8%) would welcome self-taken rectal/throat swabs. 101/232 (43.5%) would prefer to be seen in a specialist MSM service. Overall, there was no significant difference in preference between HIV-positive and HIV-negative/unsure/never tested. The overall satisfaction with reception staff was 95.5% (outstanding/good) and 99.1% with doctor/nurse (outstanding/good).
Discussion/conclusion Overall, there is high satisfaction with sexual health services currently provided to MSM locally. Most patients do not have a staff gender preference but almost half of MSM would prefer a specialist service. We concluded that offering self-taken rectal and throat swabs would be acceptable for many MSM patients.

P108 HOW DO MEN WHO HAVE SEX WITH MEN FARE IN INTEGRATED SEXUAL HEALTH CENTRES? AN AUDIT OF HEPATITIS B VACCINATION RATES BEFORE AND AFTER INTEGRATION

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Introduction In Scotland, Health Improvement Scotland (HIS) standards require that 70% of men who have sex with men (MSM) attending specialist sexual health services who are not known to already be immune should receive at least one dose of hepatitis B vaccine. The integration of sexual health services could theoretically disadvantage MSM.
Objectives Audit was performed before and after integration of genitourinary medicine (GUM) and sexual and reproductive health (SRH) services in April 2011 to assess the impact of service redesign.
Methods HBV vaccination eligibility, uptake and course completion by MSM registering as new patients in general sexual health and specialist MSM clinics was audited retrospectively for 6 month periods before and after integration of services.
Results Pre-integration 239 MSM registered for a first episode of care: 62.8% were eligible for vaccination. Post-integration 25.3% of 343 new patients were eligible. The proportion of eligible men receiving at least 1 dose of vaccination pre- and post-integration was unchanged (130/150 = 86.7% vs 78/87 = 89.7%, p = 0.6458, Chi^2 0.2223043) However, there was a significant reduction in the proportion of men receiving 3 doses of vaccination; (76/150 = 50.7% vs 30/87 = 34.5%, p = 0.0157, Chi^2 5.834).
Discussion SRH services continued to provide very high levels of initiation of HBV vaccination, even during the period