identify young people at risk; commissioners should ensure that opportunities are not lost with online access. We suggest commissioning of a one stop shop model for under 18s or robust online screening protocols to ensure opportunities for intervention are not lost.

P194 ROLLING OUT THE UK'S FIRST REGIONAL MSM HPV VACCINATION PROGRAMME: EARLY EVALUATION AND PRACTICAL CONSIDERATIONS

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Introduction The four countries in the UK had different interpretations of the JCVI HPV vaccination recommendations. We aim to describe our experience to date of the full vaccination programme that commenced in our region in October 2016.
Methods We conducted a retrospective review of our opportunistically-offered vaccination programme, using both electronic and paper records.
Results From October 2016 until end January 2017, 827 vaccines were administered to 609 patients. The records of 274 vaccinees were analysed. 59% were HIV negative, 41% positive. 99% were MSM, aged 18 – 67, 12% were over 45, 43% were diagnosed with an STI or had PEP in the preceding 6 months, 74% had no documented history of genital warts. 11% attended solely for the HPV vaccine at their second visit. 91% of HIV positive patients re-attended for their second vaccine at their usual HIV clinic appointment. An estimated completion rate, calculated using those who re-attended as planned at one month and received a second vaccination, was 83%. For the HIV positive cohort, this was higher still at 95%.
Discussion We found that opportunistically vaccinating this cohort resulted in only 11% of all second attendances being solely for a HPV vaccine, and only 6.5% in the HIV positive cohort. Our completion rate, calculated using data at one month, was high. We aim to present a full six months of data.

P195 HOW PREPARED ARE GUM AND HIV CLINICS IN LONDON TO RESPOND TO THE HEPATITIS A OUTBREAK? A SURVEY OF VACCINATION POLICY AND LOGISTICS

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Introduction From late 2016, Hepatitis A virus (HAV) infection in MSM increased in incidence in the UK and has reached outbreak status. By February 2017, 42 confirmed or suspected cases had been reported in London. An outbreak committee was convened by Public Health England and as part of this work data was gathered to ascertain current levels of vaccination and future needs in MSM attending GUM/HIV clinics.
Methods Clinical leads for GUM and HIV services in London were e-mailed a survey asking about past HAV vaccination policy, requirements for vaccine, logistics of vaccine provision, acute HAV infection reporting and contact tracing policy.
Results 14/17 (82%) NHS Trusts, representing 23 clinics responded to the survey.

Abstract P195 Table 1 HAV Vaccination Provision for MSM in GUM and HIV clinics in London

Never stopped in GUM	Stopped in GUM in last 2 years	Stopped in GUM in last 2–10 years	Stopped in GUM >10 years ago
3/23 (13%)	6/23 (26%)	7/23 (30%)	7/23 (30%)
Offered to all HIV+ patients		**Offered to selected HIV+ patients only**	
20/23 (87%)		3/23 (13%)	

4/23 (17%) GUM clinics restarted routine vaccination in 2017. Only 3 HIV clinics were able to estimate background HAV immunity in their MSM as being 70–90% immune/vaccinated. The barriers to roll out of vaccination were identified as cost/funding (17/23 74%); logistics of provision (11/23 48%) and vaccine supply difficulties (7/23 30%). All clinics would contact trace acute HAV cases internally, 6/23 (23%) would notify the Health Protection Team by phone and the rest would notify using the BASHH/PHE notification form.
Discussion The provision of HAV vaccination for MSM in London GUM clinics has been variable, leading to a significant proportion of MSM potentially remaining non-immune. The main barriers to vaccination have been funding, logistics and vaccine supply. If the outbreak is to be halted, these barriers need to be overcome.

P196 THE COST TO FIND ONE CASE OF SYPHILIS

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Introduction Cost effectiveness is an important consideration especially in the context of constrained budgets. For the National Chlamydia Screening Programme, doubling Partner Notification (PN) was modelled to reduce the cost per diagnosis by £60 and improves gender equity (Turner et al, BMJ. 2011; 342:c7250. doi: 10.1136/bmj.c7250); however, it is not known how PN impacts on a less common but growing Syphilis epidemic. We therefore looked at the impact of PN for patients with Syphilis using a new PN tool.
Methods The Syphilis diagnoses and testing for one year from February 2016-2017 were determined for two clinics, prices for testing and PN were derived from the integrated sexual health tariff (www.pathwayanalytics.com) and PN data was obtained from SXT (www.sxt.org.uk).
Results The Syphilis incidence was 257/30,641 and the cost of a full screen £75; consequently, the cost per Syphilis diagnosis was £8,941. Ten percent of patients coded as partners were found to be infected with Syphilis. The PN outcomes of 248 (96%) patients with early infectious Syphilis were known: 132 partners were verified as seen and tested (KPI=0.53), representing 13 new diagnoses. The cost to deliver PN was £4903 [248*(£17.33 tariff & £2.40 SXT)] and ten partners need to test at £750 [10*£75] to diagnose one case, making the

overall cost per Syphilis diagnosis £5,653. PN initiated testing was estimated to reduce the cost per syphilis diagnosis by £3,288.
Discussion PN services reduce the cost to diagnose Syphilis and support case finding. More work is required to target testing and improve PN.

