transmitted infections (STIs) doubled in older people between 1996 and 2003, the fastest rise in all age groups.
Aim(s)/objectives To assess the health care needs of women aged 40 and over attending an integrated sexual health clinic in South London.
Methods Retrospective case notes review of 200 randomly selected female patients aged 40 and over attending between 2nd June 2014 and 30th May 2015.
Results 1728 out of 5039 women (34%) who attended the sexual health clinic were aged 40 and over. In the sample of 200, mean age was 46.6 years (range: 40–73 years). Ethnicity: Black 111 (55%), White 57 (29%), Other 32 (16%). 110 women (55%) attended for STI-related reasons (symptoms/partner notification/possible exposure/treatment). 41% attended for contraception and 10.5% for asymptomatic screen. Of 150 tested, 29 (19.3%) had STIs. STIs were: genital herpes 8 (5.3%), trichomoniasis 7 (4.7%), genital warts 5 (3.3%), chlamydia 2 (1.3%) and gonorrhoea 1 (0.7%). Overall condom use was 22.9%.
Discussion/conclusion A significant proportion of women accessing sexual health services were aged 40 and over. 1 in 5 women were diagnosed with an STI. Under a quarter of women used condoms, indicating sexual risk taking behaviour. The sexual health needs of older people will continue to increase, given our rapidly ageing population. There is therefore a need to develop age-specific health promotion strategies and to challenge assumptions regarding sexuality in older age.

P048 WHAT FACTORS CAUSE DELAY IN TERMINATION OF PREGNANCY? A LITERATURE REVIEW OF THE EVIDENCE

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Background/introduction Although abortions performed at earlier gestations are relatively medically safer and less costly, nonetheless in many settings there exists a small minority of women who receive abortions in the second trimester. The difficult circumstances faced by women seeking later abortions have been highlighted, but it is not always clear what factors lead to abortions being performed later in pregnancy.
Aim(s)/objectives To identify the causative factors of later (second trimester) abortion, analyse the impact of service provision on timing of abortion and highlight other factors relevant to delay in seeking or obtaining abortion.
Methods A literature search was conducted using Medline and Embase databases, and results were limited to English language studies from the last 20 years in settings where termination of pregnancy was legally available.
Results Most delays tended to act on one or more of three periods: identification of pregnancy, decision-making, and obtaining an abortion having made a decision. Delays in suspecting or confirming the pregnancy were key drivers in later termination and were particularly pronounced in young people; service-related delays were common, though small, and were often compounded by logistical factors such as financial difficulties.
Discussion/conclusion The causes of later abortion are many and complex, and very commonly overlap; more research is needed to analyse how these factors interact to cause delay. The association of low socioeconomic status with increased abortion delay suggests more must be done to ensure the accessibility of abortion services.

Abstract P049 Table 1 HIV+ MSM

ASPECT OF ASSESSMENT	Number (%) n = 85
Sexual history taken	77 (91)
If sexual history taken, Sexually active in past 12 months	60 (78)
Of those who are sexually active, STI screen offered	58 (97)
Of those with screen offered, STI screen done	53 (91)
STI detected:	10 (19)
1. Chlamydia trachomatis	1 (10)
2. Neisseria gonorrheae	8 (80)
3. Syphilis	1 (10)
4. Warts	2 (20)
5. Acute Hepatitis C	2 (20)
Recreational drug history	63 (74)
If recreational drug history taken, recreational drugs use disclosed	17 (27)
If recreational drug history taken, chemsex specifically disclosed	3 (5)

P049 AUDIT: RATES OF SEXUAL HISTORY TAKING AND SCREENING IN HIV POSITIVE MEN WHO HAVE SEX WITH MEN (MSM)

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Background/introduction Increased rates of STIs in MSM may in part be due to the emergence of 'chemsex'; use of recreational drugs in the context of high-risk sex. BASHH has set a target of 97% of MSM attending for a new episode being offered a screen (80% acceptance). BASHH/BHIVA guidance recommends HIV-positive patients have 6 monthly sexual histories and annual STI screens.
Aim(s)/objectives To evaluate whether HIV positive MSM patients were asked about recreational drug use, including chemsex and assessed and screened for STIs during consultations.
Methods The notes of 142 HIV positive men seen in 2015 were available, of whom 85 were MSM. Information was collected regarding sexual history, recreational drug use documentation, STI screen offer and test results.
Results 77 (91%) of the MSM had a sexual history documented, of whom 60 (78%) were sexually active. STI screens were offered to 58/60 (97%) of those who were sexually active and accepted by 53 (91%) 10 (19%) of these had an STI. A recreational drug history was taken in 63 (74%) with 17 (27%) admitting to use and 3 (5%) to chemsex (Table 1).
Discussion/conclusion Sexual history documentation was below recommended levels. 19% men tested had an STI highlighting that frequent screening in this group is essential. A quarter of patients admitted to recreational drug use, although how many were explicitly asked about chemsex is unclear. Given the increasing concern around this practice, questions about chemsex should be incorporated into the sexual history proforma.

