P136 THE EVALUATION OF A STEPPED-CARE MODEL FOR PROVIDING EFFECTIVE AND COST-EFFICIENT PSYCHOSEXUAL SERVICES WITHIN SEXUAL HEALTH

Karen Gurney*, Pip Bullemor-Day, Kathy White, Michael Yates, Rhiann Jamieson, Caitlin Kiddy, Herman Van Der Walt. *Central and North West London NHS Trust, London, UK*

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Introduction Increasing demand for sexual problems services plus reductions in commissioning have led to a need for high quality services delivered in a low-cost model within sexual health settings. A service redesign utilised a stepped-care model included the use of group therapy interventions as a first line treatment for erectile difficulties and painful sex. These interventions continued alongside existing MDT service provision.

Methods All patients accessing the service in the first 12 months were given self-report outcome measures at key points of the intervention including quantitative and qualitative aspects of change. Results are compared between those accessing an erection difficulties group, a painful sex group and individual psychosexual therapy sessions.

Results

Abstract P136 Table 1 Psychosexual intervention results

Intervention	Individual (n=32)	Erection Group (n=23)	Pain Group (n=9)
% significant change	50%	30%	22%
% change	38%	70%	67%
% reporting no change	12%	0%	0%

Discussion Further efforts to utilise group interventions for sexual problems may support the continued provision of psychosexual services in sexual health settings. Groups were evaluated favourably by service users and demonstrated considerable change. Qualitative feedback suggested distinct benefits of a group intervention over individual care. Those receiving a higher stepped intervention (individual sessions) may have been more complex and for others change in the problem in a traditional sense may not have been possible, however change was reported in other ways (i.e. affect in relation to the problem, relationship satisfaction).

P137 BURDEN OF CHRONIC LIVER DISEASE IN AN HIV COHORT

Laura Bell*, Stephen Megarity, Michelle McIntyre, Yvonne Wilson, Johnny Cash, Neil McDougall, Michael Hunter. *Belfast Health and Social Care Trust, Belfast, UK*

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Introduction HIV monitoring guidelines recommend 3-to-12 monthly monitoring of LFTs in HIV-infected patients. Liver-related deaths account for 10–15% of mortality in patients with HIV-infection. Draft NICE guidance, covering the identification of chronic liver disease, is under consultation.

Methods 200 HIV-infected patients were randomly selected from a cohort of 1000 patients. Those patients who were not engaged in care (i.e. less than 2 out-patient appointments in the past 12 months) or not on ARVs were excluded. Demographics, lifestyle factors and laboratory parameters were recorded. Patients at greatest risk of liver cirrhosis were screened using transient elastography.

Results Of the 161 HIV-infected patients on ARVs, 49 (30%) had a raised AST or ALT within the preceding year. Only 105 (65%) had a documented alcohol history. Of patients with elevated transaminases, the cause was already established in 21/49 (43%). Factors included alcohol, IM testosterone, viral hepatitis, cryptosporidium infection and hepatotoxic medication. 12 patients were found to have an AST-to-platelet ratio index (APRI) of greater than 0.7. Of these the causes identified included: 4 hepatitis C co-infected, 1 hepatitis B co-infected, 2 alcohol related, 1 Budd Chiari awaiting liver transplant, 2 medication related and 2 not established. Patients with raised transaminases were offered metabolic risk factors screening and transient elastography.

Discussion There is a small but significant burden of liver disease in patients on ARVs. Lifestyle counselling, to reduce harmful alcohol consumption and viral hepatitis infection could be improved. Implementation of NICE guidelines may improve the diagnosis of cirrhosis.

P138 CAN WE REDUCE TIME TO TREATMENT BY NAMING THE INFECTION IN A RESULTS TEXT?

Nicola Fearnley*, Sophie Brady. *Bradford Sexual Health, Locala Community Partnerships CIC, Bradford, UK*

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Introduction Previously patients testing positive for infections received a text (SMS) asking them to contact clinic. Often this led to missed calls, anxiety and delays in both communicating results and treatment. In June 2016 the wording of the text was changed to include the name of the infection and advice regarding how to access treatment.

Methods We identified all patients attending our service with chlamydia or gonorrhoea infection between April and December 2016. We excluded those who had received treatment prior to confirmation of their test result (e.g. symptomatic, contacts of infection) and those who did not receive a results text. We reviewed the records of 200 consecutive patients (100 before and 100 after introduction of the new text) and compared time to treatment in the two groups.

Results

Old text recipients median time to treatment was 2 days (d)/mean 3.3 (range 0–24d). New text recipients: median time to treatment was 2d/mean 3.9d (range 0–26d).

Discussion Naming the infection in texts has not led to a reduction in the time to treatment but the median time to treatment in both groups was short. Our health advisor team report anecdotal benefits following the new text including less time spent answering telephone calls therefore allowing more time for patient contact, beneficial since depletion of the health advising workforce. Additionally patients have been happy to agree to the text change in advance with a reported reduction in anxiety knowing the name of the infection.