related to increased uptake of chlamydia test using the less invasive method. However, the overall trend has shown some reduction in both chlamydia and other STI rates in children aged 13-15 years attending our clinic for the past eight years. The reduction might have been contributed by NSCP in addition to changes in the sexual health services locally.

P224 AGILE, DESIGN LED APPROACH TO ONLINE SERVICE DEVELOPMENT

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Introduction Sexual health services lead innovative thinking in the NHS with integrated service provision, online access and testing in non-traditional venues. Agile design-led thinking creates services that are intuitive, easy to use and valued by users (both staff and patients). It offers an alternative to pre-specifying a whole system (waterfall approach) frequently associated with unpredicted problems, identified late and requiring costly fixes.

Methods SH:24 uses an agile, design-led approach to service development delivering value by: Focusing on user need (understanding and empathising rather than assuming); Reducing cost (failing quickly, cheaply); Reducing risk (avoiding unnecessary, costly development); Creating tangible, visual, measurable outputs early (promoting understanding, collaboration and buy-in). Our agile, design-led approach included extensive user involvement; building the minimum from cycles of build, test, learn; responding to feedback, continuously improving and optimising.

Results This presentation will provide three examples describing the contribution of agile to development of:

1. Self-sampling kit instructions which delivered 76–84% return rate
2. User friendly information pages on contraception – 2000 hits daily
3. Online chlamydia treatment – 95% uptake

We will demonstrate the added value of design and agile for these examples.

Discussion An agile design led approach is championed by Government Digital Services - it involves re-framing issues as opportunities and rapidly iterating thinking by building and testing user centred prototypes - this approach minimises cost and risk while improving user experience - an approach that could add value in NHS services.

P225 DO COMMUTERS HAVE TIME FOR SAFE SEX? DELIVERING AN OUTREACH QUICK CHECK STI & CONTRACEPTION SERVICE TO LONDON COMMUTERS

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Introduction Sexual health services are under growing pressure to provide resource efficient STI screening and contraception services. At the same time busy people are seeking time efficient, convenient services to fit in with busy working lifestyles. By establishing an asymptomatic screening and contraception service in a well-known brand pharmacy at a busy mainline London railway station we hoped to meet both these needs.

Two weekly outreach sessions are provided by an Independent Nurse Prescriber covering both a lunchtime (12–4) and evening (4–8) session on different days. Appointments are booked online with minimal walk-in availability. Prescriptions are issued via FP10's and collected from the pharmacy.

Methods Of 1425 attendances in a one year period a retrospective case note review was done for a 3 month period July – Sept 2016 (329 attendances).

Results Of these 329 patients 75% (248) women and 25% (81) men, of whom 3 MSM. Age range 18–51 (mean age 27yrs) 51% (169) new patients, 187 asymptomatic screens done (1% positivity CT). 147 contraception issued (72% COCP, 21% POP, 5.4%, VR, 1.3% Patch), New contraception 15% (22/147), Maintain 78% (114) Change method 6.8% (10). 26 patients required EHC.

Discussion There is a high attendance and low DNA rate demonstrating this is a well-used, well positioned timely clinic to meet the needs of a busy commuter population. With more women expressing difficulty getting GP appointments for routine contraception more sessions like this would be appealing for the working population. The service is cost-efficient with low staffing and overheads.

P226 'AGENDER FOR CHANGE': REPRESENTING GENDER AND SEXUALITY DIVERSITY IN SEXUAL HEALTH

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Introduction Trans* identities are under-represented in UK sexual health data. One possible reason is that the traditional representation of gender within the restricted binaries of male and female contributes to the low numbers seen in sexual health services. We aimed to obtain a clearer understanding of the hidden gender and sexuality identities accessing an LGBT-targeted sexual health service.

Methods We offered full sexual health screening in a community LGBT clinic during National HIV Testing Week in 2016. A self-completed triage form was used to register patients. Additional gender identity options were added to the form. This included an 'other' box with an option to specify any gender or sexual identities that had not been represented on the form.

Results 78 patients completed the registration form. 52 identified as male and 18 female. 8 (10%) described different gender identities; 2 trans*-men, 2 demi-boys, 1 gender fluid, 1 bi-gender and 2 non-binary.

In terms of sexual orientation, 8 identified as heterosexual men, 50 as gay men, 2 as lesbian women, and 6 (2 male, 3 female and 1 non-binary) as bisexual. 11 identified themselves as pansexual and 1 (a demi-boy) as asexual.

Discussion Increasing the options during registration captured a wide variation in reported gender identity and sexual orientation. To avoid a complex, multi-option question on the registration form, we would suggest that simplifying this to 'please describe your gender' and 'please describe your sexuality' would be advantageous for both the patient and health care professional.