map patient journey, identify potential improvements, including introducing on-line booking and e-triage.
Aim(s)/objectives To evaluate 1) the proportion of patients whose visit is >2 h from entering clinic to completion of the clinical encounter 2) effectiveness of patient completed triage.
Methods Pilot data was collected over 1 day (1 week to follow). Reception staff recorded patient first arrival, and administered a patient completed questionnaire recording the timing of the clinical encounter. Questionnaires, triage forms and case notes were reviewed.
Results 49 patients attended (23 male, 26 female). Complete data were available for 15(65%) males and 18(69%) females (Table 1). 58% of patients needed to allow >2 h to attend clinic (61% symptomatic, 57% asymptomatic). Self-triage was available for 45(92%) patients, with concordance between clinician and patient in 41/45 (91%).

Abstract P155 Table 1 Time in clinic: median hours (range)

	Male	Female	Total
Duration: clinic visit	1.55 (0:55–2:49)	2.11 (1:05–4:11)	2.04 (0:55–4:11)
Time before consultation	1.17 (0.35–2.10)	1.34 (0.40–3.37)	1.30 (0.35–3.37)
Duration: clinical encounter	0.30 (0.08–2.04)	0.30 (0.05–2.00)	0.30 (0.05–2.04)
Duration: clinic visit, symptomatic	1.50 (1.06–2.08)	2.18 (2.05–3.57)	2.05 (1.06–3.57)
Duration: clinic visit, asymptomatic	2.10 (1.30–2.49)	2.00 (1.05–4.11)	2.07 (1.05–4.11)

Discussion/conclusion Provisional data shows: 1) patients spend too long in clinic and developments including online booking could potentially reduce this, and 2) most patients are able to triage themselves.

P156 HOW MUCH ANTIRETROVIRAL THERAPY DO WE DISCARD?

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Background/introduction Current audit standards for antiretroviral therapy (ART) prescribing do not include standards for quantity dispensed.
Aim(s)/objectives 1) Establish a clinical standard for the quantity of ART to dispense when initiating or switching therapy. 2) Make a qualitative assessment of avoidable discards of ART. 3) Audit prescribing against existing BHIVA standards.
Methods An HIV care unit's database was interrogated to identify 350 patients who had initiated or switched ART over 2 years to August 2014. ART prescribing and outcomes data were collected retrospectively from 110 randomly selected patients.
Results 58.2% (n = 64) switched therapy; 57.8% (n = 37) as a result of toxicity, 15.6% (n = 10) resulting from rationalisation of therapy and only 3.1% (n = 2) for virological failure. The median quantity of ART dispensed at initiation or switch was 8 weeks (IQR; 8–12) supply; discarded at switch was 1.5 days (IQR; 0–29.75) supply. Mean (SD) cost of discarded ART after switch was £311.11 (£11.54); median was £20.63 (IQR; £0-£334.94). Reasons for discard for patients in the highest cost quartile are displayed in Table 1.
Discussion/conclusion Dispensing 8 weeks of ART at initiation or switch results in a lower than expected cost of discarded ART. There is limited potential for reduction in avoidable discards by addressing the small number of high cost cases.

Abstract P156 Table 1 Reasons for discard in highest cost quartile

Indication	Number of patients	Percentage of patients	Total cost (£)
Toxicity	6	37.5%	7024.08
Renal impairment	5	31.25%	5578.81
Patient request	2	12.5%	1308.94
Drug interaction	1	6.25%	756.84
Unclear	2	12.5%	2166.21

P157 IDENTIFYING THE DEMAND FOR "TEST-NO-TALK" GU SERVICES IN A RURAL SETTING

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Background/introduction GU services are under growing pressure to provide resource-efficient screening programmes. Test-no-talk (TNT) services are gaining interest as an affordable method of asymptomatic screening.
Aim(s)/objectives Identify the proportion of our patients who might be suitable for TNT services.
Methods We retrospectively reviewed the notes of 271 new/rebook patients who were tested for any combination of chlamydia, gonorrhoea, syphilis and HIV. Patients were excluded if they had any other service or diagnosis code apart from C4. For the purpose of the study, patients were deemed unsuitable for TNT services if they were symptomatic, <18 years of age, at high risk of HIV, a recent victim of sexual assault, at risk of pregnancy, a man with a same sex partner (MSM), if female, menstruating at the time of the appointment. TNT suitability was analysed using chi-squared tests.
Results 134 men and 137 women, median age 30 and 23 respectively, were included. 202 patients (75%) were asymptomatic, of these 110 (54%) were suitable for TNT services). The association between gender and symptoms was statistically significant: 81% of men being asymptomatic compared to 69% of women (p = 0.024). 54 (49%) patients were examined, altering the management of 9. There were no statistically significant associations between age or gender and TNT suitability (p = 0.97 and p = 0.06 respectively).
Discussion/conclusion Approximately 40% of our patients undergoing STI screening could be directed towards TNT services, with careful risk-assessment at booking. Our results suggest it is safe to exclude physical examinations in TNT clinics as they rarely alter the management.

