Background/introduction Understanding patterns of chlamydia prevalence is important for addressing inequalities and assessing interventions. Population-based surveys are expensive; the best UK data come from the Natsal national surveys which are only available once per decade and not powered to compare prevalence in different localities. Estimates at finer spatial and temporal scales are required.
Aim(s)/objectives We aimed to estimate chlamydia prevalence from numbers of tests and diagnoses reported in surveillance data.
Methods Our method is based on a simple model for the infection, testing and treatment processes and informed by the literature on infection natural history and treatment seeking behaviour. By combining this information with surveillance data we obtain estimates of chlamydia screening rates, incidence and prevalence. We validate and illustrate the method by application to national and local-level data from England.
Results Estimates of national prevalence by sex and age group agree with results from the Natsal-3 survey. They could be improved by additional information on the number of diagnoses that were symptomatic. There is substantial local-level variation in prevalence, with more infection in deprived areas. Incidence in each sex is strongly correlated with prevalence in the other. Importantly, we find that positivity (the proportion of tests which were positive) does not provide a reliable proxy for prevalence.
Discussion/conclusion This approach provides a powerful tool to identify prevalence trends with time and location, and understand the effects of control strategies. Estimates could be more accurate if surveillance systems recorded which patients were symptomatic and the duration of symptoms before care-seeking.

P032 DEVELOPING A SECTOR LED IMPROVEMENT APPROACH TO SEXUAL HEALTH

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Background Sector-led improvement (SLI) is an approach where local authorities (LA) help each other to continuously improve. It is replacing more traditional performance frameworks, however, the approach lacks a clear methodology. We developed and piloted an evidence-based SLI approach to drive improvements in sexual health (SH) within LAs.
Aim(s) To develop and pilot an evidenced-based SLI toolkit
Methods Key components for effective SLI were identified following a review of the published literature. These were embedded within a co-produced, peer-review toolkit which was piloted by SH commissioners and key stakeholders from four local authorities. The pilot focussed on delivery of local chlamydia screening programmes.
Results Several key clinical and structural issues were identified through the SLI approach including low coverage, the potential to improve partner notification outcomes, low re-testing rates, threats from a reduction in spend and unclear governance. These have been put into a local action plan to focus and drive quality improvement activities. The impact of the action plans will be the focus of a follow up meeting planned for six months after the final peer review meeting involving wider stakeholders.
Discussion The SLI toolkit offers a systematic approach to evaluating complex programme activities. It was well received locally and helped key stakeholders to gain insight, catalyse self-reflection and prioritise areas for change in order to drive quality and improvement.

P033 SAFETY FIRST: COMBINED ORAL CONTRACEPTIVE PRESCRIBING IN PRIMARY CARE

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Background/introduction 80% of contraceptive care occurs in the general practice (GP) setting. UK Medical Eligibility Criteria (UKMEC) provides clear guidelines for the safe provision of appropriate contraception. The Faculty of Sexual and Reproductive Health (FSRH) and the National Institute of Clinical Excellence (NICE) offer further recommendations for combined oral contraceptive pill (COCP) initiation and continuation.
Aim(s)/objectives To establish if primary care COCP prescribing was compliant with national safety and best practice guidelines.
Methods The EMIS database of an average size, inner city GP surgery was used to analyse COCP consultations between 11/10/2015 and 11/01/2016.
Results 56 women aged 14–39 years were prescribed the COCP. In 41% of consultations there was substandard documentation of medical eligibility.

Abstract P033 Table 1 UKMEC

UKMEC Condition	% Consultations Lacking Documentation
Venous thromboembolism	28%
Smoking status	25%
Blood pressure	16%
Body mass index	16%

The COCP was prescribed without specialist input for three patients with a UKMEC 3 condition: systolic blood pressure 143, undiagnosed breast lump and first degree family history of venous thromboembolism. 87% patients did not receive advice about missed pill rules; and 21% of eligible women were not advised on the benefits of long acting reversible contraception (LARC). Only 8% of patients were risk assessed for sexually transmitted infections (STIs) and no women were offered HIV screening.

Discussion/conclusion The safety of COCP prescribing could be enhanced by improved application of UKMEC criteria. Promotion of safe sex was not undertaken despite high incidence of STIs and local availability of LARC options.

P034 ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH IN THE CALAIS "JUNGLE CAMP" FOR WOMEN. A VOLUNTEER PERSPECTIVE

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Background/introduction The number of women in the "jungle" camp in Calais, France increased in 2015 but definitive numbers are unknown. Health services report these women are a difficult to access population. Multiple small groups of grassroots volunteers support initiatives in the camp and have access to vulnerable groups.
Aims/objectives To survey volunteers opinions on access to sexual and reproductive health (SRH) care in the "jungle" camp

and protection against sexual and gender based violence (SGBV) for women.

Methods We designed an online survey and posted it on grassroots volunteer social media groups in November 2015.

Results 32 volunteers responded to our survey. Most 20/32 (63%) were short term volunteers working in a healthcare capacity n = 14/28 (50%). The average age of women reported by volunteers was 18-25 (65%). 19/28 (68%) of volunteers had encountered pregnant women and 4/29 (15%) said women disclosed sexual assault in the camp. 21/28 (75%) of the volunteers did not know how to refer women to sexual assault services. 100% of the volunteers reported inadequate protection and security measures against SGBV.

