psychosocially complex cases, facilitate multiagency (MA) working and ensure safeguarding of vulnerable young people accessing services.

**Aim(s)/objectives** To describe characteristics of young people accessing the service and compare those warranting MDTM or MA input to those in whom this was not required.

**Methods** Retrospective review of electronic patient records of new patients accessing a young people’s clinic (c16 years) from January to June 2014. Demographics, clinical and psychosocial details, MDTM case note entries or liaison with other agencies including social services, voluntary sector, mental and other health were analysed. Significance calculation: fisher’s exact test.

**Results** 159 cases reviewed. Median age 16 years: female 80%, locally resident 80%, self-referral 77%, white British 22%, black Caribbean 22%. 67(42%) required MA/MDTM working. (45%, n = 30 had MA referral/liaison). MA/MDTM patients were more likely to have health adviser input: 57% vs 21% p = 0.0001, report mental health problems: 33% vs 3% p = 0.0001, have a social worker: 27% vs 7% p = 0.0003 or if female, not on contraception: 60% vs 39% p = 0.005. Amongst those requiring MA/MDTM input 12% (n = 8) had a safeguarding concern and 7% (n = 5) were identified as at risk of sexual exploitation.

**Discussion/conclusion** MDTMs effectively enabled discussion of complex patients. MDTM/MA working was common and such cases were more likely to: lack contraception, need health adviser input, have a social worker and mental health problems highlighting an opportunity for closer working with mental health services.

### P224 THE SEXUAL HEALTH OF THE HOMELESS – AN OUTREACH SEXUAL HEALTH SCREENING PROJECT

**Background/introduction** Homeless people are at increased risk of STIs, and may struggle to attend conventional services. To improve sexual health access and knowledge for this group, THT launched a weekly outreach testing project for asymptomatic clients in June 2014 at the local homeless service. HIV point of care tests (POCT) and self-taken STI screens (SHS) were offered. Hepatitis B/C POCTs were introduced more recently.

**Aim(s)/objectives** To assess the value of the outreach service and describe project outcomes.

**Methods** User demographics and testing outcomes were collected at each attendance and reviewed at 6 months.

**Results** From June to December 2014, 129 clients presented. 83% were white British, 92% were male. The mean age was 36 (range 19–65 years). 84% identified as heterosexual, 14% bisexual and 2% homosexual. Only 26% had previously tested for HIV. Of the asymptomatic service users, 45% had a HIV test (all negative) and 23% had a self-taken SHS. Two cases were positive; one urethral chlamydia, one rectal gonorrhoea. Eighteen referrals were made to the local SH clinic for symptomatic screens, blood-borne virus (BBV) testing, vaccination and contraception. Since introducing hepatitis POCTs 2 weeks ago, 4 clients have tested and 2 were positive for hepatitis C.

**Discussion/conclusion** Prior to project launch, this client group had significant anxiety regarding HIV and BBV. Having the ability to access a full SH screen in familiar surroundings was welcomed. A significant number of infections have been identified demonstrating the importance of the outreach project, and the need for strong links with mainstream services.

### P225 REACH OUT AND TEST ME

**Background** Saunas have traditionally been where MSM participate in risky sexual activities, contracting high numbers of sexually transmitted infections (STIs) and have been ideal targets for sexual health outreach work. There has however been a recent trend towards private “Chem-Sex” parties arranged through social media. Is sexual health outreach work in the saunas still justified, particularly in these financially pressured times?

**Aim** Comparison of outreach services in a large urban centre in 2011 and 2013.