beliefs, along with provision of LARC prior to discharge needs addressing.

Discussion Despite international evidence, which strongly suggests that the use of LARC's reduce unintended pregnancies and subsequent abortions, their use in Australia remains low. There is a need to address the barriers to increasing the use of LARC's in Australia, particularly by young women who are highly fertile & have unintended pregnancies. Use of COCP is higher in Australia than in other countries. Implants, injectable and IU devices, combined are still used by fewer than 10% of Australian women and their provision in general practice is low.

Electronic Patient Records and Information Technology

P051 EVALUATION OF THE ACCEPTABILITY AND IMPACT OF AN ONLINE BOOKING TOOL

Kate Horn*, Michelle Hawkins, Emily Kilvington. *Virgin Care Ltd, London, UK*

10.1136/sextrans-2017-053232.97

Introduction Finding smarter ways of working which meet the needs of increasingly IT-savvy clients and support their busy lifestyles is always a priority and provides an opportunity to innovate.

Informed by focus groups, we developed an on-line booking system, designed to be mobile-first, empowering people to book and manage their own appointments through a secure server.

Methods We monitored use of the online booking system and impact on DNA rates, as well as user acceptability, through online feedback and continued engagement with user focus groups.

Results In the first 5 months we have seen: Average 11% of all bookable appointments made on-line, with majority completed out of hours. 75+% users accessing from a mobile device. 10% reduction in call volumes to services, saving 213 hours of admin time. Improved patient experience and choice as evidenced through user survey: Very easy or easy to book an appointment online: 84%; Very likely or likely to use the website again: 95%. As yet DNA rates have been unaffected.

Discussion The ability to book and manage appointments online has been well received by users and has reduced administrative time. Further tweaks have included a 'text to cancel' system which we anticipate will have a positive impact on DNA rates.

Investigation of different uptake rates between services has led to shared learning and it is anticipated that the average uptake of bookable appointments made online will reach the target of 20% within the next 3 months.

P052 USING MODERN TECHNOLOGY TO IMPROVE THE MANAGEMENT OF INITIAL PRESENTATION OF HERPES SIMPLEX VIRUS INFECTION – COMMUNICATION WITH PATIENTS AND DELIVERING PCR RESULTS

Rebecca Metcalfe*, Pauline Caulfield, Fiona Fargie. *Sandyford Sexual Health Service, Glasgow, UK*

10.1136/sextrans-2017-053232.98

Introduction The first presentation of Herpes Simplex Virus (HSV) may be distressing, with severe symptoms and associated stigma pertaining to the diagnosis. Initial audit confirmed clinic staff were inconsistent with how the initial clinical diagnosis was relayed to patients, the amount of information given and how follow up and PCR test results would be provided. Best practice dictates that detailed information and uncertainties around diagnosis should be communicated.

Methods Staff training was delivered using workshop style sessions and local protocol changed to highlight '10 key points' to be communicated. An SMS used to deliver positive HSV PCR results was changed to include a bitlink to clinic website 'Genital Herpes' page and link to BASHH patient information leaflet. The automated results line was changed for PCR negative results, providing information for follow up if symptoms remained. A GP letter was created for PCR positives.

Results Audit cycles were comparable in gender, age distribution, HSV type and PCR negativity rate. There was a significant improvement in the number of patients who received written information ($p=0.0043$), discussion on PCR sensitivity ($p<0.0001$), discussion on disclosure ($p<0.0001$) and significant reduction positive PCR results with no record of result being given ($p=0.0091$). There number of patients requiring follow up appointment for same episode of HSV did not change.

Discussion Using modern technology can improve communication of important information to the patient and ensure the patient receives the result appropriately. Altering electronic resources can give more information and provide a back up when the diagnosis is unclear.

P053 TOGETHER IN ELECTRIC SCREAMS: THE FRUSTRATIONS OF GUM ELECTRONIC PATIENT RECORDS

[1]David Pao*, [1]John Stevens, [2]Dan Lockton. *[1]Royal College of Art, London, UK; [2]Carnegie Mellon University, Pittsburgh, USA*

10.1136/sextrans-2017-053232.99

Introduction Many GUM clinics have shifted from paper to Electronic Patient Records (EPR). While paper has limitations, its natural functionality – e.g. free-form writing, sketching and page-turning – is intuitive and easy to exploit. EPR promises so much, but how easy or intuitive is it in current clinical GUM practice?

Methods A mixed methods paper survey asking GUM clinicians about the EPR they use.

Part one asked about usability and function with fourteen 7-point Likert-scale items. Part two guided respondents to describe qualitatively how EPR affected their sense of the clinical consultation.

Results Out of 33 surveys distributed, 28 were returned (85%) by mixed staff groups from 3 clinics using the same EPR.

Likert-scale items underwent chi-square analysis after collapsing responses into positive and negative groups. All 14 items were negatively skewed away from neutral; 8 of these were significant ($p<0.05$): history overview, accuracy with multiple visits, getting lost, mirroring clinical reality, use of graphics, amount of clicking, searchability and support of clinical practice. Further analysis will explore this deviation from neutral.

