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Transforming Sexual Health in Scotland

Cultural, Organisational and Partnership Approaches

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FOREWORD

At the start of a new decade, it is increasingly apparent that health care has to interface with society in the broadest sense as well as with the physiology of the individual. Sexual health is at the boundary between health and society. It reflects the outcomes of human behaviour, is assisted by increasingly sophisticated technology and treatments, and is influenced by legislation and policy making that shifts over time.

This collection takes sexual health as the subject for investigation, and addresses it through reviewing the experience of Scotland in the United Kingdom. The editors and contributors make a strong case for suggesting that the governance and policy context, coupled with Scotland's poor health record, have allowed creative responses to occur to address poor sexual health and to challenge some of the longstanding societal mores.

Chapters are written by experts in the field – from clinical, health improvement, policy and management – many of whom have been active players in the developments and changes that the book sets out. The approaches taken in the chapters vary depending on the aspect of sexual health being covered, and this makes the collection of wide interest. It demonstrates the high levels of innovation, lateral thinking, clarity of purpose and genuine multi-agency working that characterises the successful approach that has been taken in Scotland.

Difficult challenges remain, but there is a lot here that will benefit those elsewhere in the UK and more widely afield, and I am delighted to recommend this collection.

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PREFACE

In October 2008, a conference took place in Glasgow, Scotland attended by those who are part of the sexual health family – government Ministers, civil servants, clinicians, managers, policy-makers, researchers, academics, commissioners, health improvement specialists, public health experts, community activists, educationalists, voluntary organisations and many others. They had come together to recognise the work that has taken place across Scotland and in other parts of the UK since the development of the first national sexual health strategy - *Respect and Responsibility* - and its UK counterparts. The conference was over-subscribed and due to demand has now become an annual event.

The conference showed how far we have travelled in the last few decades in sexual health as, what was once a stigmatised clinical and health issue, has now become more open and less invisible. There are better and more accessible services, improved diagnosis and treatments, higher numbers of trained staff, wider understandings of the links between sexual health and other aspects of collective and individual experience, and a commitment from all UK national governments to improve the poor sexual health outcomes of the population.

This collection arose from the experience of organising and attending that October conference. We felt that the buzz in the room needed to be harnessed and disseminated, and that the creative activities, innovative services and insightful thinking happening across Scotland concerning sexual health should be more widely represented. Both to shed some light on the different political, cultural and structural structures in Scotland, and why that matters in a field like sexual health; as well as to share our experiences as a small nation in tackling challenging poor sexual health in the context of inequalities that are far-reaching.

This collection brings to wider attention some of the main themes that were discussed that day, with papers rewritten by their original presenters, alongside newly commissioned pieces that provide other insights. We hope that this collection appeals to those already in the sexual health family, and to all those friends and neighbours who will find something of interest here. Thanks to all the contributors and those who have provided ideas and support, especially Kelda McLean, Programme Administrator at the Glasgow Centre for Population Health.

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CHAPTER 1

Why Sexual Health is Important

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Abstract: The introductory chapter describes the motivation for the collection - to explore the cultural, social and organisational context of sexual health in twenty-first century Scotland. Written by the book's co-editors, it argues that good sexual health is vitally important, and its absence linked to social inequalities, often to discrimination and disempowerment.

The development of the first national sexual health strategy in Scotland forms the book's core, and the chapter explains why Scotland, as a devolved part of the UK, with its own government and health care system is the site for investigation. Population health in Scotland is notably worse than the rest of the UK, with health and social inequalities prominent. This context has enabled responses to emerge in relation to sexual health that the chapter suggests are of wider interest and the chapter briefly describes population demographics of Scotland, its political and geographical landscape, historical and contemporary attitudes towards sex and sexual activity, and earlier policy thinking and the type of sexual health services provided.

The structure for the book is set out, based on four sections - the social, political and cultural context; structures and services developed through the sexual health strategy; sexual health service innovation, and cross-cutting issues around partnership and integration – with information given about the authors. The chapter finishes by proposing that a momentum has begun in Scotland around sex and sexual health, and that this collection, whilst concerned about the implications of the current economic climate, argues for optimism and hope for the future.

INTRODUCTION

Good sexual health is important. It is important to individuals and couples, to society and to the continuation of the human species. Media headlines in the UK, in particular in parts of 'the tabloid press', about the number of unplanned pregnancies among young women, the rise in sexually transmitted infections, and the disturbing numbers of rape and sexual assaults, many of which never successfully progress through the criminal justice system, indicate that a number of problems exist around the framing of sexual health, from how it is reported to the fact that it is an experience not available to everyone. Within other parts of the world, often in countries with ongoing endemic political, social and environmental problems, good sexual health can be even more elusive - with devastating consequences.

As Glasier and colleagues documented, unsafe sex is the second most important risk factor for disability and death in the world's poorest communities and the ninth most important in developed countries. They report that every year, more than 120 million couples have an unmet need for contraception, 80 million women have unintended pregnancies (45 million of which end in abortion), more than half a million women die from complications associated with pregnancy, childbirth, and the postpartum period, and 340 million people acquire new sexually transmitted infections (STIs) including gonorrhoea and syphilis (Glasier *et al*., 2006).

The powerful combination of a lack of services, trained staff and treatments; of judgemental cultural and religious attitudes; widespread social inequalities, and populations who often lack access to education and are prevented from having access to information and choices has a significant role in creating these startling figures. And although few women in the UK die from complications associated with childbirth, there are still many people facing unwanted pregnancies, acquiring sexually transmitted infections (some of which are life threatening), or with a sex life that is stressful and harmful, rather than enjoyable and consensual. The fact is that good sexual

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health matters - to everyone – and its presence and absence tell us something about society, about who has power and influence, and about issues of inequality and status.

This e-book will address why the Scottish experience of sexual health is of wider relevance across the globe. Scotland's new devolved institutions, its small policy community and its shared sovereignty within the United Kingdom, are of wider relevance in an age of interdependence, networked policy and civic society diplomacy (Hassan and Warhurst, 2002). These have separate traditions from the rest of the UK along with different interpretations of health, social care and social policy (Stewart, 2004; Tannahill, 2005). Post-devolution such developments have even more consequences for a 'National Health Service' across the UK and for equal citizenship and treatment (Greer, 2009).

DEFINING SEXUAL HEALTH

This e-book is concerned with sexual health in Scotland in the twenty-first century, and how cultural, organisational and partnership approaches have been employed in a concerted effort to transform poor sexual health. It is intended to be a resource to inform other developments, to chart the Scottish story in tackling sexual ill-health and to demonstrate the kinds of actions needed to provide high-quality sexual health services. It is not however a sexual health clinical primer or expected to be the source for extensive facts and figures about sexual ill-health; this information is readily available through the links and sources provided in this collection. The Scottish situation is a unique one – in terms of the context and policy environment, and the book intends to offer ways to understand how change has been achieved in particular places at particular times.

Each chapter will explore an aspect of this agenda but all are united in construing sexual health as something that is complex and has numerous meanings to individuals, the wider population and to society as a whole. The World Health Organisation's updated definition, developed in 2002 as part of a review of global sexual and reproductive health, is universally viewed as reflecting the range of human experience and behaviours that make up sexual health:

> *A state of physical, emotional, mental and social well-being related to sexuality; not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. (WHO, 2002).*

This definition moves beyond concepts of ill health and dysfunction to consider respect, consent and rights as essential to good sexual health, indicating contemporary societal aspirations and values. As a review of sexual health definitions confirmed, the concept and definition of sexual health will continue to evolve and be shaped by historical events (Edwards and Coleman, 2004). As some of the chapters in this book convey, and as the discussion above suggests, social and public opinion has a significant effect on sexual behaviour and sexual activity, on positive and negative health outcomes, on the types of services that should be available and to whom, and who should be involved in decision-making and service delivery. In this instance we are concerned with Scotland that has a particular set of factors that shape the way that the population and wider society understand sex and sexual health, and how policy communities, networks and governmental institutions interface and interact with, and influence this.

THE SCOTTISH CONTEXT – IS IT ABOUT FAIRNESS AND CONSENSUS?

The place that this collection will investigate is Scotland – one part of the UK - with legal, educational and health care systems that are separate and different from the other nations of the UK. Since 1999, devolution has led to the establishment of a Scottish Parliament with extensive legislative (but not tax-raising) powers, which has arguably also facilitated a stronger collective

and individual identity about being Scottish and living in Scotland (Keating 2005; 2009). Much of the approach of the Scottish Government – firstly, a Labour and Liberal Democrat coalition, then a minority Scottish National Party (SNP) administration – has been about achieving consensus, partly through political necessity but partly because of the preferred co-operative nature of Scottish decision-making and arguably, Scottish life and the influence of professional networks in the wider framework of the 'negotiated autonomy' that Scotland positions itself within the UK (Paterson, 1994).

Cultural views that Scotland is a welcoming and equal society are strong, but have increasingly been challenged by those representing socially excluded groups. Morag Alexander, the Scottish Commissioner for the Equality and Human Rights Commission, issued a warning that 'the Scotland of 2030 will not be economically or socially fit for purpose unless Scots stop talking a good game on how fair and welcoming we are as a nation and start taking steps to realise our self image, saying ''we have to be braver about the change that is required to make a fairer Scotland and part of that means looking afresh at whether the consensus holds'' (Alexander, 2009).

Scottish culture, society and politics has long been shaped by a belief in its egalitarian ethos, from the influence of collectivist ideals to the historic appeal of the labour and trade union movements. However, this ethos has been very narrowly articulated, and mostly focused on the economic terrain, while displaying an ill-ease on sex, gender, race and other issues. Recent evidence has displayed a dramatic 'liberal shift' in Scottish attitudes on homosexuality and pre-marital sex from 1983-2000 which has brought Scots attitudes into comparatively the same position as England, thus showing a significant change. At the same time Scottish attitudes are hugely shaped by difference in age (Park, 2001).

WHO LIVES IN SCOTLAND AND WHERE?

Scotland's geography is a mix of towns and cities, set amongst rural and remote regions, including the Highland and over 790 offshore islands, with often very low populations. The population of Scotland has risen for the last 6 years, to now its highest for 28 years, with the estimated population in 2009 of 5,168,500, a rise of 24,300 on the previous year (*The Scotsman*, 2009a). About one-third of the population are between 16 and 44, and approximately half a million people in Scotland are not working, many of them concentrated in the West of Scotland that includes the large post-industrial city of Glasgow.

While once a fairly homogenous society, in recent times Scotland has actively encouraged immigration to help fill various skills deficits and to support what was viewed as an increasingly ageing population. This strategy has been successful in the sense that Scotland is now, at least within more urban areas, a more heterogeneous society. Official figures show a net migration gain of 20,000 people up until 2008, including 11,500 from the UK and 7,700 from overseas (including asylum seekers) (General Register Office for Scotland, 2009). However, as Professor Hanlon describes in Chapter 2, social inequalities in Scotland remain extremely problematic and continue to challenge national and local administrations and public agencies. The draft first national sexual health strategy for Scotland, with which this collection is much concerned, recognised the links between social inequalities and poor sexual health outcomes, stating:

- Rising numbers of people have Sexually Transmitted Infections (STIs), including HIV. These can severely affect people diagnosed and their sexual partners who may have the STI passed on to them.
- Teenage conceptions are amongst the highest in Western Europe and are both a symptom and a cause of social inequalities.
- Considerable numbers of people in Scotland report discrimination, abuse and sexual violence related to gender, sexual orientation or HIV status.

  (Scottish Executive, 2003a)

Positioning the need to confront discrimination and prejudice at the heart of a planned national sexual health strategy was a radical move, and as many of the e-book's chapters comment, sexism and homophobia have been part of Scotland's culture for many years, along with increasingly visible resistance - especially from women's organisations and the lesbian, gay, bisexual and transgendered (LGBT) community - that has had some influence on national policy and legislation.

SCOTS AND SEX

And what about the Scots and sex? A recent readers' survey carried out by *The Scotsman*, one of the main Scottish newspapers, found that the average Scot thinks that people should wait until the fifth date before having sex. Respondents also said that they had sex two or three times a week, with the most favoured time being a weekend night (Cowing, 2008). These views may seem quite conservative but may reflect fairly well the readership of the newspaper as, of approximately 200, 000 readers, 75, 000 are over 55 and 61% are men, with in this case, over half the respondents being over 45, and over half male (*The Scotsman*, 2009b).

As already discussed, levels of STIs and teenage pregnancy are high in Scotland, and are linked to social inequality, but also to cultural norms and values about sex and relationships. Scotland is often perceived as a society not quite at ease with itself, with a history of collective and personal repression that has affected the way that individuals and society engage, including around sex and sexuality (Craig, 2003). Talking about sex is not always easy, and the effect this can have on decision-making about when to have sex and with whom, is clear. A recent comparison between sexual health outcomes for young people in Scotland and the Netherlands found that 'in all countries with low levels of teenage pregnancies and sexual infections, adults are more accepting of sexual activity among teenagers' (Bradford, 2008). Even though the Netherlands has a more liberal attitude towards sex than Scotland, 'these countries also give clear messages that sex should occur within committed relationships and that teenagers should protect themselves against pregnancy and infection' (ibid, 2008).

The role of church and faith organisations in influencing population and individual sexual behaviour is well documented. Within Scotland this is particularly pertinent because of the importance of Roman Catholicism to a high proportion of the Scottish population, many of whom have personal links to the Republic of Ireland and the waves of immigration into Scotland from the early 19th century. The recent influx of Polish people into Scotland has also increased the number of Catholics, more of whom now attend church at the weekend than people affiliated to the Church of Scotland (Claire, 2008).

Faith organisations in Scotland have often spoken out about sexual matters, not surprisingly promoting marriage as the location for sexual activity, although recent comments by the Church of Scotland indicates a shift towards considering sex within an unmarried, intimate, relationship as being more acceptable (Swanson, 2009). The Catholic Church in Scotland, and other faiths including those who follow Islam, have also frequently commented on sex and sexual health services, especially in relation to young people with concerns that the availability of sexual health services encourages increased sexual activity amongst the young (BBC, 2004).

Scotland provides state funding for the establishment and maintenance of faith schools and of the 2722 schools in Scotland, 385 are Catholic, 1 Jewish and 3 Episcopalian. This allows, for example, Catholic schools to maintain their own religious education, for Catholic clergy to have access to schools, and for school staff to be acceptable to the Church. The other schools (bar the Jewish school) are known as 'non-denominational', and teach religious education as required by Scots Law. These facts are important when considering education and the role of the school in imparting information and guidance about sexual health and relationships, as Chapter 11 describes.

