history overview, repeated questions - particularly with symptomatic patients or with multiple episodes of care.
**Discussion** There is dissatisfaction with this EPR system, both in the way it functions and its impact on the clinician-patient consultation. Further research is warranted to assess the extent of these issues with other GUM EPR systems, and to explore ways of engaging with clinical information that help rather than hinder clinical performance.

## P054 2017 UPDATE OF DRUG INTERACTIONS DETECTED USING ELECTRONIC CARE RECORDS (ECR)

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**Introduction** In 2014 the pharmacy team completed an interaction screen of all HIV patients on a boosted antiretroviral (ARV) regimen using then recently launched NIECR. We concluded that there was a need for primary and secondary care teams to screen and manage drug-drug interactions (DDI). 56 patients in 2014 required urgent clinical intervention.
**Methods** In 2014 we reported on patients taking a boosted ARV regimen for DDI; we continued this work for all patients and this year we reviewed our interaction screening database, to assess the following: Interaction screen documented, Number of patients issued medication by their GP, Percentage of interactions identified.
**Results** 1093 unique patient records, 887 (81.2%) have a recorded H&C number and interaction screen. 468/887 patients (53%) are prescribed medication by their GP with no or no significant interactions. 235/887 patients (27%) are prescribed medication by their GP where an interaction is identified by the MDT and managed. 122/887 patients (14%) do not obtain any medication from their GP. 9/887 patients (1%) have opted out of NIECR. No patients required an immediate clinical intervention.
**Discussion** The number of patients prescribed medications by their GP has increased from 45% in our 2014 report compared with 79.3% in this review. There was a significant improvement in the latest review of interactions and no patients were identified with serious interactions. A medicines reconciliation and interaction screen before initiating/switching treatment and prior to a clinic review has enabled our cohort to avoid clinically significant DDI.

## P055 USING THE ELECTRONIC PATIENT RECORD TO SUPPORT CAPACITY PLANNING BY LINKING NEED TO LEVEL OF SERVICE

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**Introduction** Planning service capacity is key to ensuring that sexual health services continue to be functional and sustainable. We have reviewed and categorised data recorded in our electronic records system and by categorising activity and then identifying appropriate staff level associated with that activity we can more effectively plan capacity.
**Methods** We established agreement about service activity and assigned these activities to the categories of: integrated sexual health 1 and 2, integrated sexual health 3, online and telephone. Using 2016/17 quarter 2 and 3 data we grouped individual attendance records to these categories. Our analysis, based on a combination of item of service, SHHAPT coding and prescription, allowed us to robustly assign attendance to category. This was then compared with the level of care and access clients actually received in terms of staff level, and the variations showing the potential for shift across levels was established. We then audited at patient record level to provide assurance about assumptions made in the categorisation process.
**Results** The results indicated that a significant percentage of clients currently being seen in a face to face setting are appropriate for online and telephone consultations. We further identified a number of clients seeing doctors who were appropriate to be seen by nurses, indicating further shift potential.
**Discussion** This approach informs service capacity plans and drives efficiency. The potential for capacity release is tangible and can be applied to other service requirements such as training and service development. We are developing a dashboard system for responsive monitoring.

## P056 PROVIDING WRITTEN INFORMATION IN THE ELECTRONIC ERA – IS IT TIME FOR A RE-THINK?

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**Introduction** Recent BASHH guidelines state that patients should be directed to clear, accurate written or web-based information and this is often an auditable outcome. We stopped providing paper leaflets in 2016 as our electronic patient record (EPR) allows a link to web based patient information leaflet (PIL) to be sent by short message service (SMS). Our aim was to identify if this had improved uptake of written information.
**Methods** We identified 200 patients who received a positive chlamydia or gonorrhoea result and returned to clinic for treatment. Records were reviewed for offer and uptake of PIL.
**Results** 41 patients (20.5%) were sent a PIL link, 20 (10%) were documented to have declined and 139 (69.5%) had no documentation regarding PIL.
**Discussion** Provision of links to PIL was low in this patient group. This compares to our 2012 audit of chlamydia, a time of paper records, where 59% accepted a leaflet. Our EPR shows the link has been sent but requires free text to record offer or refusal, so the actual offer may have been higher and not documented. Half had the name of the infection specified in a results SMS and therefore many may have already sought web based information prior to treatment. Plans to improve our documentation of offer of PIL include consideration of a PIL link with the initial positive SMS. Patients are increasingly likely to access information online, sometimes prior to attendance and BASHH may wish to consider this in their guideline recommendations and auditable outcomes.