Introduction There is a lack of data on the sexual behaviour of patients between being tested for chlamydia, receiving the test result, and being treated. This time-period may be important in the transmission of chlamydia, as infection could continue to be spread to sexual partners whilst awaiting the test result and treatment.

We aimed to investigate the sexual behaviours of patients in this time-period in order to investigate the benefits a point-of-care test (POCT) might bring to clinical practice.

Methods A cross-sectional clinical audit of Genito-Urinary Medicine (GUM) clinic attendees in England. Clinic staff conducted a notes review of patients returning for chlamydia treatment following a positive chlamydia test result, and of age- and sex-matched chlamydia negatives attending for initial consultation. Initial consultation data were available for all patients; data on behaviour between test and treatment were available only for chlamydia-positives. The data also served as a sexual history taking audit for the GUM clinics, following British Association of Sexual Health and HIV (BASHH) guidelines.

Results Five of nine GUM clinics approached participated (July–December 2014). The sexual history BASHH auditable outcomes completion rates varied from 0–100%. 775 patients (442 females, 353 males) were included in analyses. Males with 2–4 partners, and those who reported never using a condom, were more likely to be chlamydia positive. For 21/143 (14.7%) positive patients who provided data, last new sexual contact was in the period between test and treatment.

Conclusion The BASHH 97% data recording target was only consistently met for one of six auditable outcomes, indicating required improvements in sexual history recording by GUM clinics.

Patients continue to form new sexual partnerships whilst awaiting chlamydia test results, allowing for the possibility of infecting new sexual partners. POCTs which remove the test to treatment delay could prevent this onward transmission.

P08.29 WEB-TOOL TO ASSESS THE COST-EFFECTIVENESS OF CHLAMYDIA POINT-OF-CARE TESTS AT THE LOCAL LEVEL

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Introduction Point-of-care tests (POCTs) can eliminate the delay between being tested for chlamydia and receiving the result and treatment, potentially reducing loss to follow-up. However, the cost-effectiveness of POCT implementation depends on multiple factors, including cost-per-test, clinic time, sensitivity and specificity, and the epidemiological impact of POC testing on transmission.

Decision-makers consider a complex range of information when determining potential impact of introducing a POCT. To enable commissioners, providers, POCT manufacturers and others to assess the advantages, disadvantages and uncertainty of POCTs for chlamydia in different local settings, we developed a user-friendly web-based tool (POCTiC): www.poctic.uk.net

Methods The web-tool is underpinned by a transmission-dynamic model for chlamydia, which uses behavioural and prevalence data from the National Survey of Sexual Attitudes and Lifestyle (Natsal), and reproduces local coverage and diagnosis rates from Public Health England datasets. A user group consisting of industry, sexual health facilitators, sexual health commissioners, clinicians, public health experts, and healthcare consultants, provided input throughout. The model is pre-run, but certain variables (e.g. costs) are user-determined.

Results Users can estimate changes in the number of infections and diagnoses occurring under different scenarios, with uncertainty ranges. This allows total costs, and cost per infection averted, to be calculated, while accommodating the considerable variation in chlamydia testing coverage, positivity, and diagnosis rates observed at the local level across England. The epidemiological impact of POC testing is dependent on both test performance characteristics and assumptions about the implementation of the test across local services.

Conclusion This tool enables the uncertainties surrounding chlamydia epidemiology and screening implementation to be explored. It also complements local and national knowledge, and contributes to local-level management of chlamydia infection. Users can use the tool to determine the epidemiological impact and cost-effectiveness of implementing POCTs in a particular setting.

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The other authors declare no competing interests.

P08.30 CHLAMYDIA TESTS ORDERED, BUT NOT UNDERTAKEN: SOCIO-DEMOGRAPHIC AND STRUCTURAL BARRIERS IN GENERAL PRACTICE

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Introduction Chlamydia screening at general practice clinics involves a general practitioner (GP) ordering a test and the patient providing a sample on-site or at a pathology collection centre off site. This study investigated the socio-demographic

and structural factors associated with not providing a specimen for chlamydia testing when a test is requested by GP.

Methods Chlamydia testing data for 16 to 29 year old patients, including test requests and whether the test was performed, were collected from 63 GP clinics participating in a trial of a chlamydia testing intervention in Australia. The primary outcome was "no test performed" when a test was requested by a GP. Logistic regression was used to investigate factors associated with no test performed.