LOOKING BACK AT PAST SEXUAL HEALTH SERVICES & APPROACHES TO CARE

The delivery of health care in Scotland, long separate from the rest of the UK, has been predicated on the need to work in partnership to achieve the best population health and individual outcomes. Changes that took place in other parts of the UK National Health Service to increase internal competition and to run healthcare as more of a state-funded business in the 1980s and 1990s onwards did not gain support in Scotland, and this has continued to be the case. Moves to encourage integrated working between health and social care to tackle multifaceted health and social issues have been firmly embraced in Scotland, with the development of the community health partnership model in the early part of the twenty-first century a key manifestation (Cook *et al*., 2007; Stewart *et al*., 2003). Much of this e-book is concerned with setting out responses from the National Health Service and others to meeting the challenging sexual health landscape in Scotland in the twenty-first century. It is therefore useful to look to the past and to see how far we have come. Although later chapters refer to the historical approaches in the UK to addressing sexual health, it is helpful to summarise here.[i]

Genitourinary medicine, the modern twentieth-century name for the practice of venereology in the UK, evolved from the medical specialism called venereology, itself a newly (re-)organised clinical specialism at the turn of the nineteenth - century in response to the spiralling numbers of cases of venereal disease. The establishment of a free service at the point of delivery and open access without need for referral from another medical practitioner was recommended by a Royal Commission in 1916 under the direction of Lord Sydenham. This was the first explicit acceptance that venereal diseases in the UK constituted a public health threat; whereas, previous attempts to control these diseases failed owing to a judgemental, moralistic approach from legislators, the medical profession and hospital administrators, with blame and mortal sin at its core and an acceptance that omission and explicit refusal to treat cases ethically sanctioned.

The Contagious Diseases Acts of 1864 and 1866 permitted, at the behest of a male magistrate, the legal detention and clinical examination of a prostitute in the name of disease control; and, both the Royal Commissions of 1909 and 1912 on the Poor Laws and Divorce Law sanctioned compulsory detention orders for those with venereal disease. Detention swept away the problem from public thought and sight despite the significant morbidity and mortality associated with these infections. Activist groups were formed to organise support against the provision of venereal disease treatment services in the belief that education and free services would encourage further immoral behaviour, thus fuelling the spread of venereal diseases.

A second wave of enlightenment came from the unexpected quarter of the armed forces' medical services, motivated by the need to reduce the effect of morbidity on operational effectiveness during the Great War, who instituted an innovative social model of care that included health education, better leisure facilities, lower alcohol consumption, better and free medical treatment, and freedom from punitive sanction and stigma. Civilian venereal disease care, before the inauguration of the NHS, was still undertaken by voluntary hospitals many of whom had policies on how in-patients' care should be organised - syphilis cases would go to the medical physician; gonorrhoea in men would be managed by the urologist; and the obstetrician and gynaecologist would see women with gonorrhoea.

In the aftermath of World War One, concerns in Scotland about the spread of venereal disease required local authorities to implement Venereal Diseases (VD) schemes, and to develop clinics often through voluntary hospital provision (Davidson, 2000). By 1919 in Glasgow, for example, there were VD treatment facilities within a number of hospitals and dispensaries including the Lock Hospital for Women. The Lock Hospital was one of the Magdalene Hospitals for women in the UK that were set up at the start of the nineteenth century in response to increasing public

[i]Acknowledgements to Dr Anthony Rea and Dr Audrey Brown for their contributions to this section

worries regarding prostitution, venereal diseases and women's morality, and that incarcerated women away from the rest of the population (Wilson, 1914; Mahood, 1993).

By 1927, of then 49 VD clinics across Scotland, 16 were in Glasgow, and were well attended - during the 1920s Glasgow patients accounted for 43 % of all new VD cases in Scotland (Davidson, 2000). In 1948, the broader clinical speciality of genitourinary medicine (GUM) became part of the new National Health Service, with VD diagnosis and treatment becoming a separate speciality. However, Hospital Boards in Scotland did not increase staffing, and although the Joint Sub Committee on STD (Gilloran Committee) appointed in 1971 to advise on the epidemiology, treatment and management of VD in Scotland, recommended expanded services this did not happen quickly (Davidson, 2000).

The desire to limit family size is not a new concept, and sexually active couples have informally practised family planning or birth control over many generations, without recourse to medical involvement, utilising such tactics as coitus interuptus, periodic abstinence and a variety of different materials as barrier methods. Marie Stopes, an Edinburgh born woman, who had become Britain's youngest doctor of Science at the age of 25, founded the Society for Constructive Birth Control in 1921 and opened the first birth control clinic in London in the same year. This was not without great controversy, with accusations of obscene publication for her writings, and calls for her prosecution. Nonetheless, over the next decade, birth control services flourished, with Scotland's first family planning centre – the Glasgow Women's Welfare and Advisory Clinic – opening in 1925, and by 1930 there were 20 family planning clinics. A variety of birth control societies came together in that year as the National Birth Control Council "so that married people may space out/limit their families and thus mitigate the evils of ill health and poverty" and in 1937 the Scottish Federation of Mother's Welfare Clinics formed, affiliated to the Council.

In 1939, the National Birth Control Council became the Family Planning Association (FPA), and then in 1946 the National Health Service Act opened the door for health authorities to open contraceptive clinics. Many of these clinics were provided by the FPA, but rather than the free at point of care and inclusive service we expect today, were aimed at married women who had to pay for contraceptive services. Thus the youngest and poorest were denied access. In the 1950s, the clinics began to offer pre-marital advice to women, although proof of intention to marry, in the form of the wedding bans, or a referral from a vicar was required.

The 1960s saw an era of dramatic change and sexual revolution. The National Health Service (Family Planning) Act allowed health authorities to offer family planning advice and supplies to all people, whether married or not, and on social as well as medical grounds. This led to the opening of clinics for unmarried women. The range of effective contraceptive choices increased monumentally, with the introduction of the contraceptive pill, the intra-uterine contraceptive device and laparoscopic female sterilisation and male sterilisation in the form of vasectomy. In addition, the Abortion Act 1967 provided access to safe and legal abortion when unintended pregnancy did occur, reducing the burden and risks of illegal abortion. This applied to Scotland a year later, through Section 15 of the Health Services and Public Health Act 1968 (Ministry of Health, 1968).

Despite the rapidly changing sexual environment of the 1960s, access to contraception still depended on the ability to pay. In 1974, Barbara Castle, Minister for Health, introduced the National Health Service Reorganisation Act (Parliament, 1973), resulting in the handover of around 1000 FPA clinics to the NHS, and finally achieving free at point of care provision of contraceptive advice and supplies. The following year, general practitioners also came into the NHS family planning service, and were able to provide free contraception to their patients.

CHANGING AGENDAS AT THE END OF THE TWENTIETH CENTURY

From 1975 until the end of the twentieth century, sexual health has come a long way. Technology has played a significant part, with the development of ultrasound and other tools within

gynaecology, the onset of quick and non-intrusive screening and treatment methods within GUM and of new, accessible methods of contraception. However, the rise of HIV infection, as Phil Eaglesham discusses in Chapter 9, concerns about the declining age of first intercourse and an increased awareness and understanding of LGBT (lesbian, gay, bisexual and transgender) issues have all contributed to increasing pressure for change in the last three decades of the twentieth century. Many groups lobbying for different, but often related, change and acceptance meant something had to change. In the face of strong conservative lobbies from some of the churches in Scotland as discussed above, brave leadership at a national level was required. Through *Respect and Responsibility* (Scottish Executive, 2005a), the first Scottish sexual health strategy, the Scots started the twenty-first century with the intention to transform sexual health attitudes and sexual health services. This collection describes the challenges and progress in the first decade.

THE AIMS OF THIS COLLECTION

To paraphrase a well-known homily, sex didn't start in the 1960s, and sex didn't start with the inception of national sexual health strategies in the UK including the one in Scotland. However, the period since the 2005 introduction of the Scottish strategy – *Respect and Responsibility* – provide a useful time-frame to look back and assess achievements and outcomes. This collection intends to make a timely and relevant contribution to sexual health in Scotland and to wider thinking about collaborative working to address other health issues and inequalities. It will draw on a range of key players in the world of sexual health and public health in Scotland from a variety of disciplines and backgrounds, all of whom have evidence, views and opinions that are gleaned from wide experience in the field.

It is the right time to explore in more detail the conditions which have allowed Scotland to create a particular type of sexual health service to fulfil the needs of the heterogeneous population, as this e-book will describe. Scotland sees itself as being in the forefront of the delivery of innovative sexual health services within the UK and this e-book plans to capture the approach taken within Scotland, in the view that lessons learned have significance for other parts of the UK. Understanding these pre-conditions and the ways in which the services are now provided is believed to be of considerable interest not only to other service providers in the UK but to professionals working in other sectors and in other countries.

HOW THE COLLECTION WORKS

This chapter forms the introduction to the e-book and has offered insights into sexual health and some of the controversies and agendas that characterize it. It has described the nature of the Scottish population and some of the social and cultural factors that influence them, it has reviewed the types of services that were available to people in the past in Scotland and who offered them, and has indicated the importance of sexual health to the wider health and wellbeing of populations and to society. The administrative nature of Scotland has been reviewed as have institutional responses to sexual health in Scotland over time, both of which highlight for and orient the reader towards what is distinct. The tendency towards partnership working from a health perspective in Scotland has also been covered, with the preference for partnership working and to engage across sectors to address health issues set out.

The book is organised in four main sections that reflect the areas for further investigation - the social, political and cultural context of sexual health in Scotland; the structures and the services that have been made possible through the development of *Respect and Responsibility*; good practice in population health work that has arisen and its key outcomes, and the need for, and outcomes of, integration and partnership working for services, workforce and the clinical specialities that deliver sexual health care. The four sections are central to understanding the situation in Scotland and provide an account of the successes achieved and the hurdles that have been overcome.

Section A - *Charting the social, political and cultural context of Scotland's sexual health* – continues with an agenda-shaping chapter by Professor Phil Hanlon of the University of Glasgow (Chapter 2). Professor Hanlon has had a notable role in sexual health in Scotland as the Chair of the Expert Group that devised the draft first national sexual health strategy, as well as being a notable public health expert. His chapter - *Is Scotland's health different from the rest of the UK and why?* - gives key messages concerning public health challenges in Scotland. Its main purpose is to investigate the reasons for Scotland's poor health status in comparison with the rest of the UK and Europe. It interrogates the notion that deprivation is the main cause and proposes an additional and increasing excess mortality which cannot be explained by deprivation, known as the 'Scottish effect'. After exploring possible explanations for Scotland's poor health, Professor Hanlon concludes with an examination of the impact of modernity (accompanied as it is by consumerism, materialism and individualism) on health inequalities.

This is followed by a chapter by Shirley Fraser who has been instrumental for many years in supporting the development of the national sexual health agenda in Scotland through her work in NHS Health Scotland. In Chapter 3 - *What are Scotland's sexual health challenges?* - Shirley Fraser describes the particular experiences and challenges concerning sexual health in Scotland within the time-scale of the last two decades for comparison, but specifically focusing on activity before and since the initial thinking about creating a sexual health strategy for Scotland. It covers the political and health imperatives, include some comparative information about parallel UK activity concerning sexual health strategies, and highlight the funding and policy structures that have been set in place by successive Scottish Governments. The chapter suggests that later parts of the e-book demonstrate where successes have been achieved in the context of Scottish Government commitment and leadership.

The second section, Section B – *Delivering sexual health across Scotland* – brings together three chapters that document the complex clinical, technological and data infrastructures that have been devised in partnership to facilitate and inform the sexual health developments in Scotland. The first of these is Chapter 4: *The development of sexual health service standards for Scotland*, by Dr Rak Nandwani that describes the drivers for instigating, progressing and implementing the new sexual health quality standards that operate across the NHS in Scotland to support the delivery of the sexual health strategy - overseen by NHS Quality Improvement Scotland (NHS QIS). Dr Nandwani, as with the author of the previous chapter, brings a wealth of relevant insight and experience having been seconded part-time from his post as Consultant Physician HIV and Genitourinary Medicine, NHS Greater Glasgow and Clyde as clinical adviser for sexual health at NHS QIS between 2006 and 2009.

The following chapter - Chapter 5 : *Key clinical indicators for sexual health : Current national sexual health data collection and future plans* by Dr Jim Chalmers and Felicity Naughton further describes the governance and reporting frameworks now available in Scotland that allow extensive sexual health data to be gathered and analysed. Again, this chapter contains expert knowledge as the authors have had a considerable role in national information services in the NHS in Scotland – Dr Chalmers as a Consultant in Public Health Medicine at the Information Services Division (ISD) at NHS National Services Scotland and Felicity Naughton as former DASH Project Manager at NHS National Services Scotland.

It considers the data and information structure in which sexual health services in Scotland, through the national sexual health strategy, are positioned and the steps that were taken to enhance existing data collection and reporting arrangements. The chapter reviews commitments in *Respect and Responsibility* to the centrality of data, sets out the processes and some of the outcomes, and highlights some of the new opportunities that improved systems can facilitate. This chapter with the previous and one following indicates the linked approaches that support clinicians and managers across Scotland in planning, delivering and monitoring their services; provide politicians and policy-makers with vital population health information, and ensure that clinical care is provided within an accountable and open framework.

Dr Andrew Winter in the last chapter in this section – *Chapter 6 : Managing patients differently – the Scottish National Sexual Health IT System (NaSH)* - describes the intention to provide a robust information technology (IT) structure for sexual health services in Scotland to ensure universal patient management and national reporting capabilities. This vision was at the heart of the national strategy and recognised the inability of the then existing IT systems in sexual health settings in Scotland to accommodate a changed service agenda. The creation and delivery of the NaSH project by the majority of NHS Boards in Scotland, the Scottish Government and other key stakeholders realised that aspiration as described here; Dr Winter, a GUM consultant and expert in sexual health information management, was part of the group behind the NaSH system, again bringing a sense of authority and insight to this chapter.

The next section is concerned with clinical and services outcomes of the sexual health strategy, and examples of good practice that have emerged to meet the needs of Scotland's population. The section is titled *Section C: Making a difference for population health* and the first chapter shows how the relatively small funding provided to support the strategy has been put to good effect. In Chapter 7, entitled *Scottish Sexual Health Services: Cinderella starts making her way to the ball,* Dr Alison Bigrigg and Professor Anna Glasier chart the shift in Scotland from separate family planning and genitourinary medicine services to specialist sexual health services, offering a wider range of services to a much broader range of people than was possible before. They give positive examples of how investment in local leadership, supported by high profile political backing, led to partnership working and investment by many different agencies in innovative sexual health care. A number of examples of good practice from across Scotland convey the new landscape that has arisen since the strategy.

This chapter is followed by one that details multi-agency partnership working in Glasgow and the West of Scotland to establish accessible sexual health services in line with the national strategy, but that also allowed the strategy to incorporate early learning from the resulting outcomes. Chapter 8 - *The story of Sandyford – developing accessible sexual health services in the West of Scotland* - by Dr Rosie Ilett provides a detailed insight from a participant in the process of change and innovation, and reviews developments from the 1990s onwards to radically change the design and delivery of sexual health services to improve health outcomes, culminating in the opening of the first phase of the Sandyford integrated model in 2000. Women's health work and gay men's activism in Glasgow, in collaboration with the local NHS system and other partners, directly led to this opportunity to develop integrated sexual and reproductive health care and this journey will be described, as well as its attempts to embed understandings of the social determinants of sexual health in its planning and service delivery.

