P221 SPOTTING CHILD SEXUAL EXPLOITATION (CSE) RISKS IN A SMALL RURAL COHORT; WHAT TO LOOK OUT FOR AND HOW TO EFFECTIVELY SHARE INFORMATION

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Introduction Recognition of CSE is a vital part of our work. We host a monthly multiagency safeguarding meeting (SM), alongside social services, children in care (CIC) team and hospital safeguarding. All children with high risk behaviours/vulnerabilities who have attended in the previous month are discussed including children in care, those current self-harming and those disclosing grooming or sexual assault. We will explore other factors contributing to CSE risk and demonstrate the value of the multiagency SM to care.
Methods Review of records of 90 adolescents 13-17 attending between 01/08/16 – 30/09/16. Demographics, safeguarding concerns and SM outcomes were recorded. Results were analysed using SPSS and Pearsons/Fishers tests.
Results 84% (76) were female. 13% (12) were aged ≤15. In this group a history of involuntary sex was associated with both the use of recreational drugs (p=0.002) and any diagnosis of a mental health condition (p=0.020). 12 patients were discussed at the SM. New information was shared between partner organisations in 75% (9) cases. Further results for risky behaviours can be seen in Table 1.

Abstract P221 Table 1 Spotting CSE

	Yes (%)	No (%)
History of involuntary sex	21(25.6)	61(74.4)
History of grooming	1(1.2)	82(98.8)
Sent/Received sexually explicit photos	5(8.8)	52(91.2)
Met partners on internet/social media	6(10.7)	50(89.3)
Previous or current self-harm	33(37.6)	53(62.4)
Known to Social Services	20(22.8)	68(77.2)

Discussion Discussion at the SM improves the care of vulnerable children by identifying those at risk and improving multiagency care planning. Mental health problems or illicit drug use should prompt careful evaluation for CSE risk.

P222 BISEXUAL MEN – TWICE THE FUN OR DOUBLE THE RISK?

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Introduction Men who have sex with men and women (MSMW) are a group with unique sexual health needs, increased risk of STI's and the potential to bridge homosexual and heterosexual populations. Information is lacking regarding sexual health behaviour among this group.
Aims Investigate STI testing behaviour of MSMW attending a sexual health clinic, recent sexual behaviour and STI diagnosis.
Methods Retrospective review of sexual health clinic electronic case notes of men attending with a new episode whose sexual orientation was recoded as bisexual from 1/4/2016 to 31/6/2016. Information was obtained on demographics, recent sexual partners, STI testing performed and diagnosis.
Results 78 MSMW attended during the audit period. Uptake of STI screening was high (95% genital Chlamydia and Gonorrhoea testing, 87% HIV and Syphilis testing). Extra genital site testing was performed in 70% patients. 79% had all appropriate sites tested according to their sexual history (oropharyngeal testing lacking in 12%, anal testing lacking in 1%, 8% unclear from documentation). In the previous 3 months 61% reported multiple sexual partners, 40% reported sex with both male and female partners and 66% reported unprotected sex with a new partner. Forty men reported a current regular female partner of which 29 also reported a recent male partner (27 unprotected). 23% were diagnosed with an STI following their clinic attendance.
Discussion MSMW showed high risk sexual behaviour and prevalence of STI's. Concordant male and female partners highlight the need to encourage regular screening in this group, record a detailed sexual history and offer all appropriate tests.

P223 IMPACT OF NATIONAL CHLAMYDIA SCREENING PROGRAMME IN CHILDREN AGED <16 YEARS ATTENDING A SEXUAL HEALTH CLINIC: 10 YEARS LATER

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Introduction The objectives of this study were to compare the rates of sexually transmitted infections (STIs) and the uptake of chlamydia test in a Level 3 sexual health clinic during pre and post National chlamydia screening programme (NCSP) periods. The programme has also included children aged <16 years if they are found to be Fraser competent.
Methods
The study period 1st September 2002 – 31st August 2016. Data were collected retrospectively from the Lilie Sexual Health Management System.
Results Total of 894 (N=894) children were studied; of whom 80% were girls. Age range was 13-15 years. Demographic details were similar in pre and post- NSCP periods.

Abstract P223 Table 1 STI and testing rates

	Overall STI rate	Chlamydia rate	Test Uptake
Pre-NSCP			
2003&2004 (n=160)	19%	6%	46%
Introduction of NSCP locally in 2004			
Post- NSCP			
2005&2006 (n=155)	23%	13%	59%
2007&2008 (n=156)	21%	15%	60%
Level 2 young people sexual health service was introduced in 2008			
2009&2010 (n=140), 5 years later	14%	7%	64%
2011&2012 (n=107)	8%	4%	66%
2013&2014(n=94)	12%	8%	66%
2015&2016 (n=82), 10 years later	9%	3%	67%

Discussion The rate of genital chlamydia infections had peaked during the immediate post- NSCP period. This is probably

related to increased uptake of chlamydia test using the less invasive method. However, the overall trend has shown some reduction in both chlamydia and other STI rates in children aged 13-15 years attending our clinic for the past eight years. The reduction might have been contributed by NSCP in addition to changes in the sexual health services locally.