Results During the study period there were 13225 chlamydia test requests and of these, a chlamydia test was not performed for 2545 patients (19.2%; 95% CI: 16.5%, 22.3%). Multivariate analysis found that males (adjusted OR[aOR] = 1.4; 95% CI: 1.3, 1.6), those aged 16 to 19 years (aOR = 1.3; 95% CI: 1.1, 1.4), those living in areas of increasing socio-economic disadvantage (aOR = 1.2; 95% CI: 1.1, 1.4 for each additional quintile of Index of Relative Socio-economic Disadvantage) and those attending clinics that did not provide pathology collection onsite (aOR = 1.4; 95% CI: 1.0, 1.9) had an increased odds of not testing when a test was requested.

Conclusion One in five young people did not submit a specimen for chlamydia testing despite their GP requesting it. To capitalise on efforts in general practice to increase chlamydia testing, systems need to be introduced to minimise opportunities for patients to not provide a specimen.

Disclosure of interest statement This study was conducted as part of the Australian Chlamydia Control Effectiveness Pilot (ACCEPt) which has been funded by the Commonwealth Department of Health, NHMRC, NSW Health and the Victorian Department of Health.

P08.31 SCREENING FOR CHLAMYDIA CONCURRENTLY WITH A ROUTINE PAP TEST IN PRIMARY CARE: COULD CERVICAL SCREENING CHANGES IMPACT ON CHLAMYDIA TESTING?

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Introduction The current Australian National Cervical Screening Program involves regular screening of sexually active women ≥18 years using a Pap test but changes to the program, effective in 2017, will only include women aged ≥25 years. These changes could inadvertently reduce chlamydia screening which is recommended in 15–29 year-olds and often occurs during reproductive visits. Using the ACCESS surveillance system we measured the proportion of chlamydia tests that may no longer occur in primary care following changes to the National Cervical Screening Program.

Methods Consultation, Pap and chlamydia testing data were extracted from patient management systems of 18 general practice and family planning clinics in Victoria and NSW. We calculated concurrent Pap and chlamydia testing (within 7 days) by age group, and chlamydia testing frequency among concurrent testers.

Results Between January 2009 and September 2014, 10,105 chlamydia tests were conducted among 44,694 women aged 18–30 years; 63% in 18–24 year-olds and 37% in 25–30 year-olds. In the same period, 10,178 Pap tests were conducted; 47% in 18–24 year-olds and 53% in 25–30 year-olds. The proportion of chlamydia tests conducted concurrently with a Pap test was 20% (2058/10,105), similar in both age groups. For 63% (1154/1835) of women with concurrent chlamydia/Pap tests it was their only chlamydia test during the study period.

Conclusion One in five chlamydia tests among 18–30 year-olds occurred concurrently with a Pap test and the majority of them had no other chlamydia test during the study period. Our results suggest changes to the National Cervical Screening Program could reduce opportunistic chlamydia testing in a particularly high risk group such as sexually active women aged 18–24 years. As chlamydia is mostly asymptomatic, regular and opportunistic screening is considered a key public health strategy in chlamydia control. New strategies will be needed to increase chlamydia testing in young women.

Disclosure of interest statement None.

P08.32 THE FEASIBILITY AND ACCEPTABILITY OF OFFERING OPPORTUNISTIC CHLAMYDIA SCREENING IN A NURSE-LED PRIMARY HEALTH CARE CLINIC

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Introduction Chlamydia rates are highest among young people. Screening is the best method of identifying asymptomatic infection. The study aim was to determine the feasibility and case finding effectiveness of routinely offered chlamydia screening in the nurse-led ACT Health Walk in Centre (WiC).

Methods Regardless of the purpose of their visit, all WiC attendees aged 16–30 years were offered chlamydia screening. Cases were managed by CSHC. Outcome measures were: number of specimens collected, proportion of positive tests, proportion of cases treated at CSHC and contact tracing yield.

Results 4341 people in the target age range (29.1% of total WiC presentations) attended between 13/8/12 and 31/5/13; 473 (10.9%) accepted screening. Screening was associated with female gender (293 vs. 180 p = 0.0001), 20–24 year age group and no particular reason for attendance. 28 (5.9%) tested positive (19 females, 9 males, 22 aged 16–25 years). 26/28 (92.9%) attended CSHC for treatment; 2 were treated elsewhere. 39 sexual partners were nominated by the 26 patients treated at CSHC; 23 were contacted by the index cases and 16 by CSHC staff.

Conclusions Offering chlamydia screening to young people attending the WiC is feasible and demonstrated excellent case finding effectiveness. Efforts to increase screening participation are needed.

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