negative and 1 (0.5%) not tested for HBsAg. Of the HBcAb-positive individuals, requesting details were available for 10 cases: for 8/10 both HBsAg and HBcAb were requested initially.. Of 178 (89.0%) HBcAb-negative individuals, HBsAg was performed for 49 (24.5%); all were HBsAg-negative. Across the Trust, 11,500 HBcAb tests were requested in 12 months. Assuming 89.0% HBcAb-negativity, the cost of testing 24.5% of these patients for HBsAg would almost reach £10,000.
Results Reducing HBsAg testing in HBcAb-negative individuals would provide savings. Reflex laboratory HBsAg should be implemented for HBcAb-positive patients.

P188 SAFEGUARDING ADULTS ATTENDING AN INNER CITY SEXUAL HEALTH SERVICE

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10.1136/sextrans-2016-052718.238

Background/introduction Adult safeguarding is the process of protecting vulnerable adults from harm or exploitation. In 2014 our sexual health clinic introduced an adult safeguarding proforma and a regular adult safeguarding meeting.
Aim(s)/objectives To evaluate the impact of a new safeguarding pathway.
Methods Retrospective case note review of patients entered onto the safeguarding database from April-December 2015.
Results Of 14833 adult attendances, 148 patients were identified as vulnerable (1.0% vs 0.3% in 2013, $p < 0.0001$). Notes were available for 135/148. Median age was 30 years (range 18–70); 74% female; 17% homosexual or bisexual. Main reasons for attendance were STI screening (69%) and contraception (11%). 13% of females were pregnant. Vulnerability was identified by the clinician in 64% and disclosed by the patient or carer in 27%. Mental health problems were reported in 60%; a violent or pressurised relationship in 53%; drug or alcohol consumption in 55%. 13% were asylum seekers; 7% were victims of trafficking. 7% had learning disabilities. 4% reported sex with a person in a position of trust. Two or more vulnerability factors were identified in 86%. 2% lacked capacity. 70% were discussed at the Adult safeguarding meeting, 27% were referred to the Trust safeguarding team. Other referrals included social services (7%), mental health services (5%) and police (3%). 14% had responsibility for children aged <18 years; 5% required child safeguarding input.
Discussion/conclusion A large number of vulnerable adults attend our service, highlighting the importance of robust safeguarding procedures. Greater numbers were identified following introduction of a new safeguarding pathway.

P190 SEXUAL HEALTH APPOINTMENTS BY TEXT ONLY: SPEED, SAVINGS AND SATISFACTION

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Background/introduction When setting up an appointment-based specialist GUM service within our walk-in community sexual and reproductive health service we took the opportunity to send patients their appointment details by text message rather than letters. We also send reminder texts prior to the appointment, in an attempt to reduce "Did not attend" (DNA) rates.
Aim(s)/objectives To estimate associated cost savings and patient satisfaction with the use of texts instead of appointment letters.
Methods Cost saving calculations considered costs of sending texts relative to stationery and postage and a time and motion study to estimate relative staff costs. DNA rates 6 months before and after the implementation of the text reminder service were compared using Fisher's exact test. A satisfaction survey of a random sample of patients attending the booked GUM clinics included basic demographic questions and questions about the use of appointment and reminder texts.
Results There was an estimated cost saving of 88p per appointment.

Abstract P190 Table 1 Impact of text reminders on DNA rates

	May–Nov 2013	Dec 13 – Jun 2014	
GUM Appointments	2118	1683	
GUM DNAs	589	355	
DNA Rate	27.81%	21.09%	P =< 0.001

28 satisfaction surveys were completed. 82% preferred to get their appointments solely by text.

Discussion/conclusion The use of text messages instead of letters has saved the clinic money and time, and is popular with patients. Our Trust offers 500,000 outpatient appointments per year. If only half of those were booked by text instead of letter, the trust could save more than £220,000 per year.

P191 ESTABLISHING AN INTEGRATED LEVEL 2 SEXUAL HEALTH SERVICE FOR PEOPLE WITH LEARNING DIFFICUTIES

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10.1136/sextrans-2016-052718.240

Background/introduction A local needs assessment by Public Health in 2013 identified an unmet need for sexual health services for young people (13–25 years) with learning difficulties. Public Health identified funding and developed a service specification for a local level 2 sexual service that was tendered for a pilot period of 15months. We were successful in bidding for the service.
Aim(s)/objectives We describe our journey in establishing a bespoke sexual health service for people with learning difficulties as part of our level 3 Sexual Health and HIV service. We outline the difficulties we encountered, how we overcame them and highlight learning points for other providers wishing to establish similar services.
Methods A descriptive analysis of the clinic history, service provision, staff training, clinic activity and STI and contraception diagnoses. The complexity of individual cases is captured by brief case histories.
Results The service delivery model is multidisciplinary and was developed in collaboration with all key stakeholders including the users themselves. An initial survey identified a community site co-located with the community paediatric service for disability and a Friday afternoon after school as the preferred options. We advertised the service widely including all schools for children with special education needs, social services and carers and

