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

Eleanor Lock, Michael Brady*. *Kings College Hospital NHS Foundation Trust, London, UK*

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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?

[1]Sarah Wade*, [1,2]Emily Clarke, [1,2]Raj Patel. [1]*University of Southampton, Hampshire, UK;* [2]*Royal South Hants Hospital, Southampton, UK*

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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

Anatole Menon-Johansson*, Ruslan Artykov. *Guy's & St Thomas' NHS Foundation Trust, London, UK*

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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.

Methods All booked asymptomatic screens from 1st December–13th January 2015 were analysed. These patients were registered and self-triaged as per normal and analysis of the electronic patient record was performed on the 27th January.
Results During this period 285 patients attended via the online booking service and the majority (91%) were asymptomatic and seen by the health care assistants. The median (min, max) number of appointment each weekday was 10 (1, 31) and 39% of these patients were from the local two boroughs.

Abstract P179 Table 1 Asymptomatic screens

Description	Male	Female	Total
Number	139 (49%)	146 (51%)	285 (100%)
Age in years, Median (range)	30 (21–58)	27 (18–47)	
Sexuality			
Heterosexual	106 (73%)	137 (99%)	243 (85%)
Bisexual	2 (1.4%)	1 (0.7%)	3 (1%)
Homosexual	37 (25%)	0	37 (13%)
Ethnic origin			
White	98 (67%)	100 (72%)	198 (70%)
BME	30 (21%)	25 (18%)	55 (19%)
Not stated	18 (12%)	14 (10%)	32 (11%)
Sexually transmitted infections			
Chlamydia	3 (2.1%)	5 (3.6%)	8 (2.8%)
Gonorrhoea	2 (1.4%)	2 (1.4%)	4 (1.4%)
Trichomonas vaginalis	0	1 (0.7%)	1 (0.4%)

Discussion/conclusion The majority of patients used the online booking service correctly. Further work is required to increase the range of services available via online booking.

P180 THE HOLY GRAIL, IS IT POSSIBLE? – A QUALITY IMPROVEMENT APPROACH USED TO INCREASE PRODUCTIVITY, CAPACITY AND OFFER A HIGH QUALITY AND TIMELY WALK-IN SEXUAL HEALTH SERVICE WITHIN EXISTING RESOURCE

Charlotte Hopkins*, Lina Hijazi, Monica Lascar. *Barts Health, London, UK*

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Background/introduction Patient feedback consistently informed us that they disliked waiting to be seen. Our Sexual health clinic (SHC) was facing challenges of low staff morale, uncertainty around future tendering arrangements and declining attendances. Quality improvement methods were used to empower the multidisciplinary team to find solutions for improvement and two priorities emerged, to see walk-in patients on time and to extend our evening clinic provision from two to four per week.
Aim(s)/objectives
Aims:

- To reduce the average waiting time for walk-in patients in a SHC by 50%.
- To see every walk-in patient within 20 min of the allocated slot time by April 2015.

Objectives:

- Increase productivity by 15%.
- Extend evening clinic provision within existing resource.
- Introduce asymptomatic quick check service.

Methods A quality improvement approach, using the Institute of Healthcare Improvement's model for improvement was used. The whole multidisciplinary team (MDT) met bi-monthly and ideas were tested using plan, do, study, act (PDSA) cycles. Measurement was introduced using statistical process control charts.
Results The quick check service shows a 40% increase in uptake, from 10 to 14 patients (average), (range 4–23). We introduced minimum patient allocated numbers, following these interventions there is a 42% reduction in average waiting times from allocated slot time (31 min pre and 18 min post intervention). Our productivity last month increased by 14%.
Discussion/conclusion A quality improvement approach was a successful method to improve the quality of our services, respond to patient feedback and effect change in a sexual health clinic.

P181 RETROSPECTIVE AND PROSPECTIVE ANALYSIS OF THE INPATIENT MANAGEMENT OF EPIDIDYMO-ORCHITIS

[1]Alison Toczek*, [1]Louisa Churcher, [2]Sorrush Soleimanian, [2]Sanjeeva Pallawela. *[1]North Middlesex Hospital, Deparment of Urology, London, UK; [2]North Middlesex Hospital, Department of Microbiology, London, UK*

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Background/introduction Epididymo-orchitis, a common urological diagnosis in men aged 18–50, has significant sequelae if inadequately treated. Causative organisms in patients under the age of 35 are most commonly sexually transmitted infections. In patients over 35 enteric Gram-negative organisms causing urinary tract infections are more prevalent. Empiric treatment should be commenced as per guidelines until results of investigations are known.
Aim(s)/objectives To evaluate inpatient management of epididymo-orchitis.
Methods Data was retrospectively collected from June to December 2014 for all epididymo-orchitis patients diagnosed clinically. Information was obtained from notes, radiology and pathology databases. A 3 month prospective study is ongoing to improve investigations and antibiotic prescribing.
Results 7 of 26 inpatients diagnosed with epididymo-orchitis were under 35 years of age and 19 over 35. 19 were diagnosed with unilateral epididymo-orchitis and 7 bilateral. 4 patients developed abscesses, and 1 had an orchidectomy. 6 had a first-void urine, 14 a mid-stream urine, and 3 a urethral swab. 9 patients were discharged on doxycycline and ciprofloxacin, 7 with ciprofloxacin monotherapy. Duration of treatment as an outpatient ranged from 7 to 42 days.
Discussion/conclusion Current inpatient management of epididymo-orchitis varies significantly, and a third of patients are being discharged on doxycycline and ciprofloxacin, a combination not recommended in the BASHH guidelines. BASHH recommends cefuroxime +/- gentamicin for management of inpatients over 35 years of age; however in view of the risk of clostridium difficile this may require updating. This and our ongoing prospective study may provide results to help recommend appropriate antibiotics for inpatients with epididymo-orchitis.