The final chapter in this section - *Chapter 9: Transforming services from within – the health improvement perspective* – continues to explore the importance of taking a broad model of sexual health into conceptualising sexual health and in targeting activity. Phil Eaglesham from NHS Health Scotland, and with a long career in advocating for social justice and equality, describes the significant role of health improvement in promoting good sexual health in Scotland and reviews its contribution to population health. Mr Eaglesham provides evidence of work that has been done from a health improvement perspective to address the needs of those most at risk of poor sexual health outcomes including men who have sex with men, and young people and give examples of good practice that is taking place especially in relation to partnership working, linking to specialist services and supporting multi-agency approaches. Archway – for those who have been recently raped or seriously sexually assaulted, and Open Road – for men involved in prostitution, both based in Glasgow, are given as useful case studies.

The final section of the e-book - *Section D: Exploring partnerships and integrations* – offers up for discussion other structures that underpin and support sexual health services, that have been shaped by the changes that have come through the sexual health strategy and other factors. In the first chapter, three clinicians from the Sandyford Initiative - Lorraine Forster, Dr Urszula

Bankowska, Martin Murchie - from a range of sexual health disciplines (nursing, medical and sexual health advising) focus on the workforce needed within modern sexual health services, the responses required to develop the right staff for a modernised sexual health service in Scotland and how this has been achieved. In Chapter 10 - *Modernising a new workforce fit for purpose in sexual health* - they set out the new skills and competencies required across medical and clinical disciplines to deliver an integrated sexual health service, and suggest examples of good practice to effect that change.

The final chapter in this collection - Chapter 11: *Partnership working and multi-agency approaches* by Andrew Gardiner from NHS Grampian turns its attention to the role of other agencies beyond the NHS in affecting sexual health improvement. Expectations from *Respect and Responsibility* of multi-organisational working – especially between the NHS, local authorities and the voluntary sector - to address sexual health needs in Scotland are reviewed, and the structures that have been put in place to facilitate partnership working are described. Examples of successful joint working from across Scotland are given that suggest where lessons could be learned for the future especially concerning the most vulnerable groups in the population.

LOOKING TO THE FUTURE

The e-book aims to highlight the momentum that has been created within Scotland in the last few years to change perceptions and approaches to sexual health. The national Sexual Health Strategy initially focused on specialist sexual health services but the emphasis of working with mainstream structures has created ripples which have seen sexual health become a recognised and important part of the work of many different agencies and partners. Recognition that services need to work in tandem with cultural, political and public environments has meant that more thought has gone into campaigns and discourse that meets the needs of specific groups as well as the general public. These kinds of awareness campaigns mean that individuals not involved with, or using, relevant health or other services can be drawn into the debate and have their attitudes informed and influenced, and alongside that, public understandings of sexual behaviour and sexual health can be challenged and changed.

Although there are still elements of sensational reporting, there is evidence that the media in Scotland have changed their responses to sexual health by becoming more positive and supportive, rather than focusing on negative health outcomes within a judgemental framework. The wider availability of good and robust information has meant that the media increasingly looks to informed sources such as Health Boards and to comprehensive national data rather than to organised religion and known lobby groups for opinion and knowledge. This has provided a balance and helped demystify and destigmatise to an extent sensitive matters concerning sex and relationships. It has also started a much needed move towards presenting the notion that sex and sexual health can be increasingly a good news story in Scotland.

This extensive involvement of mainstream institutions and individuals in shaping this agenda will be a central factor in ensuring sustainability of what has been achieved, in the ongoing financial pressures that central and local government and public sector agencies, including the NHS, experience in the next period. At the same time sexual health has expanded to genuinely understand its relationship to many of the key issues of great concern to Scottish health today – such as inequalities within health and social circumstances – and to embed this knowledge much more centrally in planning, delivering and monitoring services.

How will we know if the national Sexual Health Strategy has been a success? The big test will surely be if Scottish society's more open approach and greater understanding of sexual health survives the adverse financial climate we now face and passes onto the next generation of policy makers and providers as the norm. How will we know what a Scotland with 'good sexual health' looks like, and in what ways would it be different from today? Charting the path and progress

towards this will be by necessity filled with starts and stops, but we know only too well the limitations and potentials blighted and restricted by poor sexual health, and that those most excluded often have the worst outcomes. This collection, the evidence within it and the expert and insider testimonies contained, point to how change in a variety of settings can be achieved and nurtured, and gives optimism and hope for the future.

ACKNOWLEDGEMENTS

Thanks to Gerry Hassan for his insightful comments and ideas on this chapter.

CHAPTER 2

Is Scotland's Health Different from the Rest of the UK – and Why?

Phil Hanlon

University of Glasgow

Abstract: This chapter provides evidence for, and explores reasons why, understanding the poor nature of public health in Scotland is vital to understanding sexual health. As Chair of the Expert Reference Group that devised the first national sexual health strategy for Scotland, and an expert on public health, Professor Hanlon's synthesis illuminates the relationships between inequalities and poor health outcomes, and provides a convincing link to modernity, where norms around consumption and gratification have extremely negative results for individuals and society.

The chapter investigates Scotland's poor health status in comparison with the rest of the UK, and provides population data concerning morbidity and mortality to demonstrate this. Explaining that social and economic deprivation, coupled with the collective and individual experience of post-industrialisation, is often perceived as the main cause for Scotland's poor health, the author proposes that an additional and increasing excess mortality in Scotland, known as the Scottish effect, exists beyond these explanations. This effect is still not fully understood, and other possible contributory factors such as the environment, weather conditions and culture and social mores are discussed. Culture is discussed in detail as an important component of health and wellbeing, and one that may well have a critical impact on individual and collective health experiences. The chapter concludes by saying that it is essential to adopt a multi-disciplinary approach to exploring and investigating the patterns of ill health in Scotland in order to understand and address them further.

INTRODUCTION

This is a book about sexual health in Scotland. The main focus will, therefore, be on sexual health but, before launching into this central concern, we will compare Scotland's health status with the rest of the UK and Europe. We will discover that Scotland suffers from relatively poor health and that the main cause would seem to be a legacy of deprivation. But, we will also discover that there is an additional and increasing excess mortality which cannot be explained by deprivation (the so called 'Scottish Effect'). We will explore some possible explanations for Scotland's poor health before concluding with an examination of how modernity (accompanied as it is by consumerism, materialism and individualism) may be playing a part in this complex picture.

SCOTLAND HAS A HEALTH PROBLEM

A Scottish woman will, on average, die before a woman from any other Western European country. For men, only Portugal has a lower life expectancy (WHO, 2000; WHO, 2005). Compared to other Western European countries, Scotland's child, infant and elderly mortality tend to be unexceptional. However, results for working aged groups (15 – 64 years) have given rise to great concern for a number of years because, for this crucial age group, Scotland has ranked worst for men since 1978 and for women since 1958 when compared with other countries of Western Europe (Leon *et al*., 2003). A similar pattern is found when comparing Scotland with England: Scotland shows a shortfall in longevity for men and women (see Figure 1)

THE 'SCOTTISH EFFECT'

When the Scottish Parliament was established in 1999 through devolution the poor health of Scots relative to the rest of the UK and Europe rapidly became one of its key concerns. Since life expectancy was improving in both populations, this widening gap represented a relative rather than absolute decline for the Scottish population but its size and speed of change suggested the need for further investigation (Dorling, 1997). Part of the response from the research community at the time was to explore the reasons for Scotland's poor health compared to the rest of the UK. Examination of routine data showed that, if Scotland was treated as a region within the United Kingdom, it had the lowest life expectancy of any region (Scottish Council Foundation, 1998). At

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that time the orthodox view was that Scotland's poor health was due to deprivation. The main plank in the evidence to support this view was a study conducted in the 1980s by Vera Carstairs which demonstrated that deprivation explained almost all the excess mortality in Scotland compared to England at that time (Carstairs and Morris, 1989). Carstairs examined small area mortality data for Scotland and used direct standardisation to allow for differences in the age, sex and deprivation profile of equivalent English small areas. Deprivation almost completely accounted for the excess mortality in Scotland at that time. There was no Scottish effect – Scotland's health problem seemed to be a deprivation problem. However, when this analysis was brought up to date the picture had changed. A summary of the new findings can be seen in Table 1 below (Hanlon, 2001; Hanlon *et al*., 2005)

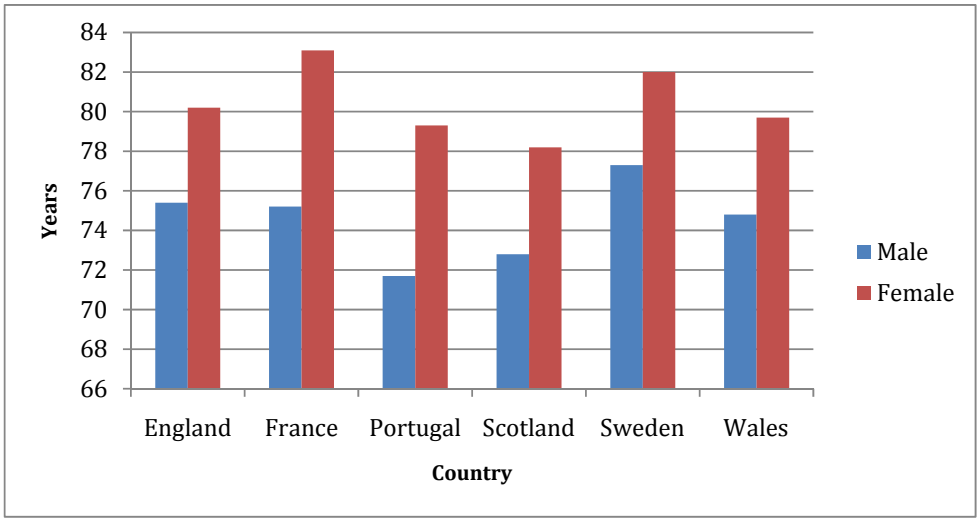

Figure 1: Life expectancy at birth by sex in selected Western European countries (created with data from WHO, 2000).

Table 1: Summary of Standardised Mortality Ratio findings of Hanlon *et al*., 2005.

	1981	**1991**	**2001**
SMR in Scotland, adjusted for age and sex	112	114	118
SMR in Scotland, adjusted for age, sex and deprivation decile	104	109	112
% Excess mortality in Scotland 'explained' by deprivation	66%	36%	33%

Scotland's age and sex adjusted standardised mortality ratios (SMRs) had grown relative to those of England and Wales between 1981 and 2001: in 1981, Scotland's SMR was 112, equating to a 12% excess mortality relative to England and Wales. In 1991, Scotland's SMR was 114 (a 14% excess mortality) and in 2001, it was 118 (an 18% excess mortality). Even though absolute death rates in Scotland fell during the period 1981-2001, the absolute fall in deaths in England and Wales was larger, thereby creating increasing relative excess mortality in Scotland. Second, at all times in recent decades Scotland has suffered from higher levels of deprivation than England but Scotland's position relative to England became less unfavourable between 1981 and 2001. Third, when death rates in Scotland were adjusted for age, sex *and* Carstairs deprivation decile, the relative excess mortality in Scotland compared to England and Wales was diminished (confirming the finding from Carstair's original paper). In 1981, the age, sex and deprivation decile adjusted SMR was 104, equating to an excess mortality in Scotland of 4% (relative to England and Wales) once due allowance had been made for deprivation. In 1991, this excess was 9% and in 2001 it was 12%. In the light of these results, is was concluded that deprivation does indeed play a key

role in contributing to the mortality gap between Scotland and England and Wales and adjusting for deprivation status resulted in a narrower mortality gap between Scotland and the rest of the UK. However, the percentage of excess mortality in Scotland that was 'explained' by adjusting for deprivation diminished at each successive Census time point. In 1981, more than two-thirds of the excess mortality in Scotland could be attributed to deprivation, but by 2001 less than half of the excess was explained in this manner, as the final row of table 1 shows.

This was a less than intuitive finding – Scotland's relative deprivation status had improved between 1981 and 2001. Accordingly, it might be expected that Scotland's population health would have improved relative to that of England and Wales between 1981 and 2001 but the reverse happened. This finding supported the notion that there was some, as yet unidentified, 'Scottish effect' in operation whereby the residents of Scotland suffered adverse health outcomes above and beyond what might be predicted from the conventionally measured deprivation status of the population (Hanlon *et al*., 2005).

Various sub-groups of the Scottish population were also examined to identify if there was a group in society that was particularly responsible for the excess mortality apparent at the national level. Two trends in mortality rates were apparent. Compared to their counterparts south of the border, mortality rates among men in Scotland of working age (15-64 years old) were significantly higher in 1981 and this disparity rose even further by 2001. Women in Scotland of the same age groups also had significantly elevated mortality rates compared to their English counterparts and while these rates were not as high as those for working-aged men in Scotland, it was clear that they contributed to the national picture. Age specific mortality rates amongst other Scottish groups (infants, children and the elderly) were either similar to those in England or slightly higher. Perhaps the most striking finding was that when age and sex standardised rates were examined within each Carstairs decile, residents of Carstairs deciles 8, 9 and 10 areas (the three most deprived categories) in Scotland had mortality rates greatly in excess of equally deprived areas in England and Wales and this excess grew between 1981 and 2001 (Hanlon *et al*., 2005).

CHANGING PATTERNS OF HEALTH PROBLEMS IN SCOTLAND

During the 1960s, Scotland, along with Northern Ireland and Finland, suffered some of the highest rates of heart disease in the world. Heart disease, accompanied by cancer, stroke and respiratory disease, not only accounted for most deaths (McLoone, 1994), when studies examined the difference in mortality between more and less deprived populations in the UK it was evident that the poor suffered and died from the same diseases as the rich – but they suffered from earlier onset and premature mortality. In short, the poor suffered from the same diseases, only earlier (Watt and Ecob, 1992; Watt, 1993). In the past two to three decades that pattern has changed. Whilst the overall health of the population of Scotland continues to improve, two major challenges confront health policy makers. First, although diseases such as heart disease, stroke and cancer are declining in incidence, extended survival with these diseases resulting from improved treatment creates an expanding need for care. Second, a new set of health problems are rising in a manner that has attracted the term 'epidemics'. These new problems (rising trends in obesity, problematic alcohol and drug use, depression, suicide, and violence) are arguably cultural as well as structural in origin and nature (Leyland *et al*., 2007; Jobst and Shostak, 1999). Importantly, these new problems have developed during a period of improving material circumstances for many Scots.

WHY DOES SCOTLAND SUFFER FROM SUCH POOR HEALTH?

Yet, the conundrum remains: Scots suffered higher mortality in the 1960s when the dominant causes were chronic diseases and they still suffer higher morality in this new century when the causes might better be described as dis-eases of modern living (Jobst and Shostak, 1999). So, the central question remains – why does Scotland suffer such poor health? We will briefly consider some of the major conceptual options – genetics, deprivation/poverty, environment, behaviour and culture.

While genetic differences between the Scottish and English populations may account for some of the excess mortality that existed in 1981, it is simply implausible that genetics can be responsible for a phenomenon that emerged over the subsequent thirty years. Also, Scotland's position at the bottom of the Western European league is, in historical terms, relatively recent. Data from the first half of the twentieth century indicates that Scotland's health between 1910 to 1950 improved faster than the European average. So, there is nothing intrinsically unhealthy about the Scots and the relative decline in mortality compared to the rest of the UK and Europe is a relatively recent phenomenon (Leon, 2003).

