serious and devastating consequences for the fetus/infant. Transmission from mother to infant most commonly occurs due to exposure during delivery (85 – 90%). Early 2014, the team caring for women with Infectious Diseases in pregnancy identified that women, with a history of genital HSV or an outbreak in pregnancy, were an at-risk group without a specific care pathway, often with differing clinical decisions regarding their care.

Methods A retrospective audit was undertaken to ascertain adherence to a newly introduced referral pathway for pregnant women who gave a history of genital herpes booking into a tertiary referral Maternity Hospital, August 2015 – August 2016.

Results Our initial audit over a 9 month period demonstrated that there was an overall deficit in knowledge regarding the new referral pathway. The 9 month audit showed that only 13 of 49 (26%) of women were referred to specialist services at any time during their pregnancy. Our subsequent audit showed 54% of women were referred for specialist consult in the period following re-education; a large improvement in awareness of our referral pathway.

Discussion Audit of practice and in particular following an introduction of a new care pathway, is an essential tool for demonstrating compliance as well as highlighting gaps which require addressing. Education targeting the team of midwives who ascertain women's history on booking into the maternity services, has improved referrals as per our 4 month follow-up audit.

P250 AN AUDIT OF THE CARE AND MONITORING OF PATIENTS CO-INFECTED WITH HIV AND HEPATITIS C IN GUM IN EDINBURGH: NEED FOR BETTER DOCUMENTATION IDENTIFIED

Helen Pollitt*, Durba Raha. *Chalmers Centre, NHS Lothian, Edinburgh, UK*

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Introduction Hepatitis C (HCV) in HIV patients increases risk of cirrhosis and hepatocellular carcinoma (HCC).

Methods We used the BHIVA guidelines on co-infection to formulate our data fields to audit our compliance with these guidelines. We gathered information from 4 different IT systems used locally and paper notes; looking back over 5 years. Data fields include: Dates of HIV and HCV diagnoses, GP contact, transmission risk, latest CD4 count, ARV regimen, date ARV started, CD4 at ARV start, was HCV diagnosed when ARV started?, HCV treatment regimen, if acute HCV was treatment started within 6-12 months, referral to specialist, transplant, drug, alcohol and mental health services, HEV screening, HAV and HBV serology and vaccine, fibroscan, LFTs, liver biopsy, risk reduction discussion, cirrhosis on liver ultrasound, AFP, endoscopy, if no HCV treatment do they have annual fibrosis assessment?

Results

Abstract P250 Table 1 Number of patients identified under GUM with HCV-HIV co-infection = 16

Patients referred to speciality	12/16
Patients treated	6/16
Mode of transmission documented	2/16
Discussion of risk of transmission documented	1/16
Cirrhosis	3/16
Ever had fibroscan	5/16
Patients referred to speciality	12/16
Patients treated	6/16
Mode of transmission documented	2/16
Discussion of risk of transmission documented	1/16
Cirrhosis	3/16
Ever had fibroscan	5/16
AFP in last year	2/3
Endoscopy documented	2/3
HCV treated	2/3
Non-treated patients (10)	
Annual fibrosis assessment	0/10
Cirrhotic patients (3/16)	

Discussion In our HIV patients documentation of HCV care is spread over four IT systems and paper notes. The collation of data to ensure each patient is receiving appropriate care and monitoring is time-consuming and unwieldy, probably the main cause for incomplete monitoring. This audit identifies a need for a cohesive way of documentation for these patients.