P173 ROUTINE ENQUIRY FOR INTIMATE PARTNER VIOLENCE (IPV) ACROSS AN INTEGRATING SEXUAL HEALTH SERVICE

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Background We have previously presented our review of routine enquiry (RE) for IPV in a genitourinary medicine (GUM) service. On-going integration with contraception services (CASH) combined with a new electronic patient record (EPR) in 2013 has prompted further review across the whole service (comprising 13 community clinics and the level 3 GUM service).
Aim Have these service changes impacted on our recommendation that RE is undertaken for all new patients? In addition, how many cases of IPV are we identifying?
Methods All new or rebook patients attending between 01/05 and 30/11/2014 where RE was documented were reviewed. Results: There were 17878 attendances (12316 new; 8724 female, 3590 male). The results are summarised below.

Abstract P173 Table 1 Routine enquiry for intimate violence

IPV routine enquiry	No of cases	%
Patient screened at least once	8614	70 (of new attendances)
Current issues documented	72 (68 female; 4 male)	0.8
Past issues documented	567	6.6

58% of those identified with current issues of IPV had attended the level 3 GUM service. In the majority, support was already in place. 567 had documentation of past issues of IPV, of which 58 had on-going needs identified. Experiences included child sexual abuse, stalking and social media harassment.
Discussion Routine enquiry for IPV is feasible across an integrated service and identifies a range of issues. The proportion screened appears stable (71% in 2013 and 70% in 2014). The scale of the problem in our population is alarming and highlights the need for adequate staff training and clear referral pathways.

P174 IMPROVING IMPLANT RETENTION RATES IN AN INTEGRATED SEXUAL HEALTH SERVICE

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Background Subdermal implants (SDI) are cost effective when used for the recommended time. Early removal of SDI reduces cost effectiveness and we were aware anecdotally that this was an issue within our service. Data was lacking however. Subsequently removal rates at 3 and 6 months have been included within our Public Health Quality Contract (PHQC). Various strategies were implemented to reduce early removal. These included: improving the consent process by amending consent form; encouraging the use of additional methods to manage unscheduled bleeding; starting a dedicated implant removal clinic in February 2014.
Aim Have the outlined service changes impacted on SDI removal rates?
Methods Data from our PHQC was obtained from 2014–15. This measured SDI removal rates as a proportion of the total SDI fitted by our service.
Results In April 2014 the 3 months removal rate was 3.53%. By November 2014 it had fallen to 0.34%.
Discussion The strategies that were implemented appear to have had the desired effect. Care was taken to ensure staff gave patients the right information prior to fitting to ensure that their expectations of how any side effects would be managed was clear at the outset. The implant removal clinics were initially slow to get established and now are fully booked for months in advance. This has led to some criticism that patients are now unable to get their implants removed easily. The challenge moving forward is to ensure that patients have any symptoms managed promptly whilst keeping retention rates high.

P175 THE IMPACT OF INTRODUCING AN ASSISTANT PRACTITIONER TO THE HEALTH ADVISOR TEAM IN A BUSY URBAN SEXUAL HEALTH SERVICE

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Background The role of Assistant Practitioner (AP) in the Health Advisor (HA) team is new and has not previously been described. It is unusual in that someone who has not had formal nursing or medical training is able to supply medicines to a patient. Our service set about developing this Agenda for Change band 4 role, with Drug and Therapeutic Committee approval, to support the clinical team.
Aim To evaluate the new role now that training is complete.
Methods List the tasks undertaken by HA and compare with those now undertaken by the AP.
Results

Traditional HA Roles	Delegated to AP
Supply Azithromycin for uncomplicated Chlamydia/contacts of (including in pregnancy)	✓
Carrying out simple Partner Notification (PN) for Chlamydia	✓
Recalling patients for treatment	✓
Following up patients via telephone calls	✓
HIV Point of Care Testing	✓
Motivational Interviewing	✓
Carrying out PN for STIs other than Chlamydia	×
Safeguarding Adults and Children	×
Support post Sexual Assault	×

Discussion The AP has proved to be a valuable additional role within our service. Rigorous training and robust protocols had to be developed but this now allows her to operate independently. Despite initial reservations about replacing a HA post with an AP of a lower band our clinical team are now supportive of this role and recognise that this delegation of tasks allows time to focus on more complex cases.