P158 EXPLORING THE FEASIBILITY OF SHORTENING THE NATIONAL CHLAMYDIA SCREENING PROGRAMME TIME TO TREATMENT STANDARD

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Background/introduction Timely treatment of sexually transmitted infections (STI) is an important factor in reducing sequelae and transmission. British Association for Sexual Health and HIV

(BASHH) standards for the management of STIs recommends treatment "in as short a timescale as possible". The National Chlamydia Screening Programme (NCSP) sets a key indicator of treating ≥95% of those testing positive within six weeks of test date.

Aim(s)/objectives To explore the feasibility of services achieving a shorter time to treatment standard.

Methods National audit data from the most recent NCSP turnaround time audit were used to explore how many services would meet treatment targets of three and two weeks from test date.

Results The current time to treatment standard of ≥95% treated within six weeks was achieved by 39% of providers (91% of positive patients receiving treatment within six weeks, due to large services having a proportionately greater impact). Using the targets of three and two weeks this fell to 28% and 4% of providers, respectively. However, this represents 88% of patients treated within three weeks and 76% within two weeks (Table 1).

Abstract P158 Table 1 Chlamydia treatment

Timescale	% of patients treated within the timescale	% of providers with ≥95% of patients treated within the timescale
Six working weeks	91%	39%
Three working weeks	88%	28%
Two working weeks	76%	4%

Discussion/conclusion 88% of positive patients were treated within three weeks from test date even though only 28% of providers would have been able to meet this time to treatment standard. Meeting a shorter time to treatment standard would be challenging but could help to drive quality improvement and may form part of updated standards for the NCSP.

P159 SEXUAL HEALTH SERVICES ARE IDEALLY PLACED TO MANAGE VULNERABLE YOUNG PEOPLE?

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10.1136/sextrans-2015-052126.202

Background/introduction Identifying and assessing the risk of child sexual exploitation (CSE) in young people is a fundamental role of sexual health clinics. The 'Spotting the signs' proforma developed by BASHH recommends assessing all those <18 yrs for risk factors.

Aim(s)/objectives The aim of this audit was to review those <18 yr olds attending the GU clinic in Brighton assessed as medium or high risk to investigate the areas of concern, the appropriateness of interventions and follow up.

Methods EPR records for all <18 yr olds between 1/4/14 and 31/10/14 were reviewed.

Results 56 patients identified, 86 attendances. 36/56 (64%) were 16–17 yrs. 48/56 (86%) were female. 23/56 (41%) were seen in the Young Person's Clinic, the rest seen throughout the service. Concerns included: sexual assault/non-consensual sex 41%, drugs and alcohol 39%, difficulties at home/in care 37%, mental health 37% and partner age/coercion 11%. 20% had concerns in ≥ 3 areas. Interventions: 24/56 (53%) already had social work or other agency involvement, 27% were referred to agencies for the first time as a consequence of their visit to the clinic. Further clinic follow up was arranged in 33/56 (59%). All patients had a clear action plan.

Discussion/conclusion This audit suggests that older young people (16–17 yrs) have significant risk factors; the same vigilance accorded to under 16's needs to be applied to this group. Sexual Health clinics are well placed to both recognise those at risk and provide ongoing support and referral.

P160 WHAT IMPACT DID THE XX COMMONWEALTH GAMES HAVE ON STIs AND SEXUAL HEALTH SERVICES IN GLASGOW?

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Background/introduction An estimated 600,000 spectators, volunteers and athletes from over 70 countries visited Glasgow for the XX Commonwealth Games, held between 23 July and 3 August 2014, doubling the city's population.

Aim(s)/objectives We sought to investigate the impact of the Games on the number of acute STIs and on service activity in core specialist sexual health services, which offer free walk-in access.

Methods We interrogated our city-wide electronic patient record system (NaSH) to measure service activity, the number of acute STIs and PEPSE prescriptions between the 9th July and the 31st August 2014. We compared these to the same time period in 2013. We prospectively asked all new clinic attendees if they were in Glasgow for the Games.

Results

Results	Games 2014	Games 2013	Difference
Total Attendances	14,973	16,440	−8.9 (↓)
New Registrations	1,986	2,150	−7.6 (↓)
Acute STI episode	623	693	−10.1 (↓)
Gonorrhoea	78	81	−3.7 (↓)
Chlamydia	372	428	−13.1 (↓)
Early syphilis	15	14	7.1 (↑)
NSU	83	78	6.4 (↑)
Trichomonas	3	2	50.0 (↑)
Primary HSV	64	79	−19.0 (↓)
PEPSE prescriptions	8	11	−27.3 (↓)

Of the 1496 attendees who responded, just 1.7% (26) were in Glasgow solely for the Games.

Discussion/conclusion Despite the huge influx of visitors, service activity and overall acute symptomatic STI incidence decreased by around 10% during and after the Games compared to 2013. We found no evidence that large sporting events increase demand for sexual health services or cause a rise in acute STIs.

P161 SEXUAL HEALTH IN GENERAL PRACTICE: DO GP PRACTICES COMPLY WITH BASHH GUIDELINES?

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Background The passing of the Health and Social Care Act 2012 committed to more services in the community provided closer to home and by GPs. Therefore most GP practices are commissioned to provide Level one STI screening.