P197 AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS TO EXPLORE THE EXPERIENCES OF PATIENTS AFTER SPEAKING WITH A HEALTH ADVISER ABOUT PARTNER NOTIFICATION

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Introduction Partner notification (PN) is pivotal in controlling spread of sexually transmitted infections (STI) by reducing onward transmission and preventing reinfection. We explored the experiences of patients undergoing PN after being diagnosed with a STI.
Methods 259 patients diagnosed with a STI over a 3 week period were invited to complete a PN survey comprising quantitative and qualitative questions. Qualitative data was analysed using Interpretative Phenomenological Analysis (IPA).
Results 76 patients, 20 female and 24 male responded (not all questions were answered). Mean age was 31 (range 16-58). 21 identified as single and 16 partnered. 29% said this was their first clinic attendance, 65% said this was their first ever STI diagnosis and 36% said they attended as a STI contact. Eight main themes were identified: (1) infection source; (2) how to contact partners; (3) difficult information to discuss 'specific sexual acts performed with every one of them'; (4) uncertainty of partner testing and treatment; (5) concern of providing partner details; (6) future expectations; (7) use of social media; and (8) Health Adviser (HA) qualities. Patients understand PN, but face barriers due to partnership dynamics and lack the skills required for PN. Further partners were contacted following consultation with a HA. Evidence of alternative PN being offered (i.e. provider referral) was limited.
Discussion In line with BASHH guidelines, the importance of specialist staff in delivering PN was evident. Novel ways to facilitate sexual history taking and methods to contact partners (i.e. social media) are preferred and should be explored further.

P198 CHEMSEX AND ANTIRETROVIRAL THERAPY NON-ADHERENCE IN HIV-POSITIVE MEN WHO HAVE SEX WITH MEN: A SYSTEMATIC REVIEW

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Introduction Chemsex is associated with ART non-adherence and may therefore negatively influence HIV disease progression. However, there is no systematic examination of evidence for this association. Our objective was to summarise the extent of ART non-adherence among chemsex drug-using HIV-positive MSM worldwide and to quantify the effect that chemsex has on ART non-adherence by comparing chemsex drug-users to non-chemsex drug-users.
Methods Pubmed and Embase were searched from inception to 25.06.15. Prevalence and analytical studies were included. Bias was assessed using a risk-of-bias assessment tool. Assessment of heterogeneity was conducted using I2 and Cochran-Q Chi2 statistics. Metaanalyses were conducted using fixed or random-effects methods. Metaregression assessed for formal statistical evidence of heterogeneity.
Results 3288 published and unpublished records were screened. Prevalence of ART non-adherence among chemsex drug-users (10 studies) ranged from 6% to 81%. 7 studies provided 10 effect measures for the association between chemsex drug-use and ART non-adherence. Chemsex drug-users had 23% higher odds of being ART non-adherent compared with non-chemsex drug-users (OR 1.23, 95%CI 1.10–1.38, I2 0%, p=0.372). Studies that used less specific definitions of chemsex drug-use found weak statistical evidence for an association (OR 1.96, 95%CI 0.52–7.31, I2 78.9%, p=0.009). Meta-regression failed to provide statistical evidence of why the effect varied between studies.
Discussion In HIV-positive MSM, the prevalence of ART non-adherence among chemsex drug-users varied widely. There was evidence of an association between chemsex drug-use and ART non-adherence. Paucity of studies and substantial heterogeneity between studies limited interpretation of results. Further well-conducted studies in a variety of settings are needed.

P199 ARE WE TESTING IN THE RIGHT LOCATIONS? USE OF PUBLIC HEALTH MAPPING TO INVESTIGATE YOUNG PEOPLE, CHLAMYDIA AND SOCIOECONOMIC STATUS

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Introduction Chlamydia testing is universal and routine in all local sexual health clinics. Projected local population increases and expansion of the university sector necessitate the appraisal of current services and future planning to meet population need.
Objective To investigate whether the current locations of Chlamydia testing services match areas of high need.
Method We obtained data from the Sexual Health in Wales Surveillance Scheme (SWS) on Chlamydia diagnoses in integrated sexual health clinics by middle super output area (MSOA) of residence for patients living in our local area. Mapping software is used to overlay Chlamydia testing behaviour and positivity against locations of FE colleges, STI testing clinics, areas of high deprivation and areas with a high proportion of young residents.
Results Between 2012 and 2016, 3,450 chlamydia diagnoses were recorded in Cardiff and Vale residents. The maps suggest that Chlamydia diagnoses were most common in areas usually habited by students. Furthermore, mapping fifths of deprivation suggested lower rates of Chlamydia in the more deprived areas, despite more testing venues.
Discussion The maps suggest University students are frequent testers and have a high positivity for Chlamydia whereas those from more deprived areas have lower rates for Chlamydia. This descriptive analysis suggests that local chlamydia testing services may not be mapped to populations at greatest need.