GPs. The service opened in March 2014 as a monthly service (Friday 2–6 pm) and was provided by an experienced dual trained speciality doctor, band 6 nurse and band 2 technician together with the community nurse specialist for children with learning difficulties. The service provided STI/HIV screening and management, a full range of contraception choices and sexual health advice. New patient appointments were 1hr and involved time with both the Dr and nurse in order to meet the complex needs of the patients. After 14 months we relocated the service to our level 3 Sexual Health centre located on the main hospital site due to practical difficulties with providing a remote service to a complex group of patients. We changed the clinic session to a regular weekly session on a Wednesday afternoon (3–6 pm). From March 2014 to Dec 2015 there have been 60 attendances by 18 patients (13F, 5M; 17 heterosexual, 1 MSM; 90% white British). 50% patients were under 25 years with a range from 16 to 40 years. Number of STI screens: GC, chlamydia and HIV = 15; GC and chlamydia only = 10; HIV only = 3. STIs diagnosed: chlamydia = 3, TV = 1, PID = 2, 1st episode HSV = 1. Contraception services provided: implant 3, IUS 1, depo 2, COCP 2, EMC 2, PT 6. Historic child sexual abuse was disclosed by three patients.

Discussion/conclusion We successfully established a dedicated sexual health service for people with learning difficulties. Although numbers of attendances are small the patients present with complex needs and require long appointment times. 38% of our patients were diagnosed with an STI. The service team benefited from additional training in learning difficulties and capacity assessments and support from senior staff in the level 3 clinic.

P192 ACUTE HEPATITIS C INFECTION: ARE WE DOING ENOUGH?

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Background/introduction Hepatitis C (HCV) is an important blood-borne virus in the UK with high morbidity/mortality. Injecting drug use has traditionally been seen as the most important risk factor for transmission in Britain, but since 2000 there has been an emergent rise in infection rates amongst HIV-positive men who have sex with men (MSM). This is thought to be driven by risky sexual/drug taking behaviours.

Aim(s)/objectives Review viral response of acute HCV infections after treatment with current NICE approved therapy.

Methods A prospective case note review was performed of patients diagnosed with acute HCV between 2004–2015.

Abstract P192 Table 1 Data for acute HCV treated within 6 months of diagnosis

Response	SVR	No SVR	Predictive value(%)
RVR	4	0	PPV = 100
No RVR	7	1	NPV = 12.5
EVR	6	1	PPV = 85.7
No EVR	1	0	NPV = 0

RVR = Rapid viral response, EVR = Early viral response, SVR = Sustained viral response, PPV = Positive predictive value, NPV = Negative predictive value.

Results There were 102 acute HCV infections. Median age 37, (range 20–61), all cases were male and MSM. 91 (89%) patients had Genotype 1 infection, and 98 (96%) were co-infected with HIV. 36 (35%) patients had a history of injecting drug use. 20 patients were initiated on pegylated interferon/ribavirin within 6 months of diagnosis.

Discussion/conclusion Only 4 (20%) acute HCV patients achieved simultaneous RVR/SVR within 6 months of diagnosis (PPV = 100%). Novel direct acting antivirals (DAAs) have SVR rates above 90%; this alone is a compelling reason to promote DAAs in managing the burden of HCV infection thus reducing propensity for onward transmission.

P193 MANAGEMENT OF PATIENTS WITH HIV AND HEPATITIS C CO-INFECTION AT A SMALL TEACHING HOSPITAL; AN AUDIT AGAINST 2013 BHIVA GUIDELINES

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10.1136/sextrans-2016-052718.242

Background/introduction HIV positive patients with Hepatitis C (HCV) progress to cirrhosis faster than patients without HIV. BHIVA guidelines 2013 recommend surveillance for cirrhosis and hepatocellular carcinoma.

Aim(s)/objectives To evaluate the management of patients with HCV and HIV co-infection against current guidelines for surveillance for liver disease, including with Liver Transient Elastography (TE).

Methods The clinical records of all patients with HIV and HCV co-infection in the last 10 years were reviewed.

Results 41 patients had co-infection; 6 patients spontaneously cleared HCV. 100% (41/41) of all new diagnoses of HCV received HCV RNA measurement. Genotyping carried out in 86% (30/35) of patients and not possible in 6 cases. Annual HCV RNA was carried out in 76% (29/38). Only 8% (3/36) cases had initial TE result. In 17/36 the result was not recorded, and there was no evidence that the TE had been carried out. In 14/36 the patient did not attend the tertiary centre. Two of the initial TEs were reported as normal (less than 7 kPa). For annual TE assessments, 5/36 were reported.

Discussion/conclusion Most patients reviewed did not have assessment for liver disease per national guidelines. Our monitoring of patients with HCV and HIV co-infection particularly with liver TE is poor. The main barrier to co-infected patients receiving care is non-attendance at the tertiary centre. The Trust is now a "spoke" in a hepatitis C network and has local TE, which may improve monitoring of co-infected patients. We will re-audit after this programme has been running for one year.

P194 SEXUALLY TRANSMITTED INFECTION (STI) SCREENING IN MEN WHO HAVE SEX WITH MEN (MSM)

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Background/introduction MSM are at increased STI risk. Easily accessible and thorough STI screening should be available to all MSM. BASHH recommendations for MSM STI screening include guidance about which tests to offer and to whom, and suggested frequency of testing.