map patient journey, identify potential improvements, including introducing on-line booking and e-triage.
Aim(s)/objectives To evaluate 1) the proportion of patients whose visit is >2 h from entering clinic to completion of the clinical encounter 2) effectiveness of patient completed triage.
Methods Pilot data was collected over 1 day (1 week to follow). Reception staff recorded patient first arrival, and administered a patient completed questionnaire recording the timing of the clinical encounter. Questionnaires, triage forms and case notes were reviewed.
Results 49 patients attended (23 male, 26 female). Complete data were available for 15(65%) males and 18(69%) females (Table 1). 58% of patients needed to allow >2 h to attend clinic (61% symptomatic, 57% asymptomatic). Self-triage was available for 45(92%) patients, with concordance between clinician and patient in 41/45 (91%).

Abstract P155 Table 1 Time in clinic: median hours (range)

	Male	Female	Total
Duration: clinic visit	1.55 (0:55–2:49)	2.11 (1:05–4:11)	2.04 (0:55–4:11)
Time before consultation	1.17 (0.35–2.10)	1.34 (0.40–3.37)	1.30 (0.35–3.37)
Duration: clinical encounter	0.30 (0.08–2.04)	0.30 (0.05–2.00)	0.30 (0.05–2.04)
Duration: clinic visit, symptomatic	1.50 (1.06–2.08)	2.18 (2.05–3.57)	2.05 (1.06–3.57)
Duration: clinic visit, asymptomatic	2.10 (1.30–2.49)	2.00 (1.05–4.11)	2.07 (1.05–4.11)

Discussion/conclusion Provisional data shows: 1) patients spend too long in clinic and developments including online booking could potentially reduce this, and 2) most patients are able to triage themselves.

P156 HOW MUCH ANTIRETROVIRAL THERAPY DO WE DISCARD?

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Background/introduction Current audit standards for antiretroviral therapy (ART) prescribing do not include standards for quantity dispensed.
Aim(s)/objectives 1) Establish a clinical standard for the quantity of ART to dispense when initiating or switching therapy. 2) Make a qualitative assessment of avoidable discards of ART. 3) Audit prescribing against existing BHIVA standards.
Methods An HIV care unit's database was interrogated to identify 350 patients who had initiated or switched ART over 2 years to August 2014. ART prescribing and outcomes data were collected retrospectively from 110 randomly selected patients.
Results 58.2% (n = 64) switched therapy; 57.8% (n = 37) as a result of toxicity, 15.6% (n = 10) resulting from rationalisation of therapy and only 3.1% (n = 2) for virological failure. The median quantity of ART dispensed at initiation or switch was 8 weeks (IQR; 8–12) supply; discarded at switch was 1.5 days (IQR; 0–29.75) supply. Mean (SD) cost of discarded ART after switch was £311.11 (£11.54); median was £20.63 (IQR; £0-£334.94). Reasons for discard for patients in the highest cost quartile are displayed in Table 1.
Discussion/conclusion Dispensing 8 weeks of ART at initiation or switch results in a lower than expected cost of discarded ART. There is limited potential for reduction in avoidable discards by addressing the small number of high cost cases.

Abstract P156 Table 1 Reasons for discard in highest cost quartile

Indication	Number of patients	Percentage of patients	Total cost (£)
Toxicity	6	37.5%	7024.08
Renal impairment	5	31.25%	5578.81
Patient request	2	12.5%	1308.94
Drug interaction	1	6.25%	756.84
Unclear	2	12.5%	2166.21

P157 IDENTIFYING THE DEMAND FOR "TEST-NO-TALK" GU SERVICES IN A RURAL SETTING

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Background/introduction GU services are under growing pressure to provide resource-efficient screening programmes. Test-no-talk (TNT) services are gaining interest as an affordable method of asymptomatic screening.
Aim(s)/objectives Identify the proportion of our patients who might be suitable for TNT services.
Methods We retrospectively reviewed the notes of 271 new/rebook patients who were tested for any combination of chlamydia, gonorrhoea, syphilis and HIV. Patients were excluded if they had any other service or diagnosis code apart from C4. For the purpose of the study, patients were deemed unsuitable for TNT services if they were symptomatic, <18 years of age, at high risk of HIV, a recent victim of sexual assault, at risk of pregnancy, a man with a same sex partner (MSM), if female, menstruating at the time of the appointment. TNT suitability was analysed using chi-squared tests.
Results 134 men and 137 women, median age 30 and 23 respectively, were included. 202 patients (75%) were asymptomatic, of these 110 (54%) were suitable for TNT services). The association between gender and symptoms was statistically significant: 81% of men being asymptomatic compared to 69% of women (p = 0.024). 54 (49%) patients were examined, altering the management of 9. There were no statistically significant associations between age or gender and TNT suitability (p = 0.97 and p = 0.06 respectively).
Discussion/conclusion Approximately 40% of our patients undergoing STI screening could be directed towards TNT services, with careful risk-assessment at booking. Our results suggest it is safe to exclude physical examinations in TNT clinics as they rarely alter the management.

P158 EXPLORING THE FEASIBILITY OF SHORTENING THE NATIONAL CHLAMYDIA SCREENING PROGRAMME TIME TO TREATMENT STANDARD

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Background/introduction Timely treatment of sexually transmitted infections (STI) is an important factor in reducing sequelae and transmission. British Association for Sexual Health and HIV