Discussion/conclusion The survey has demonstrated that the HIV testing policy has increased staff awareness and confidence in HIV testing. Late diagnosis rates continue to be monitored and misconceptions regarding HIV testing challenged.

P239 DON'T ASK, DON'T TELL: INTRODUCTION OF ROUTINE DOMESTIC ABUSE PROMPT IN GENITOURINARY WALK-IN CLINIC

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Background/introduction Domestic abuse (DA) is common and spontaneous disclosure rare. In July 2015, routine DA enquiry was introduced in a busy, inner London, walk-in genitourinary medicine clinic. All DA disclosures prompted completion of a proforma identifying ongoing risk/<3/12 (=current DA) with clear management pathway. Patients disclosing current DA were seen by Sexual Health Information Protection (SHIP) team for detailed risk assessment and referrals, as needed. Those with previous DA were offered information/referrals if indicated.
Aim(s)/objectives To review DA disclosure management following DA routine prompt introduction.
Methods A retrospective case-notes review of patients' notes (coded DA) for 3 months from 14/07/2015.
Results 137 patients (111 women,26 men): age-range 17–75 years old(mean 33), 7% (10/137) commercial sex workers, 11% (15/137) MSM/bisexual. 72% of patients had never disclosed to professionals previously. Ex-regular and current partners most common perpetrators (62%, 15% respectively). 25% (34/137) disclosed current DA. Of these, 94% (32/34) were offered SHIP referral, 88% (28/32) accepted, 75% (21/28) were seen. Referrals were made to DA services 48% (10/21), refuges 10% (2/21), MARAC 19% (4/21). 52% (11/21) had a standardised risk assessment; those who did not, 60% (6/10) were already engaged in services, 20% (2/10) didn't attend follow-up and 20% (2/10) referred to psychology. 44% (14/34) patients were discussed at Vulnerable Adults MDT. No escalation of violence was recorded.
Discussion/conclusion Patients with significant risk from DA were identified who may not have disclosed without routine prompt. This is suggested as the majority were first disclosures. Interventions to reduce the negative consequences of DA for these patients have been performed.

P240 WHAT IS THE HEPATITIS B VACCINATION COVERAGE IN MSM IN SOUTH WEST LONDON? AN AUDIT OF HEPATITIS B VACCINATION COVERAGE IN 'FIRST ATTENDEE' MSM IN A BUSY TEACHING HOSPITAL GUM CLINIC

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Background The 2001 National Strategy for Sexual Health and HIV recommended 90% uptake of Hepatitis B (HBV) vaccine in non-immune MSM at first GUM clinic attendance. The HepB3 Survey reported 95% uptake in 2008 but recent surveillance using GUM Clinic Activity Dataset-v2 (GUMCADv2) coding shows <20% uptake. A detailed regional audit was designed to investigate this apparent drop in coverage.
Aim To determine HBV vaccination coverage in 'first-attendee' MSMs.
Methods All MSM 'first-attendees' at our service between January-March 2014 were identified. Patient records were reviewed for HBV screening, vaccine-offer, vaccine-uptake, HIV testing and coding accuracy up to 18 months from first-attendance. MSM were deemed '*immune*' if surface antibody (sAb) >10 mIU/ml, core antibody positive, or self-reported vaccination-status was 'Fully-vaccinated' and no serology was done; and *eligible* for vaccination if sAb ≤10 mIU/ml, or if they reported 'Partially-vaccinated', 'Never-vaccinated', or 'Don't know' and no serology was done.
Results We identified 115 MSM 'first-attendees' (13 HIV+). 41% only attended once. Regarding vaccination-status: 41/95 (43%) reported 'Fully-vaccinated', 29/95 (30%) 'Partially-vaccinated', 12/95 (13%)'Never-vaccinated', 11/95 (12%) 'Don't-know', 1/95 (1%) 'Chronic-HBV' and 1/95 (1%) 'Cleared-HBV'. 48/103 (47%) were deemed *immune* and 46/103 (45%) *eligible*. 36/46 (76%) of *eligibles* were offered vaccination; 2/36 (6%) declined, reporting 'not at risk'. 3/32 (9%) who accepted vaccination pending sAb levels did not return for it. 31/46 (67%) of *eligibles* received ≥1 dose of vaccine, 28/46 (61%) within 42 days of first-attendance. Reasons for non-offer were not recorded. 75% of first-doses were coded. Only 15% of '*immune*' patients were coded as such (P2I). HIV-test uptake was 99% and coding accuracy was 97%.
Discussion We found below-target levels of HBV vaccination-coverage and incomplete coding of immunity/vaccination. Failure to code P2I for '*immunes*' will increase the apparent '*eligibles*' denominator in GUMCADv2 algorithms, generating incorrectly low vaccination-coverage figures. Reduced offer-rate may contribute to low vaccination-coverage and should be reviewed locally. Further regional audits may be required. Significant improvements in coding are essential for accurate surveillance of HBV vaccination-coverage using GUMCADv2.

P241 DO MEN ATTENDING A GENITOURINARY MEDICINE SERVICE KNOW IF THEIR MOST RECENT SEXUAL PARTNER WAS USING CONTRACEPTION?