We have already established that deprivation plays a major role in health and, despite what was said above, may still provide the whole explanation for the poorer mortality rates found in Scotland. For example, it may be that the Carstairs variables have over time become a less meaningful measure of deprivation. While this possibility cannot be fully discounted, there remains a strong contemporary relationship between Carstairs deprivation score and current mortality rates. High correlations have also been demonstrated between Carstairs score and more recently developed measures of deprivation (Hanlon, 2005). The 'Scottish effect' may, of course, still be due to deprivation effects that are simply not associated with the four Carstairs variables. While this explanation cannot be discounted, if it were true it would have to be the case that social class, overcrowding, car ownership and unemployment have developed systematic differences in either measurement or impact in Scotland and England and Wales and that this divergence has increased over the past 20 to 30 years. Such a possibility seems unlikely.

A recent paper (Sridharan *et al*., 2007) considers whether the spatial patterning of deprivation within Scotland could help in explaining excess mortality in relation to England and Wales. Drawing on the high concentration of the poorest health areas in the UK, the indication is that the 'geography' of poverty and the spatial pattern of deprivation may have a strong relationship with excess mortality. Scotland has 14 of the 20 most deprived areas in the UK, with Glasgow having 16 of the most deprived areas in Scotland (Scottish Executive, 2006a).

Aspects of the physical environment have been investigated over the years with few conclusive results. However, a recent review of evidence (Gillie, 2008) suggests that cloud cover in Scotland reduces sun exposure to the degree that there is, at a Scottish population level, a marginal deficiency of Vitamin D, particularly during winter and spring. Vitamin D is a vitamin that in recent years has been recognised as playing a role in switching on and off genes that influences a wide range of chronic diseases. So, a hypothesis has been forwarded that Scotland's poor health is due to the weather and is mediated through Vitamin D (Gillie, 2008). No conclusive evidence has been produced but this hypothesis is a reminder of the importance of pursuing all possible explanations for Scotland's poor health until the answer is found.

One further possible explanation is that Scots in an equivalent deprivation category have higher levels of personal risk factors. In this context it is informative to compare results from the Scottish Health Survey of 1998 (Shaw *et al*., 2000) and the Health Survey for England of 1998 (Erens and Primatesta, 1999). In Scotland, overall, alcohol consumption was higher, smoking was more prevalent (also, Scottish smokers report heavier daily smoking) and there were lower levels of physical activity. Data on total cholesterol, hypertension and obesity showed no differences that could account for the Scottish effect. It is possible that factors like smoking may, in part, account for the Scottish effect. However, since behaviours like smoking show a strong social gradient and Scotland has higher levels of deprivation, one would expect there to be higher overall levels of smoking. Unfortunately, data on risk factors are not available to compare risks and outcomes in comparatively deprived smaller areas north and south of the border, although work of this nature is now being pursued. However, modelling of such risks and outcomes has to take account of the time delay between exposure and outcomes.

Interestingly, a recent analysis of the Scottish and English health surveys demonstrates the persistence of substantially and significantly higher risk of ischaemic heart disease amongst

Scottish respondents. Although the authors tried, they could not explain the difference fully in terms of established risk factors (Mitchell *et al*., 2005). A further paper contributing to the 'Scottish effect' research is a secondary analysis of Scottish drug users recruited into a cohort study in 2001-2, who were followed up in 2004-5. The study aimed to explore the 'Scottish effect' by examining the extent to which differences in problem drug use between Scotland and England could explain the effect (Bloor *et al*., 2008). The authors established that excess mortality for men aged 15 to 54 was due to the greater prevalence of problem drug use in Scotland and concluded that mortality is greater in problem drug users in Scotland when compared to England and that the increased rate of mortality in Scottish problem drug users accounts for 32% of Scotland's excess mortality in this younger age group.

CULTURE AND HEALTH

Could the 'Scottish effect' be the result of cultural factors? In the 19th and early 20th centuries Scotland became one of the most industrialised regions on earth. Since then it has suffered profound de-industrialisation (Walsh *et al*., 2008). The poorest parts of Scotland, centred on Glasgow and its hinterland, suffered the worst effects. In the immediate post war period this was most evident through obvious material deprivation, such as poor housing and unemployment. In recent decades some of the worst manifestations of material deprivation have improved but the psychological and cultural scars remain.

The hypothesis that health and wellbeing in modern, Western-type societies like Scotland is threatened by particular aspects of contemporary culture (Eckersley, 2004) has been investigated in a three year research study by Glasgow University, 'Cultural influences on mental wellbeing in Scotland' (Carlisle and Hanlon, 2007a). Funded through the Scottish Government's National Programme for Improving Mental Health and Wellbeing and supported by the Glasgow Centre for Population Health, this study has been unique in drawing together and integrating knowledge from a wide range of literatures and disciplines, including public health, psychology, economics, philosophy, neuroscience, sociology and anthropology.

Through this work it has been possible to develop a deeper understanding of the multi-faceted relationship between culture and wellbeing. It is important to stress that the question of whether life is getting better or worse in contemporary society – and why - appears to be one of astonishing complexity, involving multiple and potentially conflicting and contradictory types of evidence. We know that the contemporary social, political, cultural and economic context in which we live has provided many benefits such as freedom of choice, individual rights, better health and social conditions, and higher levels of material comfort for many, all within a comparatively thriving economy. Yet, crucially, these considerable gains have not been achieved without equally considerable costs. One of the most significant of these costs, in terms of population health, appears to be static or declining levels of wellbeing for individuals - and a rise in rates of mental health problems and disorders – and an accompanying rise in new forms of social problems (Carlisle and Hanlon, 2007b; Carlisle *et al*., 2008; Carlisle and Hanlon, 2008).

For economists, the lack of increase in wellbeing since the 1960s is a paradox which needs explanation, because living conditions in modern societies have improved and people's incomes have increased many-fold (Easterbrook, 2003). Evidence suggests that increases in income, once past a threshold where basic needs are satisfied, produce diminishing returns in well-being. Yet this is not reflected in our daily lives, where most of us continue to pursue the accumulation of wealth, possessions and social status. Factors affecting our wellbeing, according to large surveys, are family relationships, financial situation, work, community and friends, health, freedom and personal values (Layard, 2006; Huppert *et al*., 2005). So why do we *not* devote our lives to pursuing these objectives?

Theories from evolutionary psychology shed explanatory light on that question, by suggesting that humans are driven by things good for their reproductive (evolutionary) fitness, not their happiness

(Keverne, 2005). It is this that keeps us on the 'hedonic treadmill', constantly striving against others in a zero-sum game. These theories are echoed in psychological research which shows that we are not happy when those around us are better off; that we quickly adapt to improved (or, sometimes, to worsened) circumstances; and that we are extremely averse to losing whatever we do happen to have. This suggests that we are wired by evolution for competition rather than contentment and burdened with a positional psychology.

Researchers from the new discipline of Positive Psychology (Nettle, 2005; Seligman *et al*., 2005) suggest that improved levels of individual well-being can be achieved by behaving compassionately towards others, and by valuing what we have instead of what we would like to have. On the one hand, this seems like sound advice, but on the other hand it flies in the face of some forceful contemporary influences such as materialism and consumerism. Such advice can also lead to reactionary social policy recommendations. For example, policies to restrict social mobility in order to keep families and communities together have been suggested (Layard, 2006). Evidence from researchers with an interest in the relationship between biology, culture and well-being argue that the picture is still more complicated because the experience of emotional wellbeing is the combined product of biological, social and cultural factors (Huppert *et al*., 2005).

Social and cultural theory suggests that Western culture is pathological for individual and social well-being yet fulfils particular psychological needs that arise from modern forms of society. There is enormous cultural pressure on us to consume, in the name of certain contemporary ideals about what constitutes 'the good life'. This is not a trivial issue. Widespread social change in recent centuries and the abandonment of traditional sources of meaning and social values mean that a sense of self and purpose in life are no longer given. Their development thus becomes a key task for all of us: consumption practices therefore provide us with meaning, purpose and a way of constructing appropriate personal and social identities. This points to the ways in which we seek to solve our contemporary existential crisis, whilst simultaneously maintaining the modern way of life with all its comforts.

It is important not to jump to conclusions about the nature of the relationship between economic status and participation in consumer culture, nor to assume that there is a straightforward relationship between poverty and exclusion from consumption. While poverty restricts the possibility of participating in consumer culture, it does not necessarily prevent it. Dominant social and cultural values around consumption are likely to be a spur, rather than disincentive. The serious consequences of consumerism for many individuals, in terms of increasing personal debt, for example, are now well known.

SEXUAL HEALTH

This critique of modern consumer culture has obvious applications to sexual health. Sex and sexual images have been commodified and sold back to us: a process that has added to the sexualisation of many of our communication media. This process puts pressure on individuals to conform to the sexualised images that are used to sell everything from cars to deodorants. Also, the marketing of other products like alcohol have an obvious impact on risky sexual behaviour. Subsequent chapters will deal with sexual health in Scotland so this chapter has deliberately painted on a wider canvas. However, the interaction between the themes of this chapter and sexual heath are clear. Scotland suffers from poor health and exhibits a 'Scottish effect', the cause of which remains the subject of much research. Scotland is also an advanced economy in the modern world where the dis-eases of addictions, obesity, poor mental health and compromised sexual health can be traced back to a complex of modern cultural factors. This analysis suggests that we will need wide ranging and inter-disciplinary research to better understand the problems of health in Scotland and fresh thinking if solutions are to be devised.

CHAPTER 3

What are Scotland's Sexual Health Challenges?

Shirley Fraser

NHS Health Scotland

Abstract: The concluding chapter in the first section provides an insider view of the development of Respect and Responsibility - the first sexual health strategy for Scotland. Written by Shirley Fraser, a leading expert in sexual health policy-making in Scotland, it describes the experiences and challenges in identifying policy and service responses in sexual health that are acceptable to the public, to clinicians and managers in the NHS, to national and local government, and the array of interest groups and communities of interest. The chapter reflects back on the last two decades, during which significant social, cultural and organisational shifts concerning sexuality and sexual behaviour have occurred in Scotland and elsewhere, specifically focussing on activity and thinking before and since the strategy.

The author covers the political and policy pressures and opportunities surrounding the Scottish strategy, and describes parallel activity in national sexual health policy elsewhere in the UK. The structures that were established to create and oversee the implementation of Respect and Responsibility are charted, alongside the strong political support that the devolved Scottish Government (of successive political complexions) has provided. The chapter asserts that the Scottish strategy (although changed from draft to final outcome) contains a broader understanding of sexual activity, and the social determinants of sexual ill-health, than others in the rest of the UK, with the adoption of a population health approach, and the decision to see children and young people as a critical target group, but not to the exclusion of others, differentiating the Scottish perspective.

INTRODUCTION

This chapter sets out the particular experiences and challenges concerning sexual health in Scotland within the time-scale of the last two decades for comparison, but specifically focusing on activity before and since the initial thinking about creating a sexual health strategy for Scotland. It will cover the political and health imperatives, include some comparative information about parallel UK activity concerning sexual health strategies, and highlight the funding and policy structures that have been set in place by successive Scottish Governments. It sets the scene for other chapters in this collection, notably those in Section C, that demonstrate where successes have been achieved in the context of Scottish Government commitment and leadership.

As Chapter 1 discussed, Scotland is one of the four countries that make up the United Kingdom and has its own government. Of its population of 5.16 million, 18% are under 18 years, 63% are working age and 19% pensionable age and over. Its population density is greatest in the central belt corridor between Edinburgh and Glasgow with the next largest conurbations in Aberdeen, Dundee and Inverness – 42% of the country is defined as remote and rural. As the previous chapter described, religion and faith perspectives continue to have a strong influence in Scotland, and this is particularly significant in the context of sexual health. The developments that this chapter sets out are contextualised within an historical context of policy and service changes concerning sexual health in the UK, including

Scotland. Whilst sexual health policy in the early 1970s was viewed as ground-breaking by those living outside the UK, it is now sometimes seen as being relatively conservative and based primarily on moral judgements, particularly around sexuality and an over-emphasis on young people's sexual ill health. This dichotomy can be argued to have become increasingly more stark in recent times. For example, seeming widespread public acceptance of explicit sexual imagery and language in different media strongly contrasts with a reluctance to make comprehensive sex

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and relationships education for children and young people a statutory requirement. The outcomes of these contradictory positions are apparent as Scotland, together with the rest of the UK, continues to experiences the highest rates of conceptions among teenage girls and rising rates of sexually transmitted infections, in particular Chlamydia and HIV, as the figures below indicate.

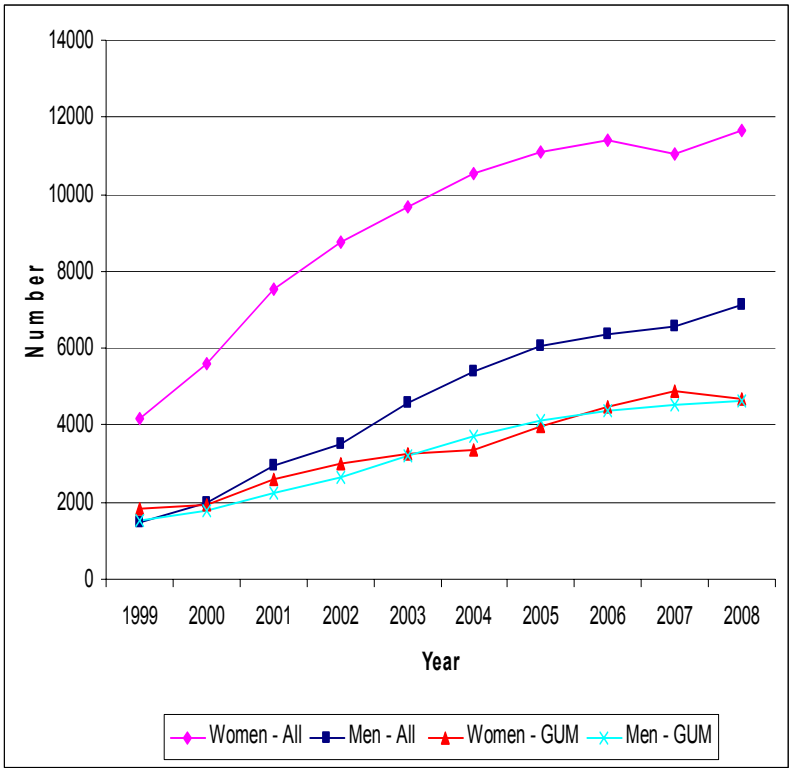

Figure 2: Diagnoses of genital Chlamydia, made in all clinics and GUM clinic settings, by gender, 1999-2008. (NHS National Services Scotland, 2009)

