Results Of 39 patients (29 male, 10 female), mode of transmission was 27(69%) sexual, 11(28%) vertical, and 1 unknown. The vertically-acquired cohort have lower CD4 counts (64% vs 93% CD4 >350), more resistance mutations (including triple class resistance) and lower rates of viral suppression (45% vs 90%) compared to the sexually-acquired cohort. Retention in care is also lower, (72% vs 92% attending in the last year). STI rates are high overall but higher in the sexual transmission cohort, 75% vs 55%.
Discussion/conclusion The under 25 HIV clinic cohort comprises 2 distinct groups: a vertically -acquired cohort with poorer outcomes, who consistently require more support and motivation to remain engaged in care; and a sexually-acquired cohort who adhere to HAART, but have higher rates of STIs and would benefit from support involving motivational interviewing and health promotion.

P137 TACKLING HIV RELATED STIGMA AND DISCRIMINATION WITHIN NHSGGC SERVICES

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Background/introduction Individuals with HIV report experiencing stigma and discrimination. Outcome 5 of the Scottish Government Sexual Health and BBV Strategy (2011–15) aims to address this issue. Locally a system was established to record and collate events on a 'third party' basis, which revealed that most incidents occurred within NHS services.
Aim(s)/objectives In collaboration with the HIV Patient Forum, we examined HIV stigma among NHSGGC staff by:

- Assessing knowledge of HIV
- Measuring HIV attitudes and beliefs
- Capturing staff experiences of HIV stigma

Based on the findings, we are developing an appropriate staff CPD programme.
Methods Between 8–23 July 2013, an anonymous self-complete questionnaire was sent to all 38,000 NHSGGC employees. This was circulated by email from the Director of Public Health with reminders issued via internal staff bulletins.
Results A 10% completion rate was achieved (n = 3,971 responses). Staff

- had variable knowledge of HIV which was much poorer in relation to treatment advances and routes of transmission.
- held mixed attitudes with less favourable attitudes correlated to poor knowledge
- reported practice which could be perceived as discriminating against patients
- expressed a strong desire for greater knowledge and access to training

Discussion/conclusion This survey from the largest UK NHS employer provides evidence that poor knowledge and attitudes are based on outdated information and assumptions which in turn leads to poor patient experiences. This has provided a platform to develop pro-active anti-stigma approaches ranging from a staff-facing campaign, refreshed HIV training and development of a patient empowerment toolkit.

P138 CASH DIRECT: INCREASING PATIENT CHOICE AND ACCESS TO LARC

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Background/introduction Busy lifestyles and women's continued need and desire for reliable methods of contraception, has led to the development of 'CaSH Direct' which offers LARC assessments and procedures at times that are convenient to women but without the need for multiple visits to.
Aim(s)/objectives CaSH Direct aims to:

- Increase women's access to LARC
- Reduce demand on clinics
- Increase women's choices of times and location of procedure
- Reduce the time women spend in clinic
- Make more efficient use of staff time

Methods Women attending clinic and requesting a LARC are offered a telephone consultation at a time that is convenient to them (day or evening) meaning women do not need to take time away from work or family to access the service avoiding the need to wait in clinic to be assessed. Clients are then contacted by a sexual health practitioner who completes an assessment over the phone allowing the woman to take the call in an environment that is familiar to her and without the cost or time implication of attending clinic. A suitable appointment time is made at the end of the assessment for the client to attend an agreed clinic for the procedure to be carried out.
Results Client feedback has proved to be favourable for the service with 70% rating the service as excellent, pressure in walk-in clinics has been eased and appointment times are being utilised more effectively.
Discussion/conclusion CaSH Direct has made a positive impact on service provision and client choice through innovative and effective use of skills within the service.

P139 TO ATTEND OR NOT TO ATTEND – "WHY" IS THE QUESTION?

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10.1136/sextrans-2015-052126.182

Background/introduction Documents such as "10 high impact changes for genitourinary medicine 48 h access" produced by the Department of Health (DH) in 2006 have helped reduce waiting times and increase capacity. Our service experienced a significant increase in the rate of non-attendance of appointments following a change in service base in February 2014. In response we decided to ascertain whether adopting some or all of the DH's high impact changes would improve the poor attendance.
Aim(s)/objectives On review we were already employing most of the recommended changes. One omission was high impact change 5: "Review current access system and make it easier for patients to access the service", therefore we asked patients their preferred means of attendance (appointment or drop in) and times of attendance.
Methods 105 services users were questioned over a 4 week period from the 1st until the 31st August 2014.

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Results 44% preferred the option of both appointments and drop in, whilst 28% each favoured either all appointments or drop in access only. There was no preferred time of attendance.
Discussion/conclusion As the service already provides both appointments and drop in access the audit provided little to no evidence that a change to service delivery would reduce levels of non-attendance. There remains minimal data about how best to fulfil public and individual sexual health obligations, especially to an extensive rural community such as ours. A further audit on actual non-attenders could identify patterns in patient expectation.

