Background/introduction  
The duty doctor role was introduced into our integrated sexual health service in 2012 with the aim of improving patient flow through the clinic.

Aim(s)/objectives  
Three years on we wished to review the service and ensure it remains fit for purpose.

Methods  
We undertook an anonymous survey of clinical staff assessing if the duty doctor improved the service for patients and staff waiting for a second opinion; for staff teaching and learning and staff’s confidence in duty doctor knowledge.

Results  
Twenty seven members of staff completed the questionnaire. When asked to rate the utility of the duty doctor on a scale of 1 to 10 (1-no use at all, 10-indispensable) the average response was 8. The majority thought the service was better or much better for patients and staff. Only 21% thought the service should be expanded. 72% of respondents have/would bypass duty doctor. 55% would approach the duty doctor for GUM but ask elsewhere for contraception. 47% would approach for contraception but ask elsewhere for GUM. Only 25% thought a separate contraception and GUM duty doctor was needed. The service was praised for its expert 2nd opinions, quick responses and the reassurance to patients. Common problems were that the doctors were hard to contact at times and occasionally doctor’s gender was difficult for patients.

Discussion/conclusion  
The duty doctor is a valuable role, accessibility needs to be addressed but with the exception of increasing the pool of doctors who act as duty doctor the role should remain unchanged.

P178  
SPECIALIST HERPES CLINICS: IS THERE ANY POINT?

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Background/introduction  
Specialist clinics have been introduced in a number of specialities, but patient benefits have proved difficult to demonstrate, despite increased investigations and costs. Genital herpes requires extensive counselling which previous studies have demonstrated is often of poor quality.

Aim(s)/objectives  
To assess the value of a specialist genital herpes clinic, in terms of patient satisfaction and outcomes, in comparison with a general genitourinary medicine clinic at a UK level 3 sexual health service in patients with a diagnosis of first episode genital herpes.

Methods  
200 patient records of those attending a UK level 3 sexual health service with first episode herpes between 2012–2013 attending a specialist or general clinic were reviewed to assess initial management, complicating factors, and subsequent health seeking behaviour. 20 patients with a recent diagnosis of herpes attending either a specialist or general clinic were interviewed to determine patient satisfaction, and information provided on a number of key counselling topics identified by the BASHH herpes guidelines.

Results  
Provisional results from 79 patients demonstrate that those attending the specialist clinic were more likely to have complicating factors, including pregnancy, and psychological distress. Return to clinic with recurrences was 20% for the specialist and 15% for the general clinic. Full results will be available by the conference.

Discussion/conclusion  
Patients attending a specialist herpes clinic presented with more complicating factors, but despite this there was little difference between patient outcomes and satisfaction between clinics. Specialist herpes clinics may therefore be useful to manage more complex patients.

P179  
EVALUATION OF AN ONLINE BOOKING SERVICE TO ACCESS ASYMPTOMATIC SCREENING

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Background/introduction  
Symptomatic patients are prepared to wait hours for open access sexual health services; however, patients without symptoms want simple and convenient access to testing.

Aim(s)/objectives  
We therefore introduced a new online booking service for asymptomatic patients and evaluated if patients would use it correctly.

Abstracts
Methods All booked asymptomatic screens from 1st December–13th January 2015 were analysed. These patients were registered and self-triaged as per normal and analysis of the electronic patient record was performed on the 27th January.

Results During this period 285 patients attended via the online booking service and the majority (91%) were asymptomatic and seen by the health care assistants. The median (min, max) number of appointment each weekday was 10 (1, 31) and 39% of these patients were from the local two boroughs.

Objectives: to see walk-in patients on time and to extend our evening clinic provision from two to four per week.

Aims: to improve the quality of our services, respond to patient feedback and effect change in a sexual health clinic.

Discussion/conclusion The majority of patients used the online booking service correctly. Further work is required to increase the range of services available via online booking.

Abstract P179 Table 1 Asymptomatic screens

<table>
<thead>
<tr>
<th>Description</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>139</td>
<td>146</td>
<td>285</td>
</tr>
<tr>
<td>Age in years, Median (range)</td>
<td>30 (21–50)</td>
<td>27 (18–47)</td>
<td></td>
</tr>
<tr>
<td>Sexuality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heterosexual</td>
<td>106</td>
<td>137</td>
<td>243</td>
</tr>
<tr>
<td>Bisexual</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Homosexual</td>
<td>37</td>
<td>0</td>
<td>37</td>
</tr>
<tr>
<td>Ethnic origin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>98</td>
<td>100</td>
<td>198</td>
</tr>
<tr>
<td>BME</td>
<td>30</td>
<td>21</td>
<td>51</td>
</tr>
<tr>
<td>Not stated</td>
<td>18</td>
<td>14</td>
<td>32</td>
</tr>
<tr>
<td>Sexually transmitted infections</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chlamydia</td>
<td>3</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Trichomonas vaginalis</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Methods A quality improvement approach, using the Institute of Healthcare Improvement’s model for improvement was used. The whole multidisciplinary team (MDT) met bi-monthly and ideas were tested using plan, do, study, act (PDSA) cycles. Measurement was introduced using statistical process control charts.

Results The quick check service shows a 40% increase in uptake, from 10 to 14 patients (average), (range 4–23). We introduced minimum patient allocated numbers, following these interventions there is a 42% reduction in average waiting times from allocated slot time (31 min pre and 18 min post intervention). Our productivity last month increased by 14%.

Discussion/conclusion A quality improvement approach was a successful method to improve the quality of our services, respond to patient feedback and effect change in a sexual health clinic.

P181 RETROSPECTIVE AND PROSPECTIVE ANALYSIS OF THE INPATIENT MANAGEMENT OF EPIDIDYMO-ORCHITIS
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Background/introduction Epididymo-orchitis, a common urological diagnosis in men aged 18–50, has significant sequelae if inadequately treated. Causative organisms in patients under the age of 35 are most commonly sexually transmitted infections. In patients over 35 enteric Gram-negative organisms causing urinary tract infections are more prevalent. Empiric treatment should be commenced as per guidelines until results of investigations are known.

Aim(s)/objectives To evaluate inpatient management of epididymo-orchitis.

Methods Data was retrospectively collected from June to December 2014 for all epididymo-orchitis patients diagnosed clinically. Information was obtained from notes, radiology and pathology databases. A 3 month prospective study is ongoing to improve investigations and antibiotic prescribing.

Results 7 of 26 inpatients diagnosed with epididymo-orchitis were under 35 years of age and 19 over 35; 19 were diagnosed with unilateral epididymo-orchitis and 7 bilateral. 4 patients developed abscesses, and 1 had an orchidectomy. 6 had a first-void urine, 14 a mid-stream urine, and 3 a urethral swab. 9 patients were discharged on doxycycline and ciprofloxacin, 7 with ciprofloxacin monotherapy. Duration of treatment as an outpatient ranged from 7 to 42 days.

Discussion/conclusion Current inpatient management of epididymo-orchitis varies significantly, and a third of patients are being discharged on doxycycline and ciprofloxacin, a combination not recommended in the BASHH guidelines. BASHH recommends cefuroxime +/- gentamicin for management of inpatients over 35 years of age; however in view of the risk of clostridium difficile this may require updating. This and our ongoing prospective study may provide results to help recommend appropriate antibiotics for inpatients with epididymo-orchitis.