INTRODUCTION

reported experience of PPI.

Sexual and reproductive health and HIV services face unique challenges around accessing patient experience.

> We have taken a multi-dimensional approach to this challenge, including auditing PPI (Patient and Public Involvement) in sexual health services, surveying potential patients around their exprience of PPI in services. We are now building on this through spefcific targeted work with different groups to establish the diversity of need and experience.

Current PPI often centres on patients who are happy to be identified. Sexual health services are unique due to the circumstances that lead to attendance which require assurance of anonymity and confidentiality. Patients often access services sporadically, due to a crisis or risk behaviour. This can generate feelings of shame or embarassment (1,2).



A first step to build upon current PPI guidance in sexual health (3,4,5,6) was to begin building an evidence base through a snap shot audit of current practice in the region and to compare that with patient's

Design

Mixed Methods

Sexual, reproductive and HIV services in the Bristol region were sent an audit questionniare 8-11/2013 requesting details of PPI work and policy but also asking for goals and measures of PPI success. Respondants were from services, primary care, commissioners and charities.

n = 96 participants from UWE responded to an open call to N=500 students and snowballing of contacts and completed an anonymous online questionnaire. Mean age = 23.5, all had used services. 89% hetero, 5% gay/lesbian, 5% bisexual.

Results

Audit

services, many reporting no PPI policy and use of minimal 'patient satisfaction' approaches. TRAINING - 8 of 10 services responding offered PPI GOALS - many had not conceptualised what PPI was for,

VARIABILITY - there was very different practice across

often conflating PPI for research and service delivery. METHODS - responsiveness and innovation were undermined by standardised 'NHS' approches to PPI.

Survey

Only 3 respondants had ever given feedback to sexual health services they used, 20 had wanted to, 13 with positive

30% reported not being asked for their feedback and 40% did not want to give any feedback.

None, no one. 0 agreed to take part in further research.

Results reported in Meyrick et al (2016)([7]

Why

Trust is key to being open about risk behaviour, sticking with treatment and comprehensive partner notification. Those with the greater burden of ill health are often the hardest to reach. Putting patient voice at the heart of services may reduce barriers.

How

Don't ask if you don' want to know - be clear about what PPI is for and what it can or cannot change.

One size does not fill all

- different groups may want different things
- a range of methods should be offered.

Measure the difference it makes

- have a theory of change for the patient sharing and for the service listening. Use this to find theory based measures of impact of hearing and listening.

Patient Involvement in Sexual Health Service Delivery

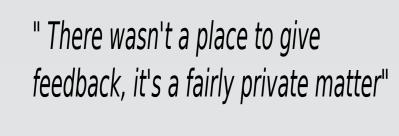
Dr Jane Meyrick Abigail Jones

Dr Debra Gray

University of the West of England jane.meyrick@uwe.ac.uk University of Winchester

" I felt embarassed enough while I was there without complaining about

it too"



Conclusions

- Services should aim to gather good quality data from a representative sample of patients using a variety of methods.
- Services should have a clear theory of what PPI data is for, evaluate its' success in reaching those goals and evidence it's impact on services and patients.
- a variety of methods (including online) should be offered and tailored for different groups with a focus on anonymity.

Research Directions

Vulnerable Groups

Research has begun around the particular needs of patients within a Sexual Assault Referral Centre as they represent a vulnerable group. Other groups for which research funding is being sought are women undergoing Termination of Pregnancy and Black and Minority Ethic Men who have sex with Men (BME, MSM). These groups have been chosen

on the basis of need and anticipated difference in contact preferences. **Experimenting with contact methods**

A range of innovative methods need to be tried out with different groups of patients using sexual health sevices, online and anonymous contact methods in order to secure more representative samples.

Theory based outcome measures

The impact of PPI work should be measured to evidence its' impact both on services and patients. Such impact data should be grounded in theories of how the process works and theoretical approaches to PPI are fundamental to our ongoing researchh aims within a healh psychology appraoch.



References

[1] Bell,J. (2009) Why embarassment inhibits the acquisition and use of condoms: a qualitative approach to understanding risky sexual behaviour. Journal of adolescence. 32(2) pp 379-391. [2] Bender, S.S. and Fulbright, Y.K. (2013) Content analysis: a review of perceived barriers to sexual and reproductive health services by young people. The European Journal of Contraception & Reproductive Health Care, 18(3) pp 159-167.

[3] NHS England (2013) Transforming Participation in Health & Care. [4] British Association for Sexual Health and HIV (2014)Standards for the management of sexually transmitted diseases. (STIs). [5] Department of Heatth (2013) Sexual Health: Clinical Governance. [6] Faculty of Reproduction and Sexual Health (2013). Service Standards for Sexual and Reproductive Health.

[7] Meyrick, J. Gray, D. & Jones A. (2016) Assessing the possibilities and challenges of patient involvement in seuxal, reproductive and HIV/AIDS services. Sexual Health 13(3) pp 213-220.

he poster is available under the Creative Commons Attribution-ShareAlike 3.0 Unported Licens Poster template by Ugo Sangiorgi based on Felix Breuer's wo