

in clinical practice which are currently not covered by the European guidelines and these need to be reviewed to provide physicians with appropriate guidance.

P127 SPECIAL INTEREST CLINIC: A NOVEL GENITOURINARY MEDICINE SERVICE INITIATIVE PROVIDING CONTINUITY OF CARE AND EDUCATIONAL OPPORTUNITIES

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Introduction External referral to dermatology and psychosexual services from genitourinary medicine (GUM) can cause delays in patient care. To counter this within our service an experienced consultant has established a Special Interest Clinic (SIC) reviewing dermatology, erectile dysfunction and complex GUM cases. Written educational feedback is offered to internal referrers. We reviewed the impact of SIC.

Aims To evaluate the service offered by SIC.

Methods Data was collated from randomly selected patient records who attended SIC between April 2012 and April 2013.

Results A total of 100 records were reviewed. 67 patients were male, 25 of whom were MSM. Patients were ethnically diverse, White British (52) being the most common ethnicity. Median age was 33 years (range 19–70). 12 patients were HIV-infected. Internal referrals predominated (96) and average waiting time from referral was 6.2 weeks (range 0.14–28). Broadly stratifying referrals 40 patients were complex GUM, 35 psychosexual medicine, 25 dermatology. The most prevalent diagnoses were erectile dysfunction (23) and lichen sclerosus (9). 9 patients required skin biopsy, 8 of which were performed within SIC. Ongoing follow up was recommended to 60 patients, of which 43 (71.7%) were retained. 27 patients were discharged after first attendance. 77 referrers requested feedback, all received it.

Conclusion Keeping patients within our service provided continuity of care. The availability of formal feedback increases educational opportunities for referrers. We recommend experienced clinicians consider establishing similar SICs in other services. A challenge services will encounter is the lack of specific SHHAPT coding for prevalent SIC diagnoses.

P128 MEETING STANDARDS IN MANAGEMENT OF SEXUAL ASSAULT: ARE WE THERE YET?

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Background/introduction Effective management of victims of sexual assault is important to encourage people to report abuse and receive care. BASHH provide guidance on management of sexually assaulted patients. We reviewed case notes of 36 patients who were treated for sexual assault.

Aim(s)/objectives

- To identify demographic characteristics of sexually assaulted victims attending the clinic.
- To understand how we meet the BASHH guidance (2011) in the management of sexual assaults.
- To assess the usefulness of locally used template for cases of sexual assault

Methods Case notes of 36 patients treated for sexual assault who attended the clinic from January 2013 to March 2014 were reviewed. A questionnaire was designed to collect data and the data was analysed using Microsoft excel.

Results 44 case notes were identified but 36 cases fulfilled the inclusion criteria. Of the 14 auditable outcomes, only documentation of essential criteria (standard 1) reached the 100% standard and six achieved above 75% of the expected standard of 100%. These include documentation of physical injuries, self-harm risk assessment, offer of emergency contraception, offer of active vaccination against Hepatitis B and assessment of child protection need. Offer of baseline STI screening was documented in 72%. Poor documentation of BASHH criteria on further referral for physical injuries (33%) and repeat testing for STIs (36%) were identified.

Discussion/conclusion Importance of complete documentation on sexual assault cases should be emphasised. Reviewing the sexual assault template to capture all necessary information was identified as a result of this audit.

P129 SHARED CLINICAL PRIORITIES IN AN INTEGRATED SEXUAL HEALTH SERVICE

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Background/introduction Demand exceeds capacity in many sexual health services. In response to this, our GUM department developed a triage policy based on agreed clinical priorities. When we integrated with the local Sexual and Reproductive Health (SRH) service, which had its own more loosely defined priorities, an essential part of the process was to agree shared clinical priorities.

Aim(s)/objectives To create a single, agreed set of priorities across an integrated sexual health service.

Methods We reviewed the existing GUM priorities, and agreed they were still applicable. We created a formal set of SRH priorities. We merged the two into an integrated set of clinical priorities that would apply across the whole service.

Results The existing GUM priorities were patients with or at significant risk of HIV, followed by patients with or at significant risk of syphilis, then gonorrhoea, then chlamydia. The SRH priorities were widespread provision of long-acting reversible contraception (LARC), followed by emergency contraception (especially IUD), high quality abortion service, services for young people and services in more deprived areas. The single, agreed set of priorities for the integrated service were HIV-positive patients, women with unplanned pregnancy and under 16's; followed by patients at high risk of HIV, high risk of unplanned pregnancy, and/or people living in areas of high deprivation.

Discussion/conclusion Creating shared priorities has proved invaluable when pressure on the service builds up. Both services had to shed priorities that might have hitherto been regarded as "sacrosanct".

P130 DOES USE OF A PRO FORMA IMPROVE MANAGEMENT OF COMPLAINANTS OF SEXUAL ASSAULT?

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