Results 44% preferred the option of both appointments and drop in, whilst 28% each favoured either all appointments or drop in access only. There was no preferred time of attendance.
Discussion/conclusion As the service already provides both appointments and drop in access the audit provided little to no evidence that a change to service delivery would reduce levels of non-attendance. There remains minimal data about how best to fulfil public and individual sexual health obligations, especially to an extensive rural community such as ours. A further audit on actual non-attenders could identify patterns in patient expectation.

P140 MISSED OPPORTUNITIES FOR ENSURING ADEQUATE CONTRACEPTION: LESSONS FROM A RURAL SEXUAL HEALTH SERVICE

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Background/introduction Our county-wide service is undergoing increasing integration which makes public health sense. Ideally, risk of both sexually transmitted infections and pregnancy should be addressed with patients.
Aim(s)/objectives We looked at missed opportunities for ensuring adequate contraception during routine GU appointments.
Methods A retrospective notes review of 50 consecutive new female attendances over 2/12 was conducted, with a follow up at 4/12 to check contraception initiation or pregnancy.
Results Consultations were conducted by 16 different staff, 44%(7) of whom are trained to initiate oral contraceptive pills (OCPs), 4 fit implants and 2 fit IUCD/IUS. 23 and 27 patients were seen by nurses and doctors respectively. Contraception methods, including none, were universally documented. 22(44%) patients were using long acting reversible methods of contraception (LARC) and 28%(14) an OCP. Pill compliance was documented in 5(36%) and advice given in 1 case. Only 4 (14%) of the 28 non –LARC patients had LARC discussion. 7 patients used condoms and 7 no contraception. 5(36%) of these were advised to book a contraception clinic (CC)/GP appointment for contraception, 2 of whom failed to attend a subsequent CC. 1 patient was quick- started on an OCP. 2 patients were known to have conceived during the subsequent 4/12; 1 had LARC and 1 OCP at initial visit. 6(12%) and 1 patient/s were deemed at risk of pregnancy and appropriately provided with emergency contraception respectively.
Discussion/conclusion There were missed opportunities to maximise contraception efficacy. Time restrictions and lack of staff training pose barriers which we need to address.

P141 HOW ACCURATE IS CLINICAL CODING IN RECENTLY INTEGRATED SEXUAL HEALTH SERVICES?

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Background/introduction Clinical coding in England provides monitoring data for Public Health England via the Genitourinary Medicine Clinic Activity Dataset (GUMCAD) and Sexual and Reproductive Health Activity (SRHAD) returns. In London, this data is also used to reflect activity for the Integrated Sexual Health Tariff (ISHT) which may form the basis for payment in future. Integration of contraception and GUM services presents a challenge in maintaining accuracy of clinical coding.
Aim(s)/objectives To audit the accuracy of SHAPPT, SRHAD and SRH coding in a multi-site integrated sexual health service, comparing sites traditionally providing GUM services vs contraception.
Methods Local standards were agreed; 95% of patients should have accurate SHAPPT, SRHAD and SRH codes. 229 records from 2 GUM sites and 53 from 1 contraception site were audited from attendances between May and July 2014.
Results

	Traditional GUM (% correct)	Traditional contraception (% correct)
"T" codes	140/142 (99%)	22/25 (88%)
P1A, P1B, P1C codes	209/229 (91%)	7/34 (21%)
A-C codes	58/67 (86.5%)	3/11 (27%)
SRHAD	31/46 (67%)	29/31 (94%)
SRH	2/20 (10%)	5/9 (55%)

Discussion/conclusion As expected, the accuracy of coding reflected the traditional nature of the sites. The locally set standard of 95% was only reached on one occasion. Missing SRH codes alone would equate to lost income of £1259 from 77 visits if the ISHT was in place. Staff training and weekly capture and correction of missing HIV codes through targeted email reminders has resulted in an improvement in coding.

P142 USING THE "SPOTTING THE SIGNS" PROFORMA IN A GUM CLINIC TO FACILITATE IDENTIFICATION OF CHILD SAFEGUARDING CONCERNS

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Background/introduction In the wake of recent events regarding child sexual exploitation, BASHH produced the 'Spotting the Signs' guidance. Our GUM department has been using the 'Spotting the Signs' proforma since August 2014 for all under 16 year olds routinely and any patients aged 16–17 where concerns identified.
Aim(s)/objectives The aim of this project was to review the data gathered using the proforma and review the number of safeguarding referrals made.
Methods All under 16s and any patients aged 16–17 seen between August and December 2014 were identified. A retrospective case note review was undertaken of all the proformas. Data gathered included non-consensual sex, age differences, drug and alcohol issues, coercion and number of referrals to child safeguarding.
Results 20 patients were identified (16 female, 4 male); 18 cases were under 16 years. Two patients aged 16–17 had been assessed using the proforma. 50% of patients were identified as having mental health issues, 55% were identified with concerns regarding exploitation and 20% were noted to have problematic drug/alcohol use. 55% of patients were referred to safeguarding services.