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 – 2/3rd 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

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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 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

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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.

Of the 92 given a same day appointment, 36 (39%) reported pain/dysuria, 23 (25%) were contacts of an STI, 2 required PEP, 6 had discharge, 3 recurrent HSV, 2 patients had been diagnosed with Chlamydia elsewhere, 2 had non-specific symptoms, 1 requested a TOP and 1 reported sexual assault. 12 had lumps or itching, 4 were asymptomatic.

Discussion This review demonstrated that questionnaire based triage is effective and as it is quicker than face to face triage, capacity can be increased. 77% of patients were offered same day review which highlights the importance of flexibility within services to ensure patients can be seen within 48hrs when appropriate.

P161 ABSTRACT WITHDRAWN

P162 NHS GGC STAFF HIV ANTI-STIGMA CAMPAIGN

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10.1136/sextrans-2017-053232.205

Introduction People living with HIV, and maintained on ARVs, can live long and healthy lives.

Consequently, there is a growing cohort of people living and ageing with HIV, who are attending NHSGGC for non-HIV related conditions. However, many patients report experiencing stigma and discrimination within these services. NHSGGC responded to this by creating a HIV anti-stigma campaign.

Methods A baseline staff survey was conducted to ascertain knowledge, attitudes and training needs. These results and input from the HIV Patient Forum shaped the campaign, which consisted of: A range of materials, merchandise and activity including posters, road shows, factsheets; training, digital updates and direct messaging to service managers; A patient toolkit which empowers them to challenge stigma and discrimination; Short dramatic videos illustrating patient experience; A repeat staff survey was carried out in 2016

Results 4000 responses to the baseline survey; 9,325 unique website hits; 300+ staff engaged at road shows; 15 delegates attending training; 1,521 responses to the repeat survey; excellent partnership working between NHSGGC staff and members of the patient forum.

Discussion The campaign was successful in raising HIV with non-specialist staff. However, uptake of training was low despite an expressed need. Lack of time to train in non-mandatory areas was an issue. Those that did attend training evaluated it well. Results from the repeat survey will shape future interventions for staff.

P163 HAART PRESCRIBING AND BHIVA STANDARDS OF CARE FOR PEOPLE LIVING WITH HIV AUDIT

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10.1136/sextrans-2017-053232.206

Introduction We audited our service against the BHIVA 2013 Standards of Care for People Living with HIV, BHIVA treatment guidelines for HIV-1-positive adults 2015 and North West 2015 treatment algorithm for HIV-1-positive adults 2015.

Methods This is a retrospective audit involving the review of all patient notes (84). 64 patients were excluded as they were started on medication before 2013.

Results 40% of all patients had a CD4 count of more than 350 when they were started on medication and 10% had a CD4 count of <200. Only 5% had HIV related symptoms. 15% were started as prevention of transmission.

30% (6 in 20) of patients were started on treatment on/after 2015. Only 17% (1 in 6) of these patients had been prescribed treatment according to the North West 2015 algorithm (The patient was given Kivexa based therapy when they could have had Truvada). First line therapy according to BHIVA 2015 guidance was prescribed in 100% of patients (Standard of care target >75%).

100% of patients adhered to their medication within the first 3 months (Standard of care target >95%). None of the patients who had viral loads done had experienced virological rebound (Standard of care target <2%).

Discussion We are 100% compliant to the BHIVA treatment guidelines while only 17% compliant to the North West algorithm. To improve our service and make it more viable, we will update our proforma according to the North West algorithm, which reflects the availability of cheaper generic drugs and NHS England guidance.

P164 AUDIT OF THE MANAGEMENT OF GENITAL HERPES INFECTION IN COLCHESTER SEXUAL HEALTH CLINIC

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10.1136/sextrans-2017-053232.207

Introduction Genital Herpes infection, caused by Herpes simplex virus is one of the common sexually transmitted infections in the UK. According to Public Health England STI report (2015) the percentage increase of newly diagnosed Herpes infection from 2006 to 2015 is 67%. BASHH published new Herpes management guidelines in 2014. We evaluated the management of Herpes infection at our clinic against these guidelines using electronic patient records over a six month period in 2015.

Methods Retrospective case notes review of all patients diagnosed with genital herpes infection (coded C10A) from July to December 2015. Individual case records were scrutinised and evaluated against auditable outcome measures outlined in BASHH 2014 guidelines.

Results There were 102 newly diagnosed Cases of HSV in this 6 month period. All patients had HSV detection by PCR confirmation and 100% had at least one detected HSV typed. Recommended antiviral therapy offered to 95% of the patients who presented within 5 days of onset of symptoms (target 97%). The percentage of patients who were given verbal and written information about HSV was 54%.

Discussion Our audit shows we met the BASHH standards by virologically confirming and typing all diagnoses of genital herpes infection. We failed to meet the standards on patient education and documentation. Since April 2016, our service has switched to new electronic patients records which has a dedicated section on patient education This will help improve our performance. This will be re audited next year.