P050 IMPROVING MANAGEMENT AND PARTNER NOTIFICATION OUTCOMES OF WOMEN TREATED FOR PELVIC INFLAMMATORY DISEASE (PID) BY INNOVATIVE YET SIMPLE BESPOKE MEASURES

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Background PID is a common condition seen at genitourinary clinics. BASHH published NICE approved guidelines in 2011. To improve consistency amongst clinicians we designed a simple *aide memoire* tick-box sticker. To improve health adviser (HA) contact and reduce "did-not-attend" (DNA) rates we established a HA staffed telephone follow-up clinic

Methods We regularly audit both management of PID and follow-up and so were able to compare data (2011–2015) to demonstrate improvements in practice with these changes

Outcome Partner notification rates improved from 50% to 67% helped mainly by the telephone clinic as HA documented in all cases whether partners had been screened/treated. 82% had a recording of symptom change, previously 77%. For those followed-up using the telephone clinic proforma this was 100%. Results for the number of named male contacts screened for infection and/or treated have improved (2011 = 0.21; 2014 = 0.38; 2015 = 0.48) and we now achieve above the BASHH target (0.4 – large city centre clinic). Over the past five years introducing these measures into clinic has improved all outcomes except DNA rate which remains stubborn (33% vs 27%). For a large city centre clinic the reasons behind this are complex and varied

Conclusions Innovative yet simple measures can be easily introduced which have a positive impact on guideline adherence and also make audit an easier task. With the advent of EPR in many clinics these initiatives should be transferable and aid standardising management across the GU network particularly during this time of change and service integration

P051 AN AUDIT OF BLOODBORNE VIRUS SCREENING AND SAFER SEX ADVICE FOR SEX WORKERS

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Background/introduction Commercial Sex Workers (CSW) are at increased risk of STIs including Hepatitis B virus (HBV) and, for some, Hepatitis C virus (HCV) and sexual assault. These risks can be reduced by vaccination, post-exposure prophylaxis (PEP) awareness and condoms.

Aim(s)/objectives To audit management against clinic policy with respect to documentation of: HBV status; offering vaccination (vacc.) to HBV negative; HCV test; HIV test; PEP information/awareness and offer of condoms. Additional data was collected on new/prior STIs, recreational drugs, and same sex contact.

Methods Casenotes of all attenders between 01/01/12 and 30/09/15 with a SW code were reviewed and additional data collected regarding vaccine uptake.

Results 56 (7 males (12.5%), 49 females (87.5%)) individuals with a total of 243 episodes, with a median of 3 (1–17) visits, were identified. Median age of 30 (range 18–63) with 51 (91%) of white British ethnicity. 38 (67.9%) reported an STI diagnosis prior to the period audited and 13 (23.2%) had $\geq$1 new STI during this period, median 1 (1–3). 21 (37.5%) reported current/recent use of recreational drugs and 31/54 (57.4%) documented same sex contact, (including MSM contact for females). PEPSE was issued at 2/243 (0.8%) of episodes.

Discussion/conclusion The main limitation of the audit was dependence on SW code. Performance was good (>95%) for HBV documentation at first/subsequent visits, offer of HIV test, whilst HCV testing and documentation re. condoms and PEPSE awareness were suboptimal (45–80%). None were IVDU, and policy re. HCV testing in CSW will be reviewed given the low positivity rate.

Abstract P051 Table 1 Blood borne viruses in sex workers

	Test offered	Test accepted	Tested positive
HBV at first visit (*n* = 56)	55 (98.2%)	55 (98.2%)	1 (eAb + sAg)
HCV test (episode, *n* = 243)	193 (79.4%)	176 (91%)	0
HIV test (episode, *n* = 243)	239 (98.4%)	222 (92.9%)	0
	Documented	**HBV status at first visit (*n* = 56)**	**Outcome of those with unknown status at first visit (*n* = 33)**
HBV status (episode, 243)	239 (98.4%)	1 past infection (1.8%)	4 immune (12.1%)
		1 chronic HBV (1.8%)	7 undergoing vacc. (21.2%)
		20 immune post vac (35.7%)	10 vacc. at first visit (30.3%)
		1 not tested (1.8%)	7 vacc. at later visit (21.2%)
		33 status unknown (58.9%)	3 declined vacc, (9.1%)
			2 did not attend vacc. (6.1%)
	Documented	**Not documented**	
PEPSE info/awareness (episode, 243)	111 (45.7%)	132 (54.3%)	
Offered condoms (episode, 243)	174 (71.6%)	69 (28.4%)	

P052 MEN WHO HAVE SEX WITH MEN (MSM) PRESENTING WITH REPEAT BACTERIAL SEXUALLY TRANSMITTED INFECTIONS (STI) REPORT HIGH USE OF ALCOHOL AND PARTY DRUGS

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Background/introduction Bacterial sexually transmitted infections (Chlamydia, Gonorrhoea and Syphilis) are increasing in men who have sex with men in the UK. The reasons for this include alcohol and recreational drug use, availability of PrEP and awareness of HIV treatment as prevention, and social media.