P224 AGILE, DESIGN LED APPROACH TO ONLINE SERVICE DEVELOPMENT

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Introduction Sexual health services lead innovative thinking in the NHS with integrated service provision, online access and testing in non-traditional venues. Agile design-led thinking creates services that are intuitive, easy to use and valued by users (both staff and patients). It offers an alternative to pre-specifying a whole system (waterfall approach) frequently associated with unpredicted problems, identified late and requiring costly fixes.

Methods SH:24 uses an agile, design-led approach to service development delivering value by: Focusing on user need (understanding and empathising rather than assuming); Reducing cost (failing quickly, cheaply); Reducing risk (avoiding unnecessary, costly development); Creating tangible, visual, measurable outputs early (promoting understanding, collaboration and buy-in). Our agile, design-led approach included extensive user involvement; building the minimum from cycles of build, test, learn; responding to feedback, continuously improving and optimising.

Results This presentation will provide three examples describing the contribution of agile to development of:

1. Self-sampling kit instructions which delivered 76–84% return rate
2. User friendly information pages on contraception – 2000 hits daily
3. Online chlamydia treatment – 95% uptake

We will demonstrate the added value of design and agile for these examples.

Discussion An agile design led approach is championed by Government Digital Services - it involves re-framing issues as opportunities and rapidly iterating thinking by building and testing user centred prototypes - this approach minimises cost and risk while improving user experience - an approach that could add value in NHS services.

P225 DO COMMUTERS HAVE TIME FOR SAFE SEX? DELIVERING AN OUTREACH QUICK CHECK STI & CONTRACEPTION SERVICE TO LONDON COMMUTERS

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Introduction Sexual health services are under growing pressure to provide resource efficient STI screening and contraception services. At the same time busy people are seeking time efficient, convenient services to fit in with busy working lifestyles. By establishing an asymptomatic screening and contraception service in a well-known brand pharmacy at a busy mainline London railway station we hoped to meet both these needs.

Two weekly outreach sessions are provided by an Independent Nurse Prescriber covering both a lunchtime (12–4) and evening (4–8) session on different days. Appointments are booked online with minimal walk-in availability. Prescriptions are issued via FP10's and collected from the pharmacy.

Methods Of 1425 attendances in a one year period a retrospective case note review was done for a 3 month period July – Sept 2016 (329 attendances).

Results Of these 329 patients 75% (248) women and 25% (81) men, of whom 3 MSM. Age range 18–51 (mean age 27yrs) 51% (169) new patients, 187 asymptomatic screens done (1% positivity CT). 147 contraception issued (72% COCP, 21% POP, 5.4%, VR, 1.3% Patch), New contraception 15% (22/147), Maintain 78% (114) Change method 6.8% (10). 26 patients required EHC.

Discussion There is a high attendance and low DNA rate demonstrating this is a well-used, well positioned timely clinic to meet the needs of a busy commuter population. With more women expressing difficulty getting GP appointments for routine contraception more sessions like this would be appealing for the working population. The service is cost-efficient with low staffing and overheads.

P226 'AGENDER FOR CHANGE': REPRESENTING GENDER AND SEXUALITY DIVERSITY IN SEXUAL HEALTH

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Introduction Trans* identities are under-represented in UK sexual health data. One possible reason is that the traditional representation of gender within the restricted binaries of male and female contributes to the low numbers seen in sexual health services. We aimed to obtain a clearer understanding of the hidden gender and sexuality identities accessing an LGBT-targeted sexual health service.

Methods We offered full sexual health screening in a community LGBT clinic during National HIV Testing Week in 2016. A self-completed triage form was used to register patients. Additional gender identity options were added to the form. This included an 'other' box with an option to specify any gender or sexual identities that had not been represented on the form.

Results 78 patients completed the registration form. 52 identified as male and 18 female. 8 (10%) described different gender identities; 2 trans*-men, 2 demi-boys, 1 gender fluid, 1 bi-gender and 2 non-binary.

In terms of sexual orientation, 8 identified as heterosexual men, 50 as gay men, 2 as lesbian women, and 6 (2 male, 3 female and 1 non-binary) as bisexual. 11 identified themselves as pansexual and 1 (a demi-boy) as asexual.

Discussion Increasing the options during registration captured a wide variation in reported gender identity and sexual orientation. To avoid a complex, multi-option question on the registration form, we would suggest that simplifying this to 'please describe your gender' and 'please describe your sexuality' would be advantageous for both the patient and health care professional.