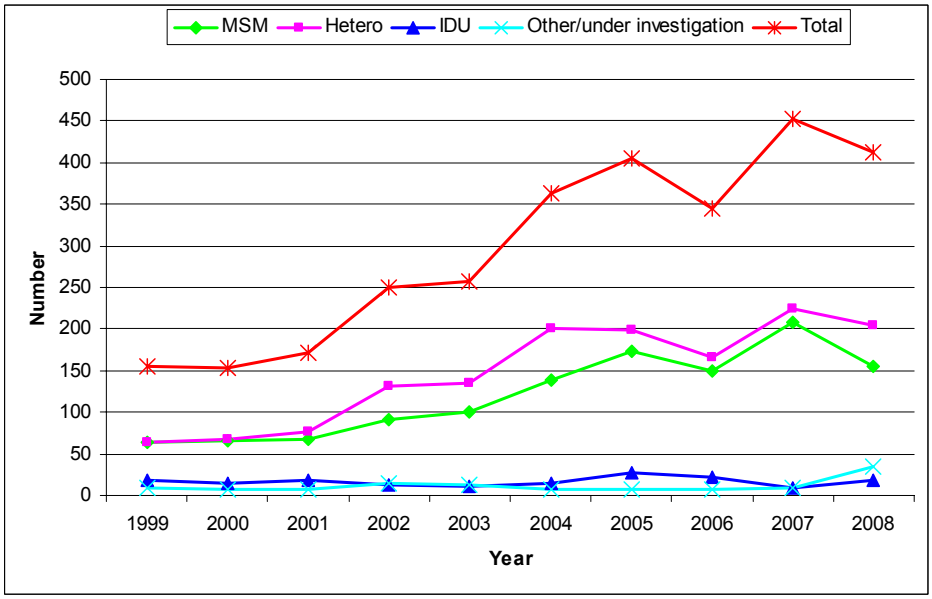

Figure 3: HIV diagnoses in Scotland by transmission category, 1999-2008 (NHS National Services Scotland, 2009)

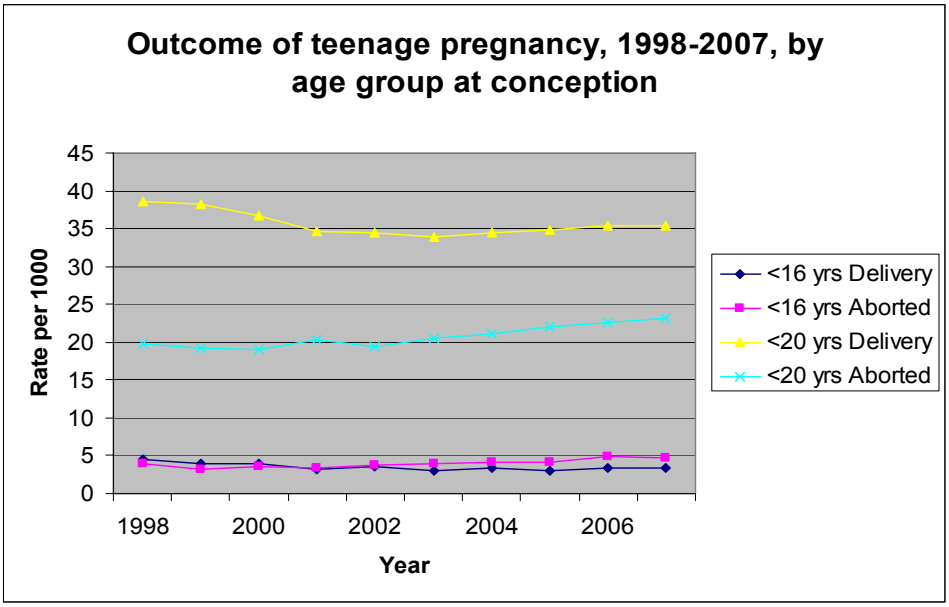

Figure 4: Outcome of teenage pregnancy, 1998-2007, by age group at conception. (ISD Scotland, 2009)

All of this poses challenges in securing and maintaining quality and inclusive services and in promoting positive sexual health and wellbeing across the whole of Scotland.

SEXUAL HEALTH POLICY ACROSS THE UK

Early Developments

As Chapter 1 describes, the 1960s and 1970s saw major policy shifts in the UK, including Scotland, to liberalise family planning and reproductive health services for women, and specifically to widen out access for unmarried women. This was significant but until 1983 there had been no discussion about restricting access to services on grounds of age. This was challenged by the Gillick case that opposed the rights of young people under 16 to access contraception and other sexual health services without parental consent. Whilst this opposition was overturned by the House of Lords in 1983 and pertains directly to English law, it did have implications for young people's services in other parts of the UK. Specifically in Scotland, the Fraser guidelines were developed to support health professionals identify the competence of young people under 16 to understand the implications of contraception as well as identifying whether any sexual activity was consensual. Whilst these guidelines have no legal basis, they have been usefully applied to engage young people in meaningful discussions around their sexual behaviour; and a useful summary of the Gillick case and the Fraser guidelines has been developed by NSPCC (Walters, 2008). Current work is underway to develop specific guidance concerning young people and child protection under the recently approved Sexual Offences (Scotland Bill) (Scottish Parliament, 2009).

Besides the need to ensure that young people receive good services to prevent poor sexual health outcomes, there has long been a concern to reach those most at risk of contracting HIV. As Chapter 9 discusses, much activity to raise awareness about HIV and AIDS has been led by the voluntary sector including agencies such as National AIDS Trust and Terrence Higgins Trust. This has often been hampered by external barriers that have needed to be challenged to promote wider public health. For example, with the removal of UK-wide restrictions concerning advertising condoms in 1987, specific work to promote awareness around HIV was undertaken by both voluntary and statutory sectors – with the first national campaign starting in 1986 followed by successive bursts until mid 1993.

Most people can remember the "Tombstone" adverts to highlight the then expected HIV epidemic in the UK but their long term impact on the target audience has been much debated. The number of deaths among those with HIV has reduced in recent years, mainly as a result of more effective combination therapies and lesser to earlier diagnosis, but the incidence of HIV transmission is rising, with many younger men now being infected. Although there is some evidence of the success of HIV awareness campaigns in reducing infection (Nicoll *et al*., 2001), some gay activists feel that health messages about safer sex do not always successfully engage younger men. As Paul Burston recently commented in an article in the gay press:

> *For those of us who are 40-plus . . . we didn't need icebergs, we saw friends die in hospital. The younger generation thankfully, haven't witnessed this, and only get these mixed messages from the campaigns' (Dehani, 2009).*

As will be discussed later, and as Chapter 9 also mentions, a draft national strategy and action plan concerning HIV and AIDS has recently been published (Scottish Government, 2009a).

Sexual Health Strategies outside Scotland

Each of the nations that make up the UK have developed sexual health policies in slightly different ways. Scotland and Wales have adopted a more holistic approach to sexual health and wellbeing whilst England and Northern Ireland have separated out teenage pregnancy from "adult" and STI focused sexual health strategies. Backed up by large scale media campaigns and significant funding (£60m), England launched its Teenage Pregnancy Strategy[i] in 1999 under the auspices of the Social Exclusion Unit, now the Department for Schools, Children and Families (2009). This focused on parents, sex and relationships education and increasing the participation of teenage parents in education, training or employment as a means of reducing long term social exclusion. At a local level, work was driven by designated Teenage Pregnancy Co-ordinators, mainly based in local government, tasked with achieving clear targets of reducing unintended pregnancy in under 18 year olds. Whilst there was significant funding, there has been criticism that it is not always possible to identify how this has been used at a local level and in some instances has been mainstreamed into wider budgets. Whilst there has been an overall reduction in pregnancies among young women aged under 18, efforts have been made to link up those areas not achieving their projected reductions in teenage pregnancy with more successful areas and there are some indications that this is beginning to show results (French *et al*., 2007; London School of Hygiene and Tropical Medicine *et al*., 2005; Norton, 2000).

In 2002 the Department of Health in England launched its evidence informed sexual health and HIV strategy (and subsequent action plan) which was intended to support further service development, particularly around genitourinary medicine (GUM) services (Department of Health, 2001). With two year funding of £47.5m, reductions in STIs and HIV were sought through the provision of tiered services – aimed at ensuring that patients could access the most appropriate level of care suitable for their needs. There were few links with the earlier Teenage Pregnancy Strategy and little cognisance paid of the social implications of sexual ill health. Both of these strategies are scrutinised by an Independent Advisory Group whose reports are formally responded to by the two Government Departments responsible for them.

Northern Ireland launched its Teenage Pregnancy and Parenthood strategy in 2002 (Department of Health, Social Services and Public Safety, 2002) and then in 2008 its sexual health strategy (Department of Health, Social Services and Public Safety, 2008). Both reflect a cross-departmental working tradition and a social inequalities holistic approach which should if implemented appropriately result in a more rounded response to sexual health and wellbeing. Issues still remain in relation to access to abortion services (termination of pregnancy is still illegal

[i] The National Teenage Pregnancy Strategy was based on the Report produced by the Social Exclusion Unit in 1999 and refreshed through the Teenage Pregnancy Next Steps - July 2006 and Teenage Parents Next Steps - July 2007

in Northern Ireland) but this is under review by the Northern Ireland Executive and voluntary organisations like the fpa (as FPA, previously the Family Planning Association is now titled) are active in advocating for a law change (fpa NI, 2001; fpa NI, 2003).

The Welsh Assembly produced a sexual health framework in 2000 (National Assembly for Wales, 2000) which too was based on a wider social model of tackling poor sexual health outcomes with emphasis on education, health promotion and services – but with no budget initially identified. Subsequent documents have built on this framework but with limited funding.

DEVELOPMENT AND IMPLEMENTATION OF SCOTLAND'S SEXUAL HEALTH STRATEGY

The Scottish Executive's commitment to address Scotland's poor record on unintended teenage pregnancies and sexually transmitted infections, including HIV/AIDS, was first flagged up in *Our National Health: A Plan for Action, A Plan for Change* (Scottish Executive, 2000) with a commitment to developing a national strategy made in *Improving Health in Scotland: the Challenge* (Scottish Executive, 2003b). The issues to be addressed included:

- The fact that there was a general decline in the overall pregnancy rate in under 16s in Scotland, but with a rate still the second highest in western society
- The significant links between deprivation and sexual ill health - a central issue in Scotland due to inequalities as Chapters 1 and 2 discuss
- An environment where condoms are only used to prevent pregnancies rather than also as a means of protection against sexually transmitted infections
- The increasing diagnoses of STIs especially Chlamydia and HIV
- The rising rates of terminations of pregnancy and repeat terminations in women over 25

In summer 2003, the then Minister for Health and Community Care in the Scottish Government commissioned the former Public Health Institute of Scotland to lead the development of a draft sexual health strategy for Scotland (Scottish Executive, 2003a). Following an analysis of sexual health strategies internationally and in other UK countries and a two year period of policy development and engagement with key partners, including the establishment of a multi-agency and multi-disciplinary Expert Reference Group as Chapter 4 describes, *Respect and Responsibility, Scotland's first sexual health and relationships strategy,* was published in January 2005 (Scottish Government, 2005a). This process was not without challenges. The consultation on the draft strategy inevitably reflected some of the underlying social and cultural tensions within the multi-agency group that developed it, and demonstrated the range of opinion within Scottish society. Professor Hanlon, who chaired the group recently said:

> *There were three broad camps. Some clinicians only wanted the strategy to deliver more resources for sexual health services in the NHS. Progressives wanted a wide range of changes that amounted to nothing less than a transformed society – crucially, a change in norms and values towards greater acceptance of diversity. The conservatives wanted to emphasise moral dimensions of sexual expression and, within that camp the Catholic Church was determined to retain control of the sex education agenda within their own schools. The Scottish Executive was cautious because they had very recently experienced the trauma of the debate over Clause 2A*[ii] *and the Catholic Church seemed able to exercise real influence over them, particularly in their central belt electoral heartlands. The result*

[ii] The *Ethical Standards in Public Life etc. (Scotland) Bill* was introduced in the Scottish Parliament on 1 March 2000. This included the repeal of section 2A (commonly referred to as Section 28 or Clause 28) of the *Local Government Act 1986*. Section 2A was introduced to prohibit local authorities from intentionally promoting homosexuality and from promoting the teaching of homosexuality as a pretended family relationship in publicly funded schools. The bill was enacted later that year.

> *was that the final implementation achieved a great deal but not as much as had been hoped by many who helped write the draft strategy. (Hanlon, 2009)*

This strategy provided an evidence-informed national action plan for improving sexual health and relationships across all ages (having learnt from the approaches elsewhere in the UK and internationally, the all age inclusion was deliberate). Underpinned by the WHO definition of sexual health, as Chapter 1 sets out, it promotes the principles of respect for self, respect for others and strong relationships. In recognising the diversity of lifestyles in the population in Scotland, the action plan seeks to improve access to information and services whilst enabling flexibility for local services to respond to local needs. The overarching and interdependent aims of the action plan are:

- *Providing better services* by improving the quality, range, consistency, accessibility and cohesion of sexual health services that are safe, local and appropriate
- *Promoting respect and responsibility* by supporting everyone in Scotland to acquire and maintain the knowledge, skills and values necessary for good sexual health and well-being
- *Preventing sexually transmitted infections and unintended pregnancy* by positively influencing the cultural and social factors that impact on sexual health

To achieve these aims, actions are directed to key national and local health care and local government statutory agencies as well as to Scottish Government. To supplement the existing funding of around £10m, central funding of £5m per year was provided and strong visible leadership and direction provided through:

- Minister for Health and Community Care chairing a national sexual health advisory committee (known as NSHAC) that brought together public, voluntary and academic sectors
- Lead Clinicians in sexual health appointed in each of the 14 NHS Boards in Scotland to guide and support local implementation
- Appointment of Executive Director Leads in each NHS Board and Strategic Leads in each of the 32 local authorities to ensure that the multi-faceted and partnership approach to sexual health was firmly embedded
- Sexual Health Strategy Groups established across Scotland with cross cutting membership of health, local government and voluntary sector interests
- Learning from the robustly evaluated national health demonstration project on young people's sexual health, Healthy Respect, being shared throughout Scotland (see Chapter 7 for a full discussion of this project)
- Clear and transparent reporting mechanisms with progress and funding published and considered by the Scottish Government on its annual visits to local areas
- A continued emphasis on achieving the target for reducing unintended pregnancies (reducing pregnancy rate in 13-15 year olds from 8.5 in 1995 to 6.8 by 2010)

During the period 2005-2008, progress was particularly made in:

- Developing more integrated sexual health and reproductive services as Section C of this book describes
- Increasing the focus on opportunistic testing and treatment of key sexually transmitted infections including Chlamydia among young people, antenatal HIV testing
- The promotion of drop in services for young people and service standards through the Healthy Respect model and others (Healthy Respect, 2009)

- The development of nine quality standards for sexual health services which cover services, communication and workforce issues as well as highlighting links between sexual health and HIV as Chapter 4 discusses
- Improved national data collection through the monitoring of key clinical indicators and development of national electronic clinical data system across family planning and genitourinary medicine services and integrated sexual health services – see Chapter 5 for full information about the NaSH system.
- Co-ordinated efforts to promote positive sex and relationships education within schools and other educational settings with a review of activity in secondary schools as Chapter 11 discusses
- Sharing learning and experiences around evidence and practice through a specific Wellbeing in Sexual Health (WISH) network for practitioners across sectors (NHS Health Scotland, 2009a)

REVIEW OF PROGRESS AND NEXT STEPS

In 2007, NHS Health Scotland, in joint collaboration with the Scottish Government, commissioned a stock-take of *Respect and Responsibility* with a view to assessing whether the actions were in the right direction or if a renewed focus was required. This internal review highlighted the need to continue support for sexual health service provision but also emphasised the need to better influence the sexual wellbeing culture of Scotland so that wider issues around sexual health could be addressed (and in so doing aim for improved reductions in sexual ill health). The review emphasised the continued need for strong leadership at both national and local levels.