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Background/introduction Unintended pregnancy is a significant problem. In 2014 in England and Wales 184,571 abortions were performed. Contraceptive methods generally focus on females. Males have the potential to contribute significantly to the contraceptive decisions in their relationships.
Aim(s)/objectives To demonstrate what knowledge male patients have of their partner's contraception status.
Methods Electronic proformas for male GUM patients in the region studied were amended to include a question that assessed whether or not the attending patient was aware if their most recent sexual partner (MRSP) was using contraception. After this was in place, notes of all male patients classified "new"/"rebook" who attended in January 2016 were studied. Those coded MSM (men who have sex with men) were excluded. An Excel workbook was created from the data of the 396 patients. Patients assessed on alternative proformas were excluded, as were those

of practitioners not engaging in the study. 159 of the remaining 201 patients had the appropriate proforma section completed.
Results 125/159 (78.6%) had performed unprotected sexual intercourse (UPSI) with their MRSP. 120/159 (75.4%) stated that they knew whether or not their MRSP was using contraception. Of the 39 (24.6%) who didn't know, 10 had performed only protected sex with their MRSP and a further two had vasectomies. Of the remaining 27 (17%), 19/27 (70.4%) classed their partner as "Casual" and 8/27 (29.6%) "Regular". 19/37 (51.3%) men having UPSI with a casual partner didn't know if they were on contraception.
Discussion/conclusion Poor knowledge of partner's contraceptive status is demonstrated. This may highlight a potential area for future intervention.

P242 ARE POINT OF CARE TESTS PRICKING POSITIVE PEOPLE?

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Background/introduction/Aims To establish whether point of care testing is being carried out in the appropriate populations. We endeavoured to see if our rapid HIV testing met the guideline specificity of 99.4%
Methods We carried out a retrospective analysis of 674 patients who received point of care tests (POCTs) after attending the sexual health clinic at the Royal Liverpool Hospital between October 2014 and May 2015. We reviewed the point of care tests based upon the indication, age and sex of the patient. The outcome measures included whether the test was reactive or not and the final result of the laboratory HIV test. Indications were defined by individual staff members logging the information and if multiple indications were given, the aspect deemed to be higher risk was used
Results Of the 674 patients 499 were female and 175 were male. The four most common indications were for testing were MSM (36%), Worried/Anxious (15%), PEP (11.5%) and HIV positive partner (9%). 31 tests (4.8%) were reactive and 23 tests (3.4%) produced a corresponding positive final laboratory result. This equated to a specificity of 98.77%. Positivity of indications varied remarkably-MSM, 3.7% versus Worried,0%.
Discussion/conclusion The study developed our understanding of the uptake of POCTs. A larger sample could have increased the specificity to the national guidance. The variability in documentation made it difficult to categorise risk in different indications. For example, indications of "high risk" and "worried" are vague and potentially misleading.

P243 CHARACTERISING NEW HIV DIAGNOSES IN NORTH WEST NORTHERN IRELAND

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Background/introduction North West Northern Ireland is a predominately rural population. New HIV diagnoses in Northern Ireland are rising.
Aim We sought to characterise the new diagnoses being made in this region.
Methods The service became a consultant-led service on a daily basis in November 2015 and since this date has been offering ongoing care for PLWH. We analysised demographic details of new HIV diagnoses including sex, age and sexual identity. Details regarding the health location of the first positive test and surrogate markers at diagnosis were also recorded.
Results Since November 2015 there have been 7 new HIV diagnoses. Two tested positive within the GU service; external referrals with a new positive test included 1 from General Practice, 1 from Oral Surgery and 3 from Gastroenterology. Of the 7 new diagnoses 6 were in men. All were of white Northern Irish ethnicity. 3 men were MSM and 3 were heterosexual. 6 of the 7 are thought to have acquired their HIV within NI. Age range at diagnosis was 27–64 years old, but 6/7 were 44 years old or over. One patient disengaged from care following diagnosis and no surrogate markers were obtained as a result of patient's refusal for further blood tests. Of the 6 that have remained in care only 1 patient had a baseline CD4 count of greater than 350 cells/mm^3; 2 patients had a CD4 < 200 cells/mm^3 at diagnosis.
Conclusion Although small numbers so far, this analysis suggests that new HIV diagnoses in this region are of an older age with advanced HIV.

P244 HSV SEROTYPES IN FIRST EPISODE GENITAL HERPES IN NORTH WEST NORTHERN IRELAND

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Background/introduction Most populations have observed an increase in the role of HSV-1 as a cause of genital herpes simplex virus (HSV)
Aims To analyse HSV serotypes in first episode genital herpes in North West Northern Ireland.
Methods All patients who tested positive for HSV and were coded as C10A from 01/03/2015 – 01/03/2016 were included. Demographic details including sex, age, ethnicity and sexual identity were recorded. The confirmed serotype (HSV-1 vs HSV-2) was noted.
Results A total of 36 cases of first episode genital HSV was seen. 100% were white Caucasian (35/36 White UK); 29 were female and 7 were male. All females self-reported as heterosexual and of the 2/7 men were MSM. Overall median age at diagnosis was 23 years old (range 16–40). Of the 36 positive PCR tests 83.3% (30) were HSV-1 and 6.7% (6) were HSV-2. The median age at diagnosis for HSV-1 was also 23 years (range 16–32); 26 were female and 4 male. Of the 6 positive who tested positive for HSV-2, 3 each were male and female.
Conclusion It is well documented that HSV-1 is increasingly prevalent as a cause of first episode genital HSV, our rate of 83% for HSV-1 infection is notably high. Although not a significant diagnostic or management challenge this may reflect a lower prevalence of HSV-2 infection within the local sexually-active population or an increasing level of sexual risk behaviour capable of transmitting HSV-1 infection. Local clinicians need to be aware of the differences in prognosis for HSV-1 infection such that accurate information and advice can be given to help reduce stigma traditionally attached to HSV-2 infection.