

**P154 HOW WELL ARE WE MANAGING LYMPHOMA IN OUR HIV COHORT OVER 5 YEARS: A REGIONAL AUDIT IN THREE MAIN HUBS**

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10.1136/sextrans-2017-053232.198

**Introduction** Since the introduction of antiretroviral therapy, the life expectancy of HIV infected patients has increased significantly. As the incidence of opportunistic infections accounting for HIV related deaths has declined, malignancies now account for an increasing proportion of these mortalities, with lymphoma presenting second most commonly. In order to determine whether HIV positive patients with lymphoma are receiving best care, patients from three hubs within the region were reviewed.

**Methods** Data was collected retrospectively from HIV positive patients with lymphoma from 1<sup>st</sup> of January 2010 to 31<sup>st</sup> of December 2014.

**Results** Total number of patients in the study was 25 across the three centres with 8,12 and 5 patients from each centre. All patients underwent the recommended diagnostic procedures for diagnosis and 96% received appropriate imaging for staging. Of the 20 patients where documentation was available, 70% were diagnosed with stage IV lymphoma and 50% had the International Prognostic Index (IPI) score of 3 or more. 5-year survival rate was 72% and in those followed up for a minimum of 2 years the 2-year progression free survival rate was 100%. 28% patients died during the study period, 43% of whom had a late diagnosis.

**Discussion** Management of lymphoma within three centres in the region is in line with current best practice guidelines. In order to improve the survival further, early diagnosis and treatment of HIV were identified as crucial factors necessitating increased awareness of HIV testing.

**P155 EVALUATING THE EFFECTIVENESS OF GRAM STAIN MICROSCOPY IN IDENTIFYING GRAM NEGATIVE INTRACELLULAR DIPLOCOCCI SUGGESTIVE OF GONORRHOEA NEISSERIA**

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10.1136/sextrans-2017-053232.199

**Introduction** Gram stain microscopy is an effective tool in the management of gonorrhoea in symptomatic patients, allowing for the visual identification of suspicious bacteria, which when also considering the history and risk, can be indicative of a current gonorrhoea infection allowing for rapid treatment and partner notification initiation. This is an on-going audit to verify the effectiveness of in-house diagnostics.

**Methods** All patients found to have a positive culture result for gonorrhoea had their notes reviewed to ascertain if presumptive gonorrhoea had been diagnosed at attendance as well as the presence of symptoms, contact status and vaginal flora grade (in women). If microscopy was undertaken but negative, the slide was also reviewed. Slides found to be positive were feedback to staff members.

**Results** Data from July 2016 – January 2017:

**Male urethral samples** 147/157 (93.6%) infections were correctly identified, when asymptomatic contacts were excluded

147/154 (95.5%) were identified, and of those not identified, 4 were negative on review.

**Female cervical samples** 5/20 (25%) infections were correctly identified, when asymptomatic contacts were excluded 5/19 (26.3%) were identified. Of those not diagnosed on the day, 9 were negative on review.

**Discussion** Microscopy identified 95.5% of symptomatic male urethral infections and 26.3% of female cervical samples. There was also a low 'failure' rate, only 7/24 slides were positive on review and therefore 'true missed' on day diagnoses. Effective on day diagnosis can prevent further transmission, allow faster access to antibiotics, allow for prompt partner notification and is a rewarding skill for the GU staff.

**P156 WHAT IS TELEPHONE ACCESS REALLY LIKE FOR GUM CLINIC PATIENTS IN THE U.K.?**

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10.1136/sextrans-2017-053232.200

**Introduction** How patients fare when accessing care by telephone at GUM clinics in the UK can be assessed by 'mystery shopping' methods. This study aimed to establish current access levels when contacting clinics by telephone and investigate the potential barriers.

**Methods** During October – November 2016 all 262 GUM Clinics in the UK were called during clinic opening times on eight occasions, each by male and female researchers posing as patients requesting to be seen as soon possible.

**Results** Overall 1589/1905 (83.4%) calls were offered an appointment. Of these, 63.7% of 'patients' were invited to attend a walk-in service. Most clinics were consistently contactable, with 72.9% of calls being answered on the first attempt, however 22.9% of clinics were un-contactable at on at least one occasion. Contacting a clinic over four calls can establish the probability of clinic access, with 68.8% of clinics accommodating a minimum of 6/8 callers.

The time to speak to a human ranged from 1 second – 39 minutes. The mean length of conversation was 93 seconds, with longer speaking time increasing chance of success. Although male and symptomatic 'patients' spent longer on the phone, females were 14.6% more likely to offered an appointment ( $p=0.037$ ). Symptomatic scenarios did not have improved access over asymptomatic contacts ( $p=0.074$ ).

**Discussion** Access appears to be falling further below the BASHH standard. Various difficulties in establishing contact were identified, including long hold times and the need for multiple call attempts, that may be barriers to patient access.