At local level, the appointment of Lead Clinicians and specifically designated leads at NHS Board and local authority level was seen as being a strong lever for ensuring a continued focus on sexual health issues, something which had been lacking before the strategy was in place. The impact of these arrangements are further discussed in Chapter 7. Additionally, having "ring fenced" funding which was annually reported on was cited as an important lever to initiate progress. At national level, the need for a smaller national committee with a continued focus on sexual wellbeing but with the inclusion of HIV issues was suggested, and the Minister for Public Health and Sport in the Scottish Government [iii] has demonstrated continued commitment for this topic by chairing this group. This commitment has cut across the different political allegiances of Scottish Government administrations since the launch of the original strategy, demonstrating the cross-party support for its aims. There is also a flourishing Cross-Party Group on Sexual Health in the Scottish Government structure that is attended by a number of MSPs (Members of the Scottish Parliament) and representatives of the NHS, the prison service and the voluntary sector [iv].

Whilst much progress had been made on the 83 actions originally set out within *Respect and Responsibility*, it was agreed that there should be more focus given to those areas where further progress was essential to address the sexual wellbeing needs of Scotland. The Scottish Government identified these further actions in a separate document - *Respect and Responsibility: delivering improvements in sexual health outcomes 2008-2011* (Scottish Government, 2008a) which emphasised the following long term outcomes:

- Reduced levels of regret and coercion
- Reduced levels of unintended pregnancy, particularly in those under 16 but also to see a reduction in the number of repeat abortions in all ages

[iii] A new Ministerial portfolio that arose after the election of the first Scottish National Party to form the Scottish Government in 2007.

[iv] See http://www.scottish.parliament.uk/msp/crossPartyGroups/groups/cpg-shealth.htm for full information.

- Reduced levels of sexually transmitted infections, recognising that there will first of all have to be an increase due to increased testing
- Increased access to sexual health information and uptake of services
- Reduced levels of HIV transmission, particularly amongst men having sex with men
- Reduced levels of undiagnosed HIV, particularly amongst men having sex with men and people from African populations who now live in Scotland

NHS Boards and their stakeholder partners are working towards achieving these outcomes in their own areas, supported at national level through the provision of training, resources and quality standards. Annual visits by the Scottish Government are undertaken to ensure progress is maintained on achieving the greatest impact on poor sexual health outcomes but also to identify where further national support may be required. The continuing challenge is engagement with local authorities that provide education, social care and other services across Scotland, and to ensure that sexual health fits into the new mechanism of Single Outcome Agreements (SOAs) that has been established by the Scottish Government to direct the delivery of national objectives by local authorities. The overall intention, as Chapter 11 discusses, is that all aspects of these outcomes become embedded in all parts of health and social care, as well as in education, and reach all parts of the population, not just focusing on the sexual health needs of young people.

Whilst there was an earlier internal report on HIV health promotion (Scottish Executive Health Department, 2001), this was never formally launched or adopted nationally and although *Respect and Responsibility* did include HIV as part of its repertoire, there was some concern that giving the rising epidemiology of HIV, especially among men who have sex with men, it was not being given the due regard it required. This was reinforced by the strategy's review which indicated there should be a greater focus on HIV issues, particular in relation to the prevention of HIV transmission and the co-ordinated and consistent delivery of high quality care and treatment for people with HIV in all parts of Scotland. The Scottish Government is currently engaging with key stakeholders on its draft HIV Action Plan (Scottish Government, 2009a) and the central aims of this plan are to:

- Prevent HIV infection where possible
- Detect infection early
- Provide high quality treatment and ongoing support to those who need it.

Whilst this will focus on HIV issues, there is a continued need to ensure that both this Plan and the work related to the national sexual health strategy operate in tandem so that sexual health and HIV are seen as complementary.

IMPROVING THE SEXUAL HEALTH AND WELLBEING CULTURE OF SCOTLAND

Whilst *Respect and Responsibility* aimed to promote positive sexual wellbeing, it was recognised that the initial implementation has focused primarily on actions to reduce sexual ill health. As other chapters in this book comment, societal culture is critical to individual and group behaviours, and to resulting health outcomes. From now until March 2011, there have, and will be, specific actions to address the culture around relationships and sexual health, notably:

- A broad-based social marketing campaign about sexual health aimed at the general population aged between 20-40 which will provide a backdrop to other activities (led by the Scottish Government)
- Specific social marketing activities for professionals and target audiences on firstly, the promotion of longer-lasting reversible contraception that includes IUS, IUD and implants as a means of reducing unintended pregnancies and repeat terminations in all ages, and secondly,

on approaches to support HIV prevention with men who have sex with men (and then with African communities)

All of this work is being informed by attitudinal research with the target audiences. In addition, the Scottish Government has made a commitment to provide better access to independent sexual health information including:

- A dedicated website for the public which aims to provide information on sexual health, and direct users to services and other support mechanisms www.sexualhealthscotland.co.uk
- A series of standardised leaflets on sexually transmitted infections and sexual health will be produced by NHS Health Scotland in nine core languages to ensure consistency across Scotland and become part of downloads from the new sexual health website
- Developing a common name for sexual health services across the country – sexual health Scotland.

CONCLUSION

Sexual health and wellbeing has risen up the political agenda in Scotland in recent years. It is becoming a topic of debate and deliberation but there is still much to be done to facilitate the wider holistic social model needed to address the broader socio-economic factors influencing sexual wellbeing, as originally envisaged by Scotland's sexual health strategy, *Respect and Responsibility*. This cannot be achieved without a significant change in Scotland's attitude and response to sexual health, in the approaches and messages taken by the media, in statutory and voluntary sector responses, and in the views and behaviours of the wider population. Time will tell if the efforts currently being pursued will have an impact but there can be no doubt that progress in Scotland, supported by government and using a genuine partnership model, has begun.

CHAPTER 4

The Development of Sexual Health Service Standards for Scotland

Rak Nandwani

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Abstract: This chapter opens the second section of this collection by explaining the process by which the new national sexual health clinical quality standards were devised and put into operation across Scotland. The author, Dr Rak Nandwani, was clinical adviser at NHS QIS during this period and presents their importance to the implementation and delivery of Respect and Responsibility - Scotland's sexual health strategy. The Standards themselves are included for reference, and a full commentary of their development given.

Describing the background to the strategy, the author demonstrates the associated need to formulate a coherent set of standards that embodied the expectations of the strategy and that would also provide markers of progress applied across Scotland by NHS Boards to improve sexual health and to meet Scottish Government targets. Drawing on the authors' close involvement in the evolution of what have become known as the QIS Standards, he describes the various tensions and challenges in their formulation and the iterative and consultative approach that were adopted. This was to guarantee that the statements contained clinical quality at a population level, and in relation to target groups for sexual health; as well as to ensure that they progressed the holistic model to sexual health improvement that was needed, and that they were supported by clinicians, commissioners, interest groups and other stakeholders. The chapter describes how the Standards will be monitored, once implemented, and their close relationship to the national sexual health data and information systems in Scotland.

INTRODUCTION

This chapter provides further information about the development in Scotland of an infrastructure for sexual health improvement. It explores the need for a cohesive set of clinical standards to deliver sexual health care, within the aspirations of the Scottish sexual health strategy. This is followed by a description of the process of their creation.

YEAR ZERO AND THE NEED FOR SERVICE STANDARDS

The publication of *Respect and Responsibility* (Scottish Executive, 2005a) in February 2005 marked the start of "Year Zero" for Scotland's sexual health. Critically, publication of the strategy and action plan gave a clear indication that ownership of the topic had been taken by the Scottish Executive (now Scottish Government) with strong Ministerial leadership, after a prolonged and often difficult incubation over the preceding seven years. The under-development of specialist sexual health services in Scotland had been identified as a challenge by Sir David Carter, the then Chief Medical Officer, after meeting with key providers in 1998. The final strategy was informed by the work of an Expert Reference Group in 2003 (Expert Reference Group, 2003) plus extensive public consultation and debate. After the controversy of Clause 2A, which, according to some, promoted homosexuality in schools, the debate was often polarised and conducted with involvement of the media.

A primary factor driving forward the strategy was recognition of the 'creakiness' of National Health Service (NHS) clinics in dealing with sexually transmitted infections and reproductive health, against a background of high levels of unwanted pregnancy and new infections. It was agreed that the improvement of clinical services was to be the primary focus for the initial investment of £15 million that accompanied the strategy, to be later followed by a focus on wider societal change (Scottish Government, 2009b).

However sexual health was still not perceived as a priority by many NHS boards in Scotland for a variety of reasons. With the exception of HIV, sexual health affects predominantly young people

Rosie Ilett and Alison Bigrigg (Eds)

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and is not a major killer. If a judgemental approach were adopted, many of the individuals with poor sexual health can be marginalised as "dirty and dangerous". For instance, pregnant teenagers living in social exclusion or men who have sex with men who, regardless of individual behaviour, can be stereotyped as promiscuous individuals. This stigma was worsened by the lack of a patient voice to complain about poor or absent sexual health services. Unlike individuals living with cancer or heart disease, people with gonorrhoea or genital warts are unlikely to publicise their condition by writing to politicians or NHS boards to comment on poor services, form support groups or to raise public funds for improved treatment by participation in fund-raising events or marches. Arguably, stigma (once fostered as moral disincentive to misbehave and to encourage a healthy celibate lifestyle) may be more likely to surface in a country with a Calvinist ethos; pleasure must be repaid by punishment. Poor services add to the punishment. Therefore, with so many other deserving priorities, it became easier for NHS boards to put sexual health low on the list with a corresponding decrease in the risk of offending residents. Paradoxically, given the large number of people directly affected by sexual ill-health, a significant proportion of these residents/voters were likely to have had first hand experience of services.

PRIDE AND PREJUDICE VERSUS RESPECT AND RESPONSIBILITY

Simultaneously, changes in society and sexual behaviour since the dramatic impact of the HIV tombstone advertising campaign of the mid-eighties as Chapter 3 mentioned were adding to the demand for sexual health services. Owing to deficits in sexual and relationships education in Scottish schools, it was striking that the first time some young people heard about Chlamydia or emergency contraception was when services were providing treatment to them. Data to 2000 from the UK from the National Survey of Sexual Attitudes and Lifestyles (NATSAL) (full information about the NATSAL study is available at http://www.natcen.ac.uk/natsal) and its Scotland sub-analysis (MacDowall *et al*., 2002) showed an increase in the mean number of lifetime sexual partners, a decrease in the age of coital debut, a greater proportion of the population having same sex partners and a rise in less safe sexual practices such as anal sex. The next NATSAL survey is scheduled for 2010 and it would be surprising if these trends did not continue, particularly given the impact of the internet and increased profile of celebrity/reality/pornography lifestyles into mainstream culture. Economic uncertainty may also be an additional if less predictable factor. Consensual sexual activity remains one of the few activities not currently taxed.

The overall result was that, despite consistently high levels of demand, there was wide variation in access to and quality of sexual health services in Scotland at the beginning of the 21st century. Despite best efforts, Scotland's clinics did not come out well in an episode of Panorama on BBC television aired in October 2005 (BBC, 2005) with a 17 day average wait for routine genitourinary medicine clinic appointments and a wait of 30 days in some NHS Boards, providing more time to transmit infection to others. Even though effective in treating large numbers of patients at low cost, NHS boards had (and some continue to have) few sexual health services led by appropriately qualified specialists. A patient having a heart attack would expect their care to be delivered by staff who had been appropriately and fully trained backed by diagnostic facilities, not by enthusiastic 'amateurs' without any specialist qualifications.

The situation was worsened by unconscious incompetence in some NHS boards. If there were no local full-time dedicated staff, it was not possible to identify areas or to provide strategic leadership for specialist practice to be improved upon. Much of sexual health service provision depends on local knowledge and professional relationships, so importing expertise from elsewhere is not the solution. The sub-standard state of accommodation that sexual health services are housed in within many areas of Scotland remains a stark reminder of the stigma that remains in relation to sexual health. Portacabins with peeling paint or windowless rooms in basements appear to be unsuitable for use as the endoscopy day care unit or as the fracture clinic but entirely acceptable to be designated as the sexual health clinic. This is especially sad, as for many patients below the age of 30, this is their only experience of the NHS.

THE ROLE OF NHS QUALITY IMPROVEMENT SCOTLAND

NHS Quality Improvement Scotland (QIS) is an independent Health Board created by the Scottish Parliament in 2003. It works in partnership with professionals and the public to provide guidance on effective clinical practice, sets standards for care, monitors the performance of services, supports staff to improve services and promotes patient safety (NHS Quality Improvement Scotland, 2009a). It is often (inaccurately) referred to as an "NHS watchdog", and it shares some of the functions performed by the National Institute for Health and Clinical Excellence (NICE) in England and Wales) ("MacNICE" – NICE covers both England and Wales) (National Institute for Health and Clinical Excellence, 2009). The final action point in *Respect and Responsibility* (Scottish Executive, 2005a) committed NHS Quality Improvement Scotland (QIS) to taking forward the development of appropriate clinical standards for dealing with sexually transmitted infections (STIs) in its 2005/06 work programme. This action point was crucial as it was unlikely that sexual health would have been incorporated into the heavily committed QIS work programme at this time. Previous efforts had been unsuccessful owing to competing pressures from other NHS priorities. Given the development of integrated sexual health services in Scotland, led by the launch of the Sandyford Initiative in Glasgow in 2000 (see Chapter 8), the action point subsequently broadened to incorporate the breadth of services including reproductive health.

The NHS QIS Standards Development Unit convened a preliminary Project Group to consider the work of QIS and other organisations to improve the quality of sexual health service provision in Scotland. It was immediately obvious that there was overlap with the remit of a subgroup created by the National Sexual Health Advisory Committee (NSHAC action 12 subgroup) to offer advice on developing targets appropriate to *Respect and Responsibility*. Therefore it was agreed that the work of the two groups would be brought together (National Sexual Health Advisory Committee, 2005).

LESSONS FROM THE OTHER UK NATIONS

First of all a review of existing work to inform standards development for Scotland was undertaken. Apart from conventional literature searches and evidence review (including unpublished data), this also incorporated European, Scandinavian and American service models, supporting papers and consultation feedback used to inform *Respect and Responsibility* and other sexual health strategies developed in the other UK countries (Scottish Executive, 2003c; Scottish Government, 2009c). Key lessons were learned from the implementation of the English national teenage pregnancy strategy (information available via the Department for Schools, Children and Families, 2009) and the sexual health and HIV strategy (Department of Health, 2001) which was launched in 2001. Although more of the emphasis had been on clinical interventions and HIV infection than in *Respect and Responsibility*, there were many shared themes between Scotland and England. However, it was felt that engagement of primary care to deliver comprehensive generic sexual health intervention (termed "Level 1" in England) had not been as successful as anticipated. Additionally, the target of 48 hour genitourinary medicine clinic access for all patients regardless of clinical priority had produced distortions, particularly in relation to people without symptoms who either chose to book appointments for a later date or potentially displaced unwell individuals from immediate care. Diversion of funding intended for sexual health improvement into other areas of the health budget had also been a problem in the market driven NHS in England.

