Methods As part of a cross-sectional survey, 2 large voluntary counselling and testing centres in Accra enrolled 50 newly HIV-diagnosed, antiretroviral drug-naïve adults aged 18 to 25 years. Virus from plasma samples with >1,000 HIV RNA copies/mL (Roche Amplicor v1.5) were sequenced in the *pol* gene. Transmitted drug resistance-associated mutations (TDRM) were identified according to the WHO 2009 Surveillance DRM list, using Stanford CPR tool (v 5.0 beta). Phylogenetic relationships of the newly characterised viruses were estimated by comparison with HIV-1 reference sequences from the Los Alamos database, by using the ClustalW alignment program implemented.
Results Subtypes were predominantly D (39/70, 55.7%), A (29/70, 41.4%), and C (2/70; 2, 9%). Seven nucleotide sequences harboured a major TDRM (3 NNRTI, 3 NRTI, and 1 PI- associated mutation); HIVDR point prevalence was 10.0% (95%CI 4.1% to 19.5%). The identified TDRM were D67G (1.3%), L210W (2.6%); G190A (1.3%); G190S (1.3%); K101E (1.3%), and N88D (1.3%) for PI.
Discussion In Accra the capital city of Ghana, we found a rate of transmitted HIVDR, which, according to the WHO threshold survey method, falls into the moderate (5 to 15%) category. This is a considerable increase compared with the rate of <5% estimated in the 2006–7 survey among women attending an antenatal clinic in mamobi. As ART programs expand throughout Africa, incident infections should be monitored for the presence of transmitted drug resistance in order to guide ART regimen policies.

P062 ACCESSING THE PREP POPULATION: WHAT IS THE BEST SERVICE MODEL?

Jozef Shaw*, Laurence Dufaur, Jake Bayley. *Barts Health NHS Trust, London, UK*

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Introduction Pre-Exposure Prophylaxis (PrEP) is effective to prevent HIV infections. Optimal service models for delivering this intervention are as yet unclear. We looked at our dedicated PrEP clinic in East London to identify who was accessing our service.
Methods Retrospective case note review collected demographics, PrEP use, STI rates and 'chem' use from January to November 2016. Data was analysed with STATA.
Results 116 visits from 54 patients were returned with a median age 42 years (IQR 32 – 44.5). 90% were white. Of these 54 patients, only 27 started PrEP and engaged in care. For our population, there were lower than expected rates of STI's (6% for CT and 9% for GC – any site) and a median of 4 partners in the preceding 90 days; much lower than encountered in the PROUD trial. 40% (21/54) had used 'chems' at some point, with 21% (4/21) of those 'slamming' (using intravenously) in the last 3 months. Routine urinalysis showed 30% abnormalities, but no subsequent abnormal uPCR.
Discussion As the interest and use of PrEP grows, new service models may have to be developed to accommodate this population. We saw varying levels of engagement with patients who were predominantly white with low sexual risk. Young MSM were also underrepresented. Engagement with BME and MSM communities, along with drug services, may be needed to inform effective delivery of this intervention to those most at risk.

P063 PEPSE FROM THE EMERGENCY DEPARTMENT: REDUCING MISSED OPPORTUNITIES FOR PATIENT FOLLOW UP

Stephen Megarity*, Paul Rafferty, Say Quah. *Royal Victoria Hospital, Belfast, UK*

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Introduction PEPSE is one method of reducing HIV transmission in higher risk groups. It is commonplace for PEPSE to be delivered from the Emergency Department (ED) out-of-hours. PEPSE delivered outside of GUM can be met with challenges in regard to follow up; resulting in missed opportunities for health promotion, education and STI testing.
Methods Retrospective case-note review of ED episodes from 1/4/2015–31/3/2016. Demographic information and data collected compared with audible outcomes (BASHH 2015 PEP guidelines).
Results 37 patient episodes identified; 97% male with a mean age 28.2 years. 86% of these episodes occurred out-of-hours with 84% receiving PEPSE within recommended indications (standard 90%). 81% of patients prescribed PEPSE had an HIV test within 72hours (standard 100%). In regard to follow up, 59% of all patients attended for STI testing (standard 90%). There was a 9% rate of STIs reported in those attending for follow up. 51% of all patients had an 8–12 week HIV test (standard 75%). There was 1 new HIV diagnosis reported. Introduction of an ED staff education programme and e-referral pathway has resulted in a 24% increase in patients attending for STI testing. In addition, 100% of patients using pathway had an HIV test within 72 hours and 100% of PEPSE prescriptions were within recommended indications.
Discussion Targeted quality improvement strategies can have a significant impact on PEPSE outcomes for higher risk groups. Improved follow up within GUM after PEPSE prescription in ED has increased opportunities for diagnosis and treatment of STIs, vaccine provision and patient education.

P064 AUDIT OF POST-EXPOSURE PROPHYLAXIS WITH ASSOCIATED RISK PROFILES AT THE GAY MEN'S HEALTH SERVICES, DUBLIN, 2016

[1,2]Geraldine Moloney, [1]Siobhan O'Dea*, [1]Colm O'Sullivan, [1,3]Susan Clarke. *[1]Gay Men's Health Services, Dublin, Ireland; [2]Trinity College Dublin, University of Dublin, Dublin, Ireland; [3]St James's Hospital, Dublin, Ireland*

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Introduction The incidence of HIV infection is rising in Ireland, reaching a rate of 10.6/100,000 people in 2015. MSM is the most common route of transmission, reported as 50.9% of new diagnoses. There is a comparative surge in requests for HIV post-exposure prophylaxis (PEP) in Gay Men's Health Services (GMHS), Dublin: 44% increase in 2016, vs. 2015. In 2016, a PEP proforma was devised for consistent clinical assessment of PEP requests and decisions.