Discussion/conclusion There is inadequate security in the "jungle" camp and sexual violence has been described. As the number of makeshift transit camps continues to increase throughout Europe in the current refugee crisis, it is imperative that the minimum standards of SRH are met and that there is adequate security in place to protect against SGBV.

P035 IMPROVING QUALITY OF PATIENT CARE IN A SRH SERVICE: INTRODUCTION OF ENDOMETRIAL BIOPSY FOR WOMEN WITH PERSISTENT BLEEDING PROBLEMS

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Background/introduction National Institutes of Clinical Excellence (NICE) recommends to undertake endometrial biopsy (EB) sample in cases of persistent intermenstrual bleeding and in woman aged 45 or over with failed or ineffective treatment of heavy menstrual bleeding. Since January 2015 we introduced EB in our sexual health clinics.

Aim(s)/objectives The aim was to perform a transvaginal ultrasound (TVS), undertake sexually transmitted infection (STI) screen and offer MIRENA®-IUS or other treatment options for persistent bleeding problems. This one-stop-service was meant to decrease referrals to the gynaecological service and improve a patient's journey.

Methods Retrospective analysis of all patients who underwent an EB over the past year was performed. Inclusion criteria were those specified by NICE. The exclusion criterion was postmenopausal bleeding.

Results Out of 300 patients who had a TVS (for bleeding or pain), 37 qualified for an EB. 8% of patients had additional risk factors for endometrial cancer. 2 patients had a positive STI screen and were treated. 11% of patients had chronic endometritis on EB and the rest of the biopsies were negative. 54% of patients had a MIRENA®-IUS inserted at the same visit. 78% of patients were discharged on the same day of consultation.

Discussion/conclusion Our study demonstrates that irregular bleeding problems in women presenting to sexual health clinics can be managed effectively in the same sitting. The clinician needs to be trained in TVS and EB procedures. This reduces the number of women referred to the gynaecological department for persistent bleeding problems.

P036 AUDIT OF ORAL CONTRACEPTIVE PRESCRIBING IN PATIENTS WITH CARDIOVASCULAR RISK FACTORS

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Background/introduction Foundry Lane Surgery has a practice population of 6,564 serving a young population with the high levels of deprivation, smoking and obesity.

Aim(s)/objectives To determine if any patients fulfilling UKMEC 3 or 4 due cardiovascular risk factors or a combination of two or more cardiovascular risk factors were prescribed COCP during the 6 month period 11th July 2015 to 11st January 2016.

Methods Reports were run on practice software *SystemOne* producing lists of patients who were prescribed COCP in the study period and also fulfilled UKMEC 3 or 4 criteria based on cardiovascular risk factors.

Results 201 patients were prescribed COCP in the study period under analysis. 3 individual patients (1.49%) were identified who were prescribed COCP in this period despite fulfilling criteria for UKMEC 3 or 4. One patients who received COCP for reasons other than contraception was excluded along with one patient for whom POP was deemed unsuitable due to porphyria. Three patients were identified who received COCP in spite of UKMEC 3 or 4. Two fulfilled UK MEC 3, one due to BMI > 35, one due to a combination of smoking and age > 35. One patient fulfilled UKMEC4 (BMI > 35 & smoker).

Discussion/conclusion Three patients (1.49%) were prescribed COCP in spite of fulfilling UKMEC 3 or 4. In two out of three of these patients a combination of risk factors was responsible. Practice IT systems could be optimised to alert prescribers of contraindications such as BMI, hypertension and smoking.

P037 MEN WHO HAVE SEX WITH MEN, WHO ARE DIAGNOSED WITH A SEXUALLY TRANSMITTED INFECTION, REPORT SIGNIFICANTLY MORE CHEM-SEX: A CASE CONTROL STUDY

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Background/introduction The sexualised use of recreational drugs (Mephedrone, GBL/GHB, Crystal Meth) is thought to be associated with STI acquisition however there is little data showing a direct relationship.

Methods We reviewed 130 cases of MSM with an STI attending our STI service and 130 controls (MSM attending the STI service who did not have an STI) between 5th May 2015 and 2nd Nov 2015 (6 months). We collected demographic data, sexual behaviour, drug use and STI diagnoses.

Results In the 6-month period there were 5,013 appointments with MSM. Reported condom-less anal sex was significantly higher in cases 90/121 (74%) compared with controls 65/122 (53%); ($X^2 = 11.71$, $p < 0.005$, OR 2.54). HIV prevalence was significantly higher in those with STIs: 71/130 (55%) compared to those without STIs 33/130 (25%); ($X^2 = 23.14$, $p < 0.001$, OR 3.53). Recreational drug use in the cases 38/122 (31%) was significantly greater than in controls 20/125 (16%); ($X^2 = 7.88$, $p < 0.005$, OR 2.37). In total Mephedrone was the most commonly used drug, followed by GBL/GHB.

Discussion/conclusion This data demonstrates a clear correlation between STI acquisition and recreational drug use in Men who have sex with men. Interventions to reduce party drug use should be implemented on an individual, local and national level to improve the sexual health of MSM, including reducing risk-taking behaviours.