The strategic framework for promoting sexual health in Wales (National Assembly for Wales, 2000) adopted a wide holistic approach but less detail relating to specific outcomes. Issues pertaining to rurality were especially relevant for parts of Scotland. The English and Welsh strategies both supported separately funded screening programmes for genital Chlamydia infection. Although Northern Ireland had produced a working group report on teenage pregnancy and parenthood (Department of Health, Social Services and Public Safety, 2002), efforts to develop standards had been hampered by troubles preventing the delivery of the devolved

Assembly at Stormont. Despite this, a constructive, open dialogue between key leaders in the four UK home nations continued - facilitating engagement, evidence sharing and mutual influence in shaping future strategic development. This was aided by the close-knit professional community because of the relatively small nature of sexual health compared to other disciplines. It helps if people know and respect each other and feel they are all fighting the same battle against a common foe.

The most relevant previous work in a UK context were the recommended standards for sexual health services produced in 2005 by the Medical Foundation for AIDS and Sexual Health (MedFASH) (Medical Foundation for AIDS and Sexual Health, 2005). These had been commissioned and endorsed by the Department of Health for England and covered ten key aspects of service provision. The final document ran to 127 pages and was of high quality with a clearly stated aim and rationale for each standard, descriptions of key interventions, implications for service planning and referenced with sources for guidance on practice. There were also suggested audit indicators. The Executive Director of MedFASH presented learning from the experience of producing the standards at the very first meeting of the QIS preliminary Project Group. There were two main obstacles which prevented adoption of the MedFASH standards for Scottish services. The major issue for Scotland was that they had been produced to support local delivery of the sexual health and HIV strategy for England and the subsequent White Paper *Choosing Health: making health choices* (Department of Health, 2004b). By 2005/06 there had been sufficient divergence of the devolved health services, that the commissioning architecture in England comprising primary care trusts and strategic health authorities with public service agreements and local delivery plans was markedly different to the structure of NHS boards in Scotland which had entire responsibility for local implementation.

The second problem was that the suggested audit indicators did not quantify any level of performance or outcome measure that would be required. This absence of targets meant that it would be unclear what level of progress had been achieved or what was the universal requirement for all services to achieve. Standards produced by NHS QIS are effectively mandatory for Health Boards to deliver and subject to performance review. Although not a primary consideration in relation to the MedFASH standards as endorsement by QIS would have conferred the mandatory status, it was felt that the MedFASH standards had been received as aspirational guidance rather than a blueprint for health improvement in England. Without the necessary levers, the 2005 MedFASH standards might simply gather dust on the shelf until their life passed and it was time to deliver a new set.

PRELIMINARY QIS REPORT 2006

The NHS QIS preliminary Project Group published their report in June 2006 (NHS Quality Improvement Scotland, 2006). It made four recommendations for QIS to carry forward in relation to sexual health services:

1. Develop service-level standards focusing on six key identified themes which were:
    - access to services
    - capacity of services
    - choice of service provision
    - equity of service provision
    - co-ordination of approach, and
    - quality of care delivery.

These standards would be applicable to all NHS boards delivering services and to NHS 24[i], and to non-statutory sector services secured by the NHS.

[i] NHS 24 is the national health support system in Scotland that promotes all hours access to health professionals, the equivalent to NHS Direct in England.

2. Support development of managed clinical networks.
3. Support development of key clinical indicators.
4. Adopt a cohesive approach to all quality work.

It was noted that there was already existing high quality clinical guidance for the management of individual sexually transmitted infections produced by the British Association for Sexual Health and HIV (BASHH) (British Association for Sexual Health and HIV, 2009) and for contraception and reproductive health produced by the Faculty of Family Planning (now known as the Faculty of Sexual and Reproductive Healthcare, 2009). Therefore no additional development by QIS was required for the care of specific clinical presentations.

It was also helpful that there had been extensive work already done to create a comprehensive data set available in relation to sexual health in Scotland dating back to the early 20th century. The Information and Services Division (ISD) of NHS National Services Scotland and Health Protection Scotland (HPS) collaborated to create a programme of data augmentation for sexual health (the DASH project) (ISD and Health Protection Scotland, 2009) (see Chapter 5). As previously mentioned, the co-ordination of the preliminary QIS Project Group with the NSHAC subgroup led to the availability of robust baseline data to quantify service outcomes, and to the development of the first set of key clinical indicators for sexual health (ISD Scotland 2008). These indicators formed part of a wider quality framework in Scotland developed by the National Clinical Dataset Development Programme, later feeding into implementation of the National Sexual Health (NaSH) information system which is now used to deliver sexual health services in most parts of Scotland (see Chapter 6).

PREPARATION OF DRAFT STANDARDS 2006-07

After publication of the preliminary QIS report, work proper started on preparing the draft set of standards which, after public and professional consultation, would be used as the basis for the final set of compulsory standards across Scotland. QIS appointed a sexual health clinical adviser in July 2006, who led a scoping exercise. This reviewed new evidence and engaged in discussion with executive directors, lead clinicians, patients and their representatives and others. A key task was to ensure mutual engagement with the Scottish Executive sexual health team and NHS Health Scotland who were monitoring implementation of *Respect and Responsibility* thus preventing any possibility of duplication of effort or miscommunication. This worked well and also identified issues which would require specific consideration, such as remote and rural perspectives. Evidence was drawn from Healthy Respect, the national sexual health demonstration project for young people, led by NHS Health Scotland (Healthy Respect, 2009).

The draft standards were produced in accordance with the established QIS processes to ensure they were evidence based, clear, measurable and consistent with other existing guidance (NHS Quality Improvement Scotland, 2009a). The format for each standard comprised a title (summarising the topic), a standard statement (which explained the level of expected performance), a rationale (why the standard was important) and finally criteria detailing exactly what must be achieved for the standard to be met. The criteria were either classed as essential or desirable. An essential criterion was the minimum level of performance to be achieved universally across Scotland wherever the service was provided. Desirable criteria would be a level that some services might be already have attained and for others to work towards. In order to make matters manageable for services, the focus was very much on defining the essential criteria. The standards were not designed to be exhaustive, and to examine every aspect of service delivery. They were to be carefully chosen on the basis that they covered an indicative cross-section and if these were being done well, the implication would be that other activities were also likely to be of a high standard.

In the longer term, once the final set of standards had been agreed and published, services would be given a significant time to work towards the standards, collect evidence and make improvement

if required prior to assessment of performance by external peer review and visits co-ordinated by the QIS Performance Assessment Unit. It was also to be kept uppermost in mind that services should not be heavily burdened by having to collect large amounts of evidence locally. It was anticipated that as much data as possible would be made available to NHS boards from the DASH project (ISD and Health Protection Scotland, 2009) thereby allowing local benchmarking against national and regional data. At this time, comparative information on Chlamydia testing and abortions performed before 10 weeks were most advanced from the key clinical indicator sets. From 2007, the Sexually Transmitted Infection Epidemiology Advisory Group (STIEAG) began to include data on other aspects of sexual health in their annual reports (NHS National Services Scotland, 2007).

The development of standards for HIV diagnosis, prevention and treatment and care was excluded with the exception of providing high quality sexual and reproductive health services for people living with HIV. It was noted that *Respect and Responsibility* specified that sexual health services would reduce the proportion of undiagnosed HIV passing through clinics. This had already been achieved by 2006 because of the introduction of opt-out testing (the HIV test was routinely undertaken as part of the sexual health check and blood sent for testing unless the individual declined). By 2006, 82% of all HIV tests in Scotland were being sent from genitourinary medicine clinics. The development of HIV standards subsequently began as part of the NHS QIS work programme in 2009.

PUBLIC REPRESENTATION

In November 2006, a formal meeting of non-statutory sector and community representatives was convened to overcome the previously described issues arising from the lack of a patient voice. A conscious decision was made to appoint a lay-person as the Chair of the main Standards Project Group recognising the importance of non-clinical perspectives. In addition, this had the added advantage of side-stepping any perceptions of bias between the main clinical specialties, which despite varying degrees of service integration across Scotland, ran the risk of perceived partisanship should any decision be felt to favour one group over another. The "patient/community" group meeting was beneficial at many levels. Other than providing fresh perspectives about the possible content of standards, it was also the first time that the participants drawn from different constituencies had formally met despite a shared agenda and were able to swap ideas. It was also felt to be a different dynamic to the usual process of providing community perspectives whilst reviewing predominantly clinical issues in the main Project Group.

For these reasons, NHS QIS agreed that an advocacy group should be appointed in parallel to (and not excluding representation on) the main Standards Project Group. Full details of membership are listed in the published set of draft standards (NHS Quality Improvement Scotland, 2007) however representatives were drawn from organisations including the National Union of Students, the Scottish Interfaith Council, the Scottish Catholic Education Service, Stonewall Scotland, Waverley Care, Terrence Higgins Trust, Childline Scotland, Barnardos, the Scottish Disability Equality Forum, LGBT Youth Scotland, the Scottish Prisons Service, fpa, Fair for All–LGBT, Inclusion Scotland and the Scottish Prostitutes Education Project (ScotPEP).

The advocacy group were an invaluable resource throughout the development of the draft standards commenting on each iteration. The preferred term for those using services was "individuals"; an inclusive term with no assumption made with regard to gender, sexual orientation, ethnic origin, disability, housing status or engagement in paid sex. An outstanding achievement was the agreement of a documented set of rights and responsibilities in relation to sexual health which were published as appendix 2 in the final document (NHS Quality Improvement Scotland, 2007). These described in straightforward language what a person could expect from sexual health services in Scotland and in turn actions they could take to safeguard their own sexual health. These could be adopted by a range of agencies and possibly educational establishments. They also explicitly stated that individuals were empowered to participate in

maintaining their own well-being rather than this just being the task of the NHS. The fact that agreement was reached by the diverse agencies was a positive outcome. The NHS QIS Standards Development Unit has subsequently added an advocacy group as an integral part of the development of all new standards.

DRAFT STANDARDS 2007

The QIS Sexual Health Services Standards Project Group brought together NHS multidisciplinary professionals together with non-statutory sector representatives, drawn from various parts of Scotland. Throughout the process consideration was given to remote and rural issues and in May 2007 a specific meeting was convened to ensure that the draft standards could be applied outside Scotland's central belt and to make appropriate links with the relevant work-streams of NSHAC. For the purpose of the draft standards, it was agreed that specialist sexual health services were defined as those clinical services whose primary function was the delivery of sexual health interventions (such as sexual and reproductive health clinics). The importance of psychosexual health, gender dysphoria and sexual dysfunction was acknowledged in this context but they were excluded from this working definition because of standards relating to the need for rapid access. Generic sexual health services were defined as NHS services that provided a range of more general interventions, of which sexual health might be one. This covered primary care, gynaecology or urology outpatients, community pharmacists, emergency medicine and others. It was also clear that some general practices (particularly in rural communities) could also offer specialist services providing staff had acquired appropriate competencies (Department of Health, 2006a; Royal College of Nursing, 2009) and were supported by the relevant specialists.

The QIS draft standards were launched in July 2007 (NHS Quality Improvement Scotland, 2007). There were 12 standards each linking to one of the six key themes identified in the preliminary report. There is little merit in replicating each standard, however here is a brief summary:

ACCESS

Standard 1 *Access to specialist sexual health services*

Individuals with priority conditions to be seen within two working days. Had noted the issues with non-priority individuals distorting waiting times from the English strategy. Also attempted to deal with not being able to contact the service in the first instance, as highlighted in the Panorama survey (BBC, 2005).

Standard 2 *Comprehensive provision of specialist sexual health services*

At least 2 days of local provision with the full range of contraception, STI care for men and women and HIV testing with choice of providers. Also attempted to address issues relating to inequity of local services within a short travel time.

Standard 3 *Information provision*

Consistent internal and external information in appropriate formats.

Capacity

Standard 4 *Termination of pregnancy*

70% of women seeking an abortion to have it performed before 10 weeks gestation, followed by an effective method of contraception to prevent the 1 in 4 reattendances for a further abortion.

Co-ordination of Approach

Standard 5 *Partner notification*

Ensuring contact tracing by trained staff in all settings, with targets for documented outcomes in specialist settings.

Standard 6 *Sexual health care for people living with HIV*

High levels of syphilis in HIV-positive men who have sex with men and unplanned pregnancy in women living with HIV. Important for personal well-being and to prevent onward transmission of infection, including HIV.

Equity of Service Provision

Standard 7 *Male and female sterilisation*

No more than 10% to wait over 6 months for the procedure.

Standard 8 *Chlamydia testing*

Targeting Chlamydia tests at those aged under 25 with the highest prevalence and increasing testing rates, recognising that tests were less frequently performed in young men.

Standard 9 *Hepatitis B vaccination for men who have sex with men*

Involved being able to identify those at higher risk of hepatitis B, followed by actually having systems to ensure the health intervention took place. Some limitation by difficulty in data collection and so limited to specialist settings.

Patient Choice

Standard 10 *Intrauterine and implantable methods of contraception*

Implementation of the 2005 NICE guideline on long acting reversible contraception (National Institute for Health and Clinical Excellence (NICE) 2005).

Quality of Care

Standard 11 *Appropriately trained staff providing sexual health services*

To ensure staff in all settings had been trained in both generic sexual competencies such as sexual history taking and intimate examination as well as local specialist staff holding up-to-date externally accredited qualifications as would be expected by all other medical specialties. Also specified criteria for nursing and other staff.

Standard 12 *Service delivery consistent with national guidelines*

Implementation of UK specialist guidelines for specific conditions with a documented quality programme.

The dozen selected standards were thought to be broadly representative of the cross-section of core sexual health work drawing on contraception, abortion, infection (including HIV), and partner notification, with specific inclusion of populations such as men who have sex with men, people living with HIV and young people. There was also emphasis on the processes of service delivery including access times, local provision, information, prevention and staff competencies. As previously mentioned, the quality of the standards was greatly enriched by input from the non-statutory sector, especially in relation to the use of appropriate terminology and language. By this stage, the first regional managed care networks in sexual health were starting to form under the leadership of regional planning groups brought together by NHS boards with support from QIS, as identified in the preliminary report. The Scottish Government sexual health team had also made progress towards a more cohesive approach to quality work bringing together a range of partners (Scottish Government, 2009d; 2009e).