**P157 UTILITY OF CHLAMYDIA CARE PATHWAY FOR STANDARDISATION OF QUALITY MEASURES FOR MANAGEMENT OF CHLAMYDIA TRACHOMATIS**

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10.1136/sextrans-2017-053232.201

**Introduction** The Chlamydia Care Pathway (CCP) describes individual steps of comprehensive case management for

Chlamydia trachomatis (CT) providing standardised methodology to compare outcomes. We audited CCP in a central London service to identify aspects requiring service improvement.

**Methods** All patients diagnosed with CT in 6 months in 2016 were identified from the electronic patient record system. A random sample of 60 notes was assessed against each step of the CCP.

**Results** There were 35,995 new patient appointments and 1700 patients had positive CT results. Of the sample, 32 were male, 28 female. Median age for men was 34, range 20–71 years, women 24, range 17–28 years. 14/32 of males were MSM, 18/32 heterosexual. All females were heterosexual. 14/60 of patients were contacts of CT and 11 of the male patients were diagnosed with non-specific urethritis and were treated on the same day. Test turnover time was median 6, range 2–10 days. 50/60 patients were informed on the day the results were available. Of the 35/60 patients requiring treatment, time taken for them to attend was median 1, range 0–50 days. 56/60 had documented contacts informed, 18/60 had documented contacts treated. 19/60 attended for repeat tests 3 months later of whom 2 had new infections.

**Discussion** This review identified areas for improvement, such as partner notification documentation and test turnover time. Review of other sites within the sustainability and transformation footprint is planned. This tool may be useful to commissioners for standardising quality measures and comparing performance of testing sites in a locality.

#### P158 BENEFITS OF DISINTEGRATION OF A HIV SERVICE FROM A SEXUAL HEALTH SERVICE?

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10.1136/sextrans-2017-053232.202

**Introduction** With an imminent split of our HIV service from an integrated sexual health service we felt it a timely opportunity to address anonymised blood testing in the HIV service.

Historically patients have had routine monitoring for HIV under their GUM number unless pregnant or have requested specific bloods under their name. Continued isolation of the HIV service, while complying with HIV patients wish for enhanced confidentiality, can have a negative impact on their care- increasing clinical risk and duplication of tests. As our patient age they require multidisciplinary input to manage comorbidities so integrated working is essential.

**Methods** Patients were provided with an information leaflet about the service change and completed a survey/consent form starting in December 2015. If patients agreed to the switch this was implemented for their subsequent bloods.

**Results** Our cohort size in 2015 was 394 – 2/3<sup>rd</sup> are male and over half MSM. So far 301 patient questionnaires have been analysed.

Results show 93% of patients have consented to changing to named bloods with a generally positive feedback to this change. We will present the results looking at the differences between those that consent and those that do not.

**Discussion** Results suggest that the majority of patients are not concerned about loss of anonymity through switching to named blood samples. Switching to named blood samples is one small step in reducing the isolation of HIV care.

#### P159 AUDITS OF BOTH MANAGEMENT OF CHLAMYDIA AND ALSO EMERGENCY CONTRACEPTION PROVISION AS A MARKER OF QUALITY IN AN INTEGRATED SERVICE

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10.1136/sextrans-2017-053232.203

**Introduction** The county wide sexual health service has been integrated long-term as regards health care worker (HCW) training and governance. Service delivery still remains in some units geared to towards either contraception (C+RHC) or sexually transmitted infections (STIs) management although all patient needs are addressed holistically. Is there equitable service delivery in all units?

**Methods** Audits of both chlamydia management and emergency contraception provision was carried out across all sub-units regardless of subspecialisation.

**Results** In the chlamydia audit, standards were achieved for offering anti-chlamydial treatment (100% achieved) and partner notification verified by HCW (0.47 in STI units, 0.58 C+RHC units). Standards were suboptimal for a) the offer of written information (45% for STI units 18% for C+RHC units and b) offer of retesting for under 25s (61% for STI units, 68% for C+RHC units.) Emergency contraception audit standards were achieved in offering quick start contraception (96%) but suboptimal a) for IUCD offer (73% for STI based units, 57% for C+RHC units), b) documentation of hours since last unprotected sex (58% for STI units 89% for contraception based units), c) documentation of day of cycle (69% for STI units, 89% for contraception units and d) offer of STI screens (82% in STI based units, 76% in contraception units)

**Discussion** Although variation between units exists it is noteworthy that partner notification was best delivered in C+RHC unit setting and IUCD offer in STI unit setting. Emphasis on documentation was made to staff with reaudit planned.

#### P160 TO SEE OR NOT TO SEE

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10.1136/sextrans-2017-053232.204

**Introduction** Determining which patients need to be seen on the day they attend. Sexual Health Services are challenging given the increasing demand for services and limited capacity. A new questionnaire based triage system was implemented in a busy, urban, Level 3 Sexual Health Service. We have reviewed the outcomes of implementing this triage process to assess how many triaged patients were seen the same day and the symptoms they reported, how many received future appointments and of those, how many returned. We also assessed the safety of a questionnaire based process for triage.

**Methods** Patients triaged in November 2016 were identified and their notes reviewed.

**Results** Of 255 recorded triages, 119 notes have been reviewed to date. Of these, 92 (77%) were seen the same day but 2 left before being seen. 27(23%) received a follow-up appointment, and 89% of these attended.