Methods We performed a retrospective review of all PEP requests from June-December 2016, following the introduction of this proforma. We investigated exposure types, reported use of condoms, alcohol, drugs, and partners STI status. We assessed appropriateness of PEP decisions in accordance with national guidelines, and compared risk profiles to published findings from 56 Dean Street.
Results 116 PEP assessments occurred in this time, with the specific proforma. All were evaluated as appropriate for PEP. GMHS attendees had same median age (31 years) as those of Dean Street. However, GMHS attendees reported significantly elevated risks of no condoms used (73 vs 54%; p <0.0001), more recreational drugs (30 vs 20%; p = 0.01), with an additional 13% using both drugs and alcohol. GMHS attendees reported more IAI, and significantly less group sex activity (3.5 vs 11%; p =0.02). Partner's viral or bacterial STI status was rarely known.
Discussion PEP is appropriately assessed and provided for GMHS attendees. High risk sexual behaviours are common, requiring comprehensive HIV prevention strategies for the continuing epidemic.

P065 THE GMI COMMUNITY COACHING MODEL – COACHING HIV SELF-TESTING AND SELF-SAMPLING WITHIN HIGH RISK MSM

[1]Yasmin Dunkley*, [2]Dee Wang, [1]Steve Worrall, [2]Karen Skipper, [3]Andrew Evans. *[1]Positive East, London, UK; [2]Spectra, London, UK; [3]Metro Centre, London, UK; [4]GMI Partnership, London, UK*

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Introduction In light of moves towards online provision of HIV services, e.g. self-testing, or online self-sampling, the GMI Partnership wanted to understand whether there was a way in which community based organisations could support and incorporate trends towards online provision of services, as well as understand the knowledge of at risk communities in light of changes, through the provision of community coaching on self-testing and self-sampling. The GMI Partnership provides sexual health promotion and HIV prevention services to 76,000 high risk MSM across London each year, as well as in-depth interviews with at least 4,000 MSM each year.
Methods 2888 online surveys identified existing literacy re-HIV self-testing and self-sampling in MSM (targeted via dating apps.) Recognising that literacy was limited, GMI provided community coaching on self-testing with MSM in high risk venues, to identify whether the intervention was more likely to engender comfort with new technologies (200 quantitative interviews).
Results HIV literate MSM do not understand the difference between self-testing and self-sampling.

The community coaching model ensures high levels of confidence and acceptability in self-testing technologies.
Discussion Community testing models can complement self-testing and self-sampling.

There will always be clients for whom online provision of new technologies will not work.

Scalability of the model within African groups (community based intervention).

P066 RISK REDUCTION' REFERRALS TO A SPECIALIST LONDON HIV AND SEXUAL HEALTH PSYCHOLOGY SERVICE

Caroline Coffey, Mirjana Jovanovic*, Vera Forjaz. *Chelsea and Westminster NHS Foundation Trust, London, UK*

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Introduction Considering the low number of referrals of 'risk reduction' patients to the HIV and Sexual Health Psychology service in comparison to number of patients presenting with sexual risk taking at referring sexual health clinics, we implemented a 'sexual wellbeing' service development initiative in 2016.

We aimed to compare all the 'risk reduction' referrals in 2014 to 2016 in order to reflect on the impact of the service developments implemented in 2016.
Methods A retrospective case note review was conducted to identify referral rates to psychology over a 1-year period in 2014 and 2016. Age at referral, referral outcome and number of sessions were included.
Results The number of referral increased fivefold from 2014–2016. In 2014, 23 patients were referred. The mean age at referral was 32. 16 patients opted in to the service, 13 engaged in assessment/therapy. The mean number of sessions attended was 5. In 2016, 115 patients were referred. The mean age at referral was 36. 72 patients opted in and 48 patients engaged in assessment/therapy. The mean number of sessions was 3.

40 patients are still engaged with the service and will complete an intervention.
Discussion The service development initiative has resulted in a significant increase in the number of referrals to psychology. Further service initiatives are ongoing to address the continuing low number of patients opting in and engaging with psychological interventions.

P067 ALL BETTER NOW?: COMPLETING THE AUDIT CYCLE FOR PEPSE IN THE EDINBURGH GUM SERVICE

Helen Pollitt*, Durba Raha. *NHS Lothian, Edinburgh, UK*

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Introduction Over 2014-2015 in the GUM clinic in Edinburgh we audited PEPSE (post exposure prophylaxis for sexual exposure) as per 2011 BHIVA guidelines. The initial audit results showed that we fell short of the BHIVA auditable standards, most noticeably for proportion of prescriptions within recommended criteria, completion of PEPSE course and STI testing. Based on the results of the audit and the updated 2015 BHIVA guidelines, changes were incorporated into a new local PEPSE pathway. Changes included more detailed patient discussion about whether PEPSE is recommended, providing full 28 day course at first visit if indicated and STI screening at initial visit. We have re-audited PEPSE prospectively August 2016 onwards to see if there was improvement in the standards after the new local guideline was implemented.
Method The following and demographics were documented on Excel Spreadsheet for patients who were prescribed PEPSE and compared with the results of the original audit.