P140 MISSED OPPORTUNITIES FOR ENSURING ADEQUATE CONTRACEPTION: LESSONS FROM A RURAL SEXUAL HEALTH SERVICE

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10.1136/sextrans-2015-052126.183

Background/introduction Our county-wide service is undergoing increasing integration which makes public health sense. Ideally, risk of both sexually transmitted infections and pregnancy should be addressed with patients.
Aim(s)/objectives We looked at missed opportunities for ensuring adequate contraception during routine GU appointments.
Methods A retrospective notes review of 50 consecutive new female attendances over 2/12 was conducted, with a follow up at 4/12 to check contraception initiation or pregnancy.
Results Consultations were conducted by 16 different staff, 44%(7) of whom are trained to initiate oral contraceptive pills (OCPs), 4 fit implants and 2 fit IUCD/IUS. 23 and 27 patients were seen by nurses and doctors respectively. Contraception methods, including none, were universally documented. 22(44%) patients were using long acting reversible methods of contraception (LARC) and 28%(14) an OCP. Pill compliance was documented in 5(36%) and advice given in 1 case. Only 4 (14%) of the 28 non –LARC patients had LARC discussion. 7 patients used condoms and 7 no contraception. 5(36%) of these were advised to book a contraception clinic (CC)/GP appointment for contraception, 2 of whom failed to attend a subsequent CC. 1 patient was quick- started on an OCP. 2 patients were known to have conceived during the subsequent 4/12; 1 had LARC and 1 OCP at initial visit. 6(12%) and 1 patient/s were deemed at risk of pregnancy and appropriately provided with emergency contraception respectively.
Discussion/conclusion There were missed opportunities to maximise contraception efficacy. Time restrictions and lack of staff training pose barriers which we need to address.

P141 HOW ACCURATE IS CLINICAL CODING IN RECENTLY INTEGRATED SEXUAL HEALTH SERVICES?

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10.1136/sextrans-2015-052126.184

Background/introduction Clinical coding in England provides monitoring data for Public Health England via the Genitourinary Medicine Clinic Activity Dataset (GUMCAD) and Sexual and Reproductive Health Activity (SRHAD) returns. In London, this data is also used to reflect activity for the Integrated Sexual Health Tariff (ISHT) which may form the basis for payment in future. Integration of contraception and GUM services presents a challenge in maintaining accuracy of clinical coding.
Aim(s)/objectives To audit the accuracy of SHAPPT, SRHAD and SRH coding in a multi-site integrated sexual health service, comparing sites traditionally providing GUM services vs contraception.
Methods Local standards were agreed; 95% of patients should have accurate SHAPPT, SRHAD and SRH codes. 229 records from 2 GUM sites and 53 from 1 contraception site were audited from attendances between May and July 2014.
Results

	Traditional GUM (% correct)	Traditional contraception (% correct)
"T" codes	140/142 (99%)	22/25 (88%)
P1A, P1B, P1C codes	209/229 (91%)	7/34 (21%)
A-C codes	58/67 (86.5%)	3/11 (27%)
SRHAD	31/46 (67%)	29/31 (94%)
SRH	2/20 (10%)	5/9 (55%)

Discussion/conclusion As expected, the accuracy of coding reflected the traditional nature of the sites. The locally set standard of 95% was only reached on one occasion. Missing SRH codes alone would equate to lost income of £1259 from 77 visits if the ISHT was in place. Staff training and weekly capture and correction of missing HIV codes through targeted email reminders has resulted in an improvement in coding.

P142 USING THE "SPOTTING THE SIGNS" PROFORMA IN A GUM CLINIC TO FACILITATE IDENTIFICATION OF CHILD SAFEGUARDING CONCERNS

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Background/introduction In the wake of recent events regarding child sexual exploitation, BASHH produced the 'Spotting the Signs' guidance. Our GUM department has been using the 'Spotting the Signs' proforma since August 2014 for all under 16 year olds routinely and any patients aged 16–17 where concerns identified.
Aim(s)/objectives The aim of this project was to review the data gathered using the proforma and review the number of safeguarding referrals made.
Methods All under 16s and any patients aged 16–17 seen between August and December 2014 were identified. A retrospective case note review was undertaken of all the proformas. Data gathered included non-consensual sex, age differences, drug and alcohol issues, coercion and number of referrals to child safeguarding.
Results 20 patients were identified (16 female, 4 male); 18 cases were under 16 years. Two patients aged 16–17 had been assessed using the proforma. 50% of patients were identified as having mental health issues, 55% were identified with concerns regarding exploitation and 20% were noted to have problematic drug/alcohol use. 55% of patients were referred to safeguarding services.

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