patterns or STI transmission risk. Given this context, we explored the social relevance, understandings and meanings of contemporary sexual partner types, as a first step in aligning lived realities with clinical practice to improve PN outcomes.

Methods We conducted eleven semi-structured focus groups (November 2016-August 2017), with members of the public (n=38) and sexual health clinic attendees diagnosed with an STI in the past six months (n=19) in England and Scotland. We recruited participants aged 18–65 years who identified as heterosexual or men who have sex with men (MSM), using purposive and convenience sampling. Data were digitally recorded, transcribed and analysed using thematic analysis in NVivo V.10.

Results Findings from the 57 participants (male n=34; female n=23), suggested two key themes in understanding sexual partner types: 1) nature of emotional involvement with the partner(s) and 2) time/continuity of the relationship. Both tapped into participants' relationship perspectives and shaped their understandings and use of partner terms. Interrelated subthemes involved: the different contexts, such as clinical consultations or everyday social interactions, which shaped the use of the terms 'regular' and 'casual' and associated interpretations; and the polysemy and ambiguity of the terms when they were used in combination with other words (e.g. casual sex; casual partner; casual regular) and alternate terms (e.g. random, one-off, serious relationship). There were no differences in the understandings of the terms between heterosexual and MSM participants.

Conclusion This is the first empirical evidence that challenges and provides insight into the dichotomy of sexual partner types in contemporary clinical practice. There is a need for a new socially informed, interdisciplinary classification of sexual partner types to enable better recording and communication between patients, sex partners and healthcare professionals. Improved understanding of partner types will help healthcare professionals develop and tailor PN approaches which address social and cultural influences on the way people form sexual relationships and talk about sex. This will enable targeting of resources to achieve greatest benefit to individual and population health by detecting and preventing STI transmission.

| OP32 | TRENDS IN USE OF PRESCRIBED MEDICINES BY BODY MASS INDEX AND AGE: EVIDENCE FROM THE LAST TWO DECADES USING HEALTH SURVEYS FOR ENGLAND DATA |

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Background Prescribing is the most common clinical intervention in the NHS, with annual costs exceeding £9 billion. Understanding differences in patterns of prescribed medicine use over time informs clinical practice and epidemiological research. We compare trends in prescribed medicine use by body mass index (BMI) and age to better understand the factors associated with increased prescribing.

Methods Repeated cross-sectional analysis of nationally-representative Health Surveys for England 1994–2015 (n=42 216 participants aged 20+ years with measured BMI and medicine use data). Sex-specific logistic regression models with main effects and interactions between BMI (reference: normal-weight; obese: BMI ≥30 kg/m^2), age, and survey year on taking any prescribed medicine in the last week (excluding smoking cessation products and contraception) were assessed adjusting for smoking and education. Analyses were repeated for polypharmacy (3+ medicines), and for cardiovascular and non-cardiovascular medicines. Results are presented as fully-adjusted Odds Ratios (OR) with 95% Confidence Intervals (95% CIs).

Results Overall, the age-standardised prevalence of prescribed medicine use between 1994 and 2015 increased from 37.8% (95% CI 36.7% to 39.0%) to 46.7% (45.2%–48.2%) in men and from 45.7% (44.6%–46.8%) to 53.2% (51.8%–54.6%) in women. By 2015, use of 3+ medicines had doubled to 24.6% (23.4%–25.8%) in men and to 27.2% (26.1%–28.3%) in women. Among those taking any medicine, polypharmacy rose by 1.7 times to 42.8% (39.9%–45.6%) and 45.1% (42.9%–47.2%) respectively.

Prescribed medicine use increased over time more sharply with age. However, after age-adjustment, the increase in prevalence over time was greatest in obese women (BMI-by-year interaction: p=0.003). The odds of obese women taking any prescribed medicine in the last week were 1.5 times higher than those for normal-weight women in 1994 (OR: 1.49; 95% CI 1.28 to 1.73), but had increased to 2.1 in 2015 (2.14; 1.82–2.53). Increased medicine use over time was greatest in obese men for cardiovascular medicines (BMI-by-year interaction: p=0.036). The odds of obese men aged 50–59 years taking any prescribed cardiovascular medicine in the last week were 2.1 times higher than those for normal-weight men of the same age in 1994 (2.08;1.46–2.95). The equivalent odds had increased to 3.0 in 2015 (2.98; 2.10–4.21).

Conclusion Higher BMI is associated with increased prescribing over the last 20 years regardless of age, reflecting secular rises in levels of awareness and of treatment of obesity and other co-morbid conditions, such as hypertension and diabetes, increased availability of effective secondary prevention medicines (e.g. statins, ACE inhibitors), lower thresholds for their use, and greater adherence to guidelines for their prescription.

| OP33 | PERMANENT CHILDHOOD HEARING IMPAIRMENT DETECTED THROUGH UNIVERSAL NEWBORN HEARING SCREENING: SYSTEMATIC REVIEW AND META-ANALYSIS OF PREVALENCE AND SCREENING PROGRAMME PERFORMANCE IN 1.8 MILLION INFANTS |

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Background Systematic appraisal of universal newborn hearing screening (UNHS) programme performance and the prevalence of permanent childhood hearing impairment (PCHI) detected is lacking, including for those admitted to Neonatal Intensive Care Units (NICU). We carried out a systematic review and meta-analysis of studies reporting PCHI prevalence (defined as bilateral loss ≥26 dB HL) detected through UNHS (defined as universal screening using otoacoustic emissions and/or auditory brainstem response testing by age 6 months) in very-highly developed countries (PROSPERO:CRD42016051267). We