Qualitative responses described frustration, reduced competence/autonomy, interrupted flow, poor eye contact, poor

history overview, repeated questions - particularly with symptomatic patients or with multiple episodes of care.
Discussion There is dissatisfaction with this EPR system, both in the way it functions and its impact on the clinician-patient consultation. Further research is warranted to assess the extent of these issues with other GUM EPR systems, and to explore ways of engaging with clinical information that help rather than hinder clinical performance.

P054 2017 UPDATE OF DRUG INTERACTIONS DETECTED USING ELECTRONIC CARE RECORDS (ECR)

PJ Rafferty*, EM McCarty, WW Dinsmore, CM Donnelly, CR Emerson, M Hunter, E Walker, SP Quah. *Belfast Health and Social care Trust, Belfast, UK*

10.1136/sextrans-2017-053232.100

Introduction In 2014 the pharmacy team completed an interaction screen of all HIV patients on a boosted antiretroviral (ARV) regimen using then recently launched NIECR. We concluded that there was a need for primary and secondary care teams to screen and manage drug-drug interactions (DDI). 56 patients in 2014 required urgent clinical intervention.
Methods In 2014 we reported on patients taking a boosted ARV regimen for DDI; we continued this work for all patients and this year we reviewed our interaction screening database, to assess the following: Interaction screen documented, Number of patients issued medication by their GP, Percentage of interactions identified.
Results 1093 unique patient records, 887 (81.2%) have a recorded H&C number and interaction screen. 468/887 patients (53%) are prescribed medication by their GP with no or no significant interactions. 235/887 patients (27%) are prescribed medication by their GP where an interaction is identified by the MDT and managed. 122/887 patients (14%) do not obtain any medication from their GP. 9/887 patients (1%) have opted out of NIECR. No patients required an immediate clinical intervention.
Discussion The number of patients prescribed medications by their GP has increased from 45% in our 2014 report compared with 79.3% in this review. There was a significant improvement in the latest review of interactions and no patients were identified with serious interactions. A medicines reconciliation and interaction screen before initiating/switching treatment and prior to a clinic review has enabled our cohort to avoid clinically significant DDI.

P055 USING THE ELECTRONIC PATIENT RECORD TO SUPPORT CAPACITY PLANNING BY LINKING NEED TO LEVEL OF SERVICE

Kez Spelman*, Taylor Hughs. *Essex Sexual Health Service, Provide Community Interest Company, Colchester, Essex, UK*

10.1136/sextrans-2017-053232.101

Introduction Planning service capacity is key to ensuring that sexual health services continue to be functional and sustainable. We have reviewed and categorised data recorded in our electronic records system and by categorising activity and then identifying appropriate staff level associated with that activity we can more effectively plan capacity.
Methods We established agreement about service activity and assigned these activities to the categories of: integrated sexual health 1 and 2, integrated sexual health 3, online and telephone. Using 2016/17 quarter 2 and 3 data we grouped individual attendance records to these categories. Our analysis, based on a combination of item of service, SHHAPT coding and prescription, allowed us to robustly assign attendance to category. This was then compared with the level of care and access clients actually received in terms of staff level, and the variations showing the potential for shift across levels was established. We then audited at patient record level to provide assurance about assumptions made in the categorisation process.
Results The results indicated that a significant percentage of clients currently being seen in a face to face setting are appropriate for online and telephone consultations. We further identified a number of clients seeing doctors who were appropriate to be seen by nurses, indicating further shift potential.
Discussion This approach informs service capacity plans and drives efficiency. The potential for capacity release is tangible and can be applied to other service requirements such as training and service development. We are developing a dashboard system for responsive monitoring.

P056 PROVIDING WRITTEN INFORMATION IN THE ELECTRONIC ERA – IS IT TIME FOR A RE-THINK?

Sophie Brady, Nicola Fearnley*. *Bradford Sexual Health, Locala Community Partnerships CIC, Bradford, UK*

10.1136/sextrans-2017-053232.102

Introduction Recent BASHH guidelines state that patients should be directed to clear, accurate written or web-based information and this is often an auditable outcome. We stopped providing paper leaflets in 2016 as our electronic patient record (EPR) allows a link to web based patient information leaflet (PIL) to be sent by short message service (SMS). Our aim was to identify if this had improved uptake of written information.
Methods We identified 200 patients who received a positive chlamydia or gonorrhoea result and returned to clinic for treatment. Records were reviewed for offer and uptake of PIL.
Results 41 patients (20.5%) were sent a PIL link, 20 (10%) were documented to have declined and 139 (69.5%) had no documentation regarding PIL.
Discussion Provision of links to PIL was low in this patient group. This compares to our 2012 audit of chlamydia, a time of paper records, where 59% accepted a leaflet. Our EPR shows the link has been sent but requires free text to record offer or refusal, so the actual offer may have been higher and not documented. Half had the name of the infection specified in a results SMS and therefore many may have already sought web based information prior to treatment. Plans to improve our documentation of offer of PIL include consideration of a PIL link with the initial positive SMS. Patients are increasingly likely to access information online, sometimes prior to attendance and BASHH may wish to consider this in their guideline recommendations and auditable outcomes.