Background/introduction Our level 3 GUM clinic has held an integrated young person's clinic (YPC) since 2008. As well as STI testing, we provide all methods of contraception except intrauterine devices, for <25s. Maximising the uptake of LARC is recommended as a method of preventing unplanned pregnancy. Previous audits of females attending for contraception have shown that 100% are offered LARC, but have not included females attending the YPC for other reasons.
Aim(s)/objectives To assess the utility of contraceptive methods of female patients attending and leaving the YPC, as an outcome measure for the effectiveness of contraceptive interventions.
Methods Prospective audit of 100 consecutive females attending the YPC from October 2014.
Results The average age was 19 (14–24). 77(77%) attended purely for contraception, 11(11%) for a sexual health check and 12(12%) for both. 15/17(88%) of those not using contraception and 18/21(86%) of females using condoms left the clinic with a form of hormone contraception [19/38(50%) LARC]. On arrival 28(28%) used oral contraception/Evra and on leaving 42(42%). On arrival 33(33%) had LARC and on leaving 48(48%) had LARC. LARC was offered to all females not already using it, except 2 with complex medical conditions. The commonest reasons for declining were being happy with their current method-17(17%) and fear of side effects-11(11%).
Discussion/conclusion The SRHAD proforma used by sexual health clinics only records contraception supplied. Contraception in/out is a better outcome measure of the prevalence of LARC use in a clinic's attendees, and an indicator of holistic sexual healthcare in an integrated YPC.

P244 CHILD SEXUAL EXPLOITATION – REVIEW OF INFORMATION SHARING AND IDENTIFYING PATIENTS AT RISK

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Background/introduction We are a community based, multidisciplinary team providing sexual health care for 8,000 under 20s that attend our service yearly. Child Sexual Exploitation (CSE) is an increasingly recognised problem that affects young vulnerable people across the UK. Information sharing between agencies is an important factor in identifying young people who are involved in CSE and in order to improve our practice, we retrospectively reviewed case notes of those identified as vulnerable to CSE by other agencies.
Aim(s)/objectives To identify: was information shared when a risk of CSE was identified during the sexual health consultation? What is the prevalence of strong and warning signs of CSE in this population of young people attending sexual health services?
Methods Retrospective case note review using our health authority tool for identifying CSE risks.
Results 76 of the136 young people identified had attended our service. 39/76 (51%) had at least one strong indicator for CSE. 36/39 nine were known to social work. 38/39 had documented information sharing. 11/76 (14%) had at least one warning indicator and 26/76 (35%) had no identifiable CSE risk factors. 7/26 had information shared with social work.
Discussion/conclusion Information sharing occurred for almost all patients identified with a strong risk factor for CSE. 49% of the young people identified by other agencies as at risk did not disclose information that strongly indicated CSE. Incorporation of the BASHH spotting the signs proforma and training to further increase staff awareness is being developed.

P245 A PRAGMATIC PATIENT PATHWAY ENSURING APPROPRIATE SAFEGUARDING DECISIONS FOR CHILDREN WITH GENITAL WARTS

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Background/introduction Children found to have genital warts may present to doctors of various disciplines. The experience and knowledge of these doctors in the diagnosis and management of genital warts, and the need to assess for possible sexual abuse and other sexually transmitted infections (STIs) is variable. The authors have all been contacted for advice regarding the management of these children. In order to streamline this process and ensure that all children are appropriately assessed we developed a clinical algorithm.
Aim(s)/objectives To establish a pragmatic clinical algorithm incorporating safeguarding decisions for the management of children with genital warts.
Methods A group of paediatric, GUM and forensic physicians reviewed the evidence and relevant UK guidelines, consulted with other experts in the field and drafted an algorithm for the management of children with genital warts.
Results An initial algorithm was piloted by the authors and colleagues and sent to authors of relevant UK guidelines for their opinion. The algorithm was then finalised and is now in use in our region. It is presented as a simple flowchart.
Discussion/conclusion Developing this algorithm was complicated by differing views of experts in the field and the unfamiliarity of some doctors other than GUM or forensic physicians in performing genital examinations in children and taking the required tests. We have found this algorithm to be a useful framework for clinical decision making, to support safeguarding decisions and to ensure that the required steps are taken when assessing children with genital warts.

P246 SURVEY OF IMPLANT REMOVALS IN A YOUNG PEOPLE'S SEXUAL HEALTH SERVICE

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Background/introduction A trend for young people (YP) to abandon the contraceptive implant because of intolerable side effects has been noted. YP aged 21 and under attend our Sexual Health (SH) services in London for implants at a rate of 3 inserted to every 2 removed. Replacement of a removed implant is rare: 1 replacement implant to 32 removed. We decided to investigate our clinic population for this trend.
Aim(s)/objectives To identify profile of YP who have implant removals, reasons for removal and formulate on-going support mechanisms.
Methods Staff completed questionnaires on 20 implant removals to ascertain YP profiles and reasons for remova.