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?

Emma Street*, Lindsay Short. *Calderdale and Huddersfield NHS Trust, Huddersfield, UK*

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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 – 2/3rd 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

Sumit Bhaduri*, Melanie Mann. *Worcestershire health and care trust, Worcestershire, UK*

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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 subunits 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

Sarah Seacombe, Nicola Lomax, Darren Cousins*. *Cardiff Royal Infirmary, Cardiff and Vale University Health Board, Cardiff, UK*

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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.