P176 THE ROLE OF DUTY DOCTOR IN AN INTEGRATED SEXUAL HEALTH SERVICES

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Background/introduction The duty doctor role was introduced into our integrated sexual health service in 2012 with the aim of improving patient flow through the clinic.
Aim(s)/objectives Three years on we wished to review the service and ensure it remains fit for purpose.
Methods We undertook an anonymous survey of clinical staff assessing if the duty doctor improved the service for patients and staff waiting for a second opinion; for staff teaching and learning and staff's confidence in duty doctor knowledge.
Results Twenty seven members of staff completed the questionnaire. When asked to rate the utility of the duty doctor on a scale of 1 to 10 (1-no use at all, 10-indispensable) the average response was 8. The majority thought the service was better or much better for patients and staff. Only 21% thought the service should be expanded. 72% of respondents have/would bypass duty doctor. 55% would approach the duty doctor for GUM but ask elsewhere for contraception. 47% would approach for contraception but ask elsewhere for GUM. Only 25% thought a separate contraception and GUM duty doctor was needed. The service was praised for its expert 2nd opinions, quick responses and the reassurance to patients. Common problems were that the doctors were hard to contact at times and occasionally doctor's gender was difficult for patients.
Discussion/conclusion The duty doctor is a valuable role, accessibility needs to be addressed but with the exception of increasing the pool of doctors who act as duty doctor the role should remain unchanged.

P177 DEVELOPING THE SEXUAL HEALTH WORKFORCE: DESIGNING AND DELIVERING TRAINING FOR HEALTHCARE ASSISTANTS

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Background Increasingly 'simple' sexual health services (e.g. asymptomatic screening) are provided by Healthcare Assistants (HCA's). There is no nationally accredited training for this staff group and clinical services usually provide in house training to develop their theoretical knowledge and skills.
Aim To develop and evaluate a course for HCA's working in sexual health.
Methods We designed a 2-day course covering 14 topics based on the structure of the STIF course. Content and learning objectives were devised using existing competencies and in consultation with the multi-disciplinary team. Nurses deliver the course using a mixed teaching methodology (lectures, role play and interactive workshops). Learning outcomes include:

Knowledge:

1. Understand the principles of asymptomatic STI testing
2. Understand issues relating to confidentiality, vulnerable patients and partner notification

Skills:

1. Feeling comfortable and competent taking a sexual history
2. Optimise care pathways with local relevant support services

Attitudes:

1. Understand the range of human sexualities, lifestyles and culture and their impact on transmission, prevention and counselling

Results The course has run on 2 occasions with a total of 18 attendees: both sexual health HCAs and practitioners from other specialities (e.g. A+E and gynaecology). All topics were well evaluated with a mean overall score of 4.55/5 (range 3.8–5). Free text comments were positive with specific reference to how "valuable", "useful" and "relevant" the course was.
Discussion We have designed, delivered and evaluated a successful sexual health course for HCAs that could easily be nationally accredited and delivered in other services and settings.

P178 SPECIALIST HERPES CLINICS: IS THERE ANY POINT?

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Background/introduction Specialist clinics have been introduced in a number of specialities, but patient benefits have proved difficult to demonstrate, despite increased investigations and costs. Genital herpes requires extensive counselling which previous studies have demonstrated is often of poor quality.
Aim(s)/objectives To assess the value of a specialist genital herpes clinic, in terms of patient satisfaction and outcomes, in comparison with a general genitourinary medicine clinic at a UK level 3 sexual health service in patients with a diagnosis of first episode genital herpes.
Methods 200 patient records of those attending a UK level 3 sexual health service with first episode herpes between 2012–2013 attending a specialist or general clinic were reviewed to assess initial management, complicating factors, and subsequent health seeking behaviour. 20 patients with a recent diagnosis of herpes attending either a specialist or general clinic were interviewed to determine patient satisfaction, and information provided on a number of key counselling topics identified by the BASHH herpes guidelines.
Results Provisional results from 79 patients demonstrate that those attending the specialist clinic were more likely to have complicating factors, including pregnancy, and psychological distress. Return to clinic with recurrences was 20% for the specialist and 15% for the general clinic. Full results will be available by the conference.
Discussion/conclusion Patients attending a specialist herpes clinic presented with more complicating factors, but despite this there was little difference between patient outcomes and satisfaction between clinics. Specialist herpes clinics may therefore be useful to manage more complex patients.

P179 EVALUATION OF AN ONLINE BOOKING SERVICE TO ACCESS ASYMPTOMATIC SCREENING

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Background/introduction Symptomatic patients are prepared to wait hours for open access sexual health services; however, patients without symptoms want simple and convenient access to testing.
Aim(s)/objectives We therefore introduced a new online booking service for asymptomatic patients and evaluated if patients would use it correctly.