What is striking is the surprisingly low common denominator these draft standards are pitched at, having to explicitly address fundamentals of service delivery that would be taken for granted in

many other clinical specialties. Given the concepts behind the standards were not rocket science, it is interesting that the issue which generated most debate in the Project Group discussions was the level of access that individuals should have to specialist services locally. How many days to wait for an appointment, what level of specialist expertise and how far to travel? This was more difficult to reconcile in areas near the central belt of Scotland such as Ayrshire and Galloway than in the Highlands and islands which were more familiar with the difficulties. A key contribution from the remote and rural group was the concept that services should not be "dumbed down" to a lower standard than that which would be acceptable for more populated areas.

CONSULTATION EXERCISE AND PRODUCTION OF THE FINAL SEXUAL HEALTH SERVICE STANDARDS

Following publication of the draft paper, the standards were widely circulated to relevant professional groups, health service staff, voluntary organisations and individuals providing opportunities to influence the final standards. NHS QIS used several consultation methods including open meetings, pilot peer review visits and formal public consultation to test the acceptability and measurability of the standards. All feedback from the consultation phase was considered by the project group in order to develop the final standards. The response of the project group to each comment was documented in detail and feedback provided to those who raised specific points. There were a large number of responses during the consultation from a variety of sources. The formal QIS response dealing with individual points ran to over 70 pages.

The final NHS QIS sexual health service standards were published in March 2008 (NHS Quality Improvement Scotland, 2008a). These were accompanied by a report on the budget impact of fully implementing the standards (NHS Quality Improvement Scotland, 2008b). Many of the points raised during the consultation were adopted, reflecting the increasing ownership of the standards by both the public and professionals. There were several changes between the draft and final standard set of standards. The total number of standard topics decreased from twelve to nine, by combining criteria relating to timely access, local availability and governance into a unified standard on the comprehensive provision of specialist sexual health services. The standard on male and female sterilisation was dropped as these were now covered by a wider commitment to address waiting times for all surgical procedures. The criteria were clarified to ensure consistent data, especially for figures collected nationally.

CHLAMYDIA AND YOUNG PEOPLE

The greatest changes were to the Chlamydia draft standard because of emerging evidence that the rate of long-term complications was not as high as previously thought (Low *et al*., 2007). Despite this, there was debate that Chlamydia opportunistic testing was required given the high prevalence, transmission rates and short term morbidity. Other parts of the UK continued their commitment to a formal National Chlamydia Screening Programme (NCSP). There was also a view that uptake standards should solely be concerned with young men who, despite similar prevalence to women (around 10-15%), were three times less likely to be offered a test. In parallel to the standards, the Scottish Intercollegiate Guidelines Network (SIGN), which also falls under the QIS umbrella, was updating the Chlamydia clinical guidelines. These were subsequently published (Scottish Intercollegiate Guidelines Network, 2009) together with a costing report (NHS Quality Improvement Scotland, 2009b). The final sexual health service standards are entirely consistent with the SIGN guideline with an emphasis on opportunistic testing rather than screening, concentrating testing on those aged under 25, with the highest infection prevalence and effective partner notification after cases are confirmed. The QIS project group also felt that the rates of Chlamydia test uptake were a useful hard outcome measure of engagement of young people with sexual health services. The standard was therefore broadened from Chlamydia testing alone to a wider standard ensuring the development and delivery of integrated approaches to sexual health improvement, particularly in relation to young people.

IMPLEMENTATION AND EVALUATION OF THE STANDARDS

After publication of the final set of standards, NHS boards continued the process of local implementation, led by Executive Directors and Lead Clinicians for sexual health. In reality, many Health Boards had started to review the relevant topics during the development of the draft standards in 2007, and had actively contributed during the consultation process. NHS boards collated existing national data with local evidence to implement service improvement, supported by managed clinical networks if applicable. The Scottish Government were keen to maintain the momentum generated by *Respect and Responsibility* and documented in annual reports in 2006 (Scottish Executive, 2006b) and 2007 (Scottish Government, 2007a) with external peer review visits led by QIS to assess performance in relation to the standards starting as soon as NHS boards had sufficient time to implement improvements. Unfortunately, the busy work programme of the Performance Assessment part of QIS meant it was difficult to schedule the visits before 2010/11. A draft self-assessment tool for the boards was issued as an interim step on the understanding that its release did not imply QIS visits were immediately imminent and that changes could be made to the tool as queries were raised.

At time of writing (September 2009), it is too early to evaluate the impact of the final QIS standards on sexual health service delivery in Scotland. There are also a number of external factors influencing their implementation as well as continuing changes in sexual behaviour of the population. The effect of the global economic downturn that started in 2008 is so far unknown. Paradoxically outcomes such as increasing numbers of sexually transmitted infections (STIs) may reflect improved access to services rather than a worsening of the nation's sexual health. This makes it very difficult to assess the impact of the QIS standards in isolation and critics will continue to interpret rises in sexual health numbers as negative outcomes.

National data from the 2008 report of Scotland's Sexual Health Information (SSHI) forming part of the DASH project (NHS National Services Scotland, 2008) showed a rise in the rates of diagnoses of acute STIs in NHS Boards from 2004 to 2007. In 2007, the rates of genital Chlamydia diagnosis in women aged less than 25 was greater than 2,500 per 100,000 population in six out of the thirteen Health Boards providing services in Scotland. However there was still considerable geographic variation and far lower diagnosis rates in men aged under 25. Key clinical indicator showed that progress needs to be made targeting tests towards sexually active individuals aged less than 25 who are at the greatest risk of Chlamydia infection with 71% of positive tests noted in this age group, but less than half (47%) of all Chlamydia testing in Scotland during 2007 was performed on those aged less than 25. The QIS essential criterion has been set at 60% of Chlamydia tests taken from those under 25. National key clinical indicator data also showed that the percentage of women having abortions before 10 weeks gestation had increased from 67.3% in 2006 to 69.1% in 2007 (QIS standard set at 70%). The lowest rates were in NHS Lanarkshire but progress had been made with an increase from 51.5% in 2006 to 56.8% in 2007. The number of abortions in Scotland has so far not fallen with 13,817 terminations performed in 2008.

CONCLUSION

The inclusion of sexual health service standards by NHS QIS in *Respect and Responsibility* has been pivotal in raising the priority of this topic for NHS boards in Scotland, especially as there is external review leading to publication of local outcomes and comparative performance data that can be scrutinised by the public. This has been an important step towards accountability in the absence of a powerful patient lobby. A criticism of *Respect and Responsibility* is that it has been too clinically focussed in the first phase, but it is now seeking to address the wider societal issues in its second phase. However, strong services are required to underpin prevention, education and behaviour change.

Even at this early stage, there are clear improvements in access to local services but this has been hindered by uncertainty of longer term recurrent funding. Resources to support major new

developments are obviously required, but lack of new resource can also be used as an excuse by NHS organisations who are less keen to engage with the sexual health agenda. There seems to be a tacit assumption that core funding is for every other activity except sexual health. The NHS boards that have made progress with innovative service models have supported these with funding from core health allocations. Therefore it is not just about money, it is about prioritising sexual health higher than the bottom of the heap. The paradox is that failure to modernise clinical sexual health services wastes resources by continuing with outdated practices (such as two glass urine tests to look for urethritis in men), too many or poorly performing laboratory tests on people who do not need them, inappropriate prescribing, poor data collection and lack of audit to improve outcomes.

The process of developing the NHS QIS standards was fortunate in many respects. Firstly, there was an opportunity to learn from evidence gathered in Scotland, the rest of the UK and elsewhere. Secondly, it was possible to incorporate data collection from an early stage to assess baseline outcomes to inform the level of criteria and to develop systems to monitor performance. Thirdly, the size of Scotland with a population of 5.1 million combined with a devolved health service made it a manageable undertaking supported by direct Ministerial leadership. The fourth and final advantage was the creation and functioning of the advocacy group, particularly its work in defining individual rights and responsibilities in relation to sexual health.

Reflecting on what might have been done differently, the time taken from the start of the process to the publication of the final set of standards might have been reduced. Despite this, perhaps the finished product is the better for it, especially given the amount of feedback both in development and during the public consultation. This has also given an opportunity for the standards to be considered by NHS boards and to implement local quality improvement and evidence collection. NHS QIS recognises that internal change is required to improve linkages between the constituent components of the organisation and are reviewing how to make the transition between standards development and performance assessment more seamless. At present (August 2009), it is still unclear when the external QIS review visits to NHS boards will commence. The role of general practice in the delivery of sexual health remains a challenge, given that sexual health interventions were not specified in the renegotiated GP contract. Some practices view sexual health as a core part of their function whilst others feel their role is simply signposting other services. From a personal perspective, I would have preferred the inclusion of fewer standards in the final document. Ideally no more than six high level indicator standards with a maximum of four essential criteria each, supported by national data, however, the final version as published did achieve the objective of covering the key topics and gaining support from a wide range of perspectives.

Sexual health services in Scotland have previously been characterised by marked variations in the quality of local services. From the perspective of a member of the public, it is incomprehensible why 30 minutes travel in one direction goes to a shabby service delivered as if in a time warp from the 1950s with few specialist staff. Whilst, 30 minutes travel in the opposite direction reaches a cutting-edge integrated centre of excellence where you do not have to wait a month to be seen. The ‘creakiness’ of services appears to have begun to diminish, aided by the illumination of public and parliamentary accountability. It is anticipated that figures such as the number of STIs diagnosed will rise rather than fall with improved service access, and changing sexual behaviours across the population, but the contribution of the QIS standards will not be quantifiable until 2011/12 onwards. The capacity of services to deal with the water already in the bath and to stop it overflowing has improved, but the taps now need to be turned down by the wider societal impact of *Respect and Responsibility*.

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DISCLAIMER

The views contained in this chapter are those of the author as an individual rather than on behalf of any wider organisation.

CHAPTER 5

Key Clinical Indicators for Sexual Health: Current National Sexual Health Data Collection and Future Plans

Felicity Naughton and Jim Chalmers

Scottish Government; NHS National Services Scotland

Abstract: The service improvements in sexual health across Scotland that this collection discusses have required the underpinnings of timely, accessible and accurate information to inform and facilitate activity and to monitor its outcomes. This chapter contributes to the section in this collection on the delivery infrastructure. It sets out the role of national data and information services in recording and reporting sexual health activity across the Scottish health care system, as aligned to the targets set out in the NHS QIS Standards, which the last chapter covered. The need for excellent intelligence to inform both national and local planning, and to better understand sexual ill-health and inequalities across Scotland, is clearly conveyed and demonstrated in this chapter written by two of the central players - Dr Jim Chalmers and Felicity Naughton - in the formulation and delivery of the national sexual health information system that is part of the central support system for the NHS in Scotland.

The chapter gives an insight into the various sources of national sexual health data, including clinical reporting from services across Scotland, public surveys and qualitative material, and of the uses to which it can be employed – in a systematic way, through the Information Services Division information dissemination system, and in an ad-hoc way, in response to Government requests for example. The authors ably demonstrate in this chapter the cohesive nature of the systems and the critical role that the intelligence generated has in sexual health improvement, informing policy-making and the employment of resources.

INTRODUCTION

This chapter will consider the data and information structure in which sexual health services in Scotland, through the national sexual health strategy, are positioned. It will explain the drivers for change and the steps that were taken to enhance existing data collection and reporting arrangements. This chapter, along with Chapter 4 about the Key Clinical Indicators and Chapter 6 about the NaSH patient management system, indicate the linked approaches that support clinicians and managers across Scotland in planning, delivering and monitoring their services; provide politicians and policy-makers with vital population health information, and ensure that clinical care is provided within an accountable and open framework. The chapter will begin by reviewing the commitments in *Respect and Responsibility* to the centrality of data, before setting out the processes and some of the outcomes, ending by highlighting some of the new opportunities that improved systems can facilitate.

RECOGNIZING THE DRIVERS FOR CHANGE AND MAKING THE VISION A REALITY

The publication of *Respect and Responsibility* (Scottish Executive, 2005a) by the Scottish Executive placed a particular emphasis on the need to improve access to data. It specified that such data should be of high quality and could therefore be relied upon to reflect the reality of sexual health and sexual health services in Scotland. It was also essential that the information derived from these data should be easily and widely available whilst also taking into account the sensitivity of the issues that are inherent in sexual health including ensuring client anonymity.

Rising rates of sexually transmitted infections (STIs) and teenage pregnancy in Scotland were drivers for change. The data produced by Information Services Division (ISD) and Health Protection Scotland (HPS) (both divisions of NHS National Services that provides central support

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functions to the NHS in Scotland) had consistently provided high quality data on the rising rates of STIs and teenage pregnancy which provided the evidence and thus informed the development of *Respect and Responsibility*. Data, such as that produced by ISD, were important not only in highlighting the sexual health of the population but also in showing sexual health services' performance, and were able to indicate areas that may require extra support or service development. Waiting times for sexual health services, for example, were of concern due to the potential for onward transmission as the last chapter noted.

The National Sexual Health Advisory Committee (NSHAC) as Chapter 3 describes, moved the aspirations of the strategy into reality through its series of 'Actions'. Two of these in particular were aimed at improving data - Action 12, which specified that Key Clinical Indicators (KCIs) for sexual health should be developed, and Action 13, which concerned the development of sexual health data.

DATA AUGMENTATION FOR SEXUAL HEALTH (DASH) PROJECT (HPS & ISD)

The DASH project is an HPS and ISD cross-divisional project, set up in response to *Respect and Responsibility* and the NSHAC actions as described. The project was developed in order to identify the information that was available already, but more importantly to identify the 'data deficits'. In particular, the project identified where data deficits impacted on areas of high priority and where accurate data were absolutely essential to both identify the baseline position and to provide a benchmark for future improvements. An example of this is around long acting reversible contraception (LARC). The greater provision of long lasting contraception was known to be important for tackling unintended pregnancy, but no national data was available on how many women were actually using these methods in Scotland. The DASH project worked toward supporting Action 12, the Key Clinical Indicators for Sexual Health, and Action 13, the Data Development Framework. Both of these initiatives help service planning by providing new data where there had previously been none and assist services to discover and to use existing published national data, such as statistics published by both ISD and HPS and useful publications from England. Chapter 5 provides a full account of the development of the Key Clinical Indicators and the next section describes how the data framework evolved in support.

NSHAC ACTIONS: DATA DEVELOPMENT FRAMEWORK FOR SEXUAL HEALTH (ACTION 13)

The data development framework for sexual health examined existing data and put it in a format that was clearly and easily accessible by NHS Boards across Scotland and other interested parties including the Scottish Government. This not only made data more easily available but also brought it to the attention of those who were not using national data on a regular basis. Published data on GUM clinics, lab results, maternity and primary care prescribing are all invaluable for informing effective sexual health service planning and delivery monitoring.

The data development framework was also able to highlight areas where data were either not readily available or not available at all, and to attempt to address these deficits. DASH works closely with NHS Boards and the Lead Clinicians for Sexual Health to ensure that areas identified as a priority have available and useful data. As stated above, increasing the usage of LARC was identified as a national priority to help decrease teenage pregnancy, but no information about uptake existed. The DASH project used existing data sources to produce a baseline on LARC usage and updates these data annually to identify progress. As Figure 5 illustrates, this new data gives a clear indication of the starting point and captures progress over the following two years as NHS Boards introduced strategies to increase uptake in the context of service developments in specialist sexual health and primary care as set out within *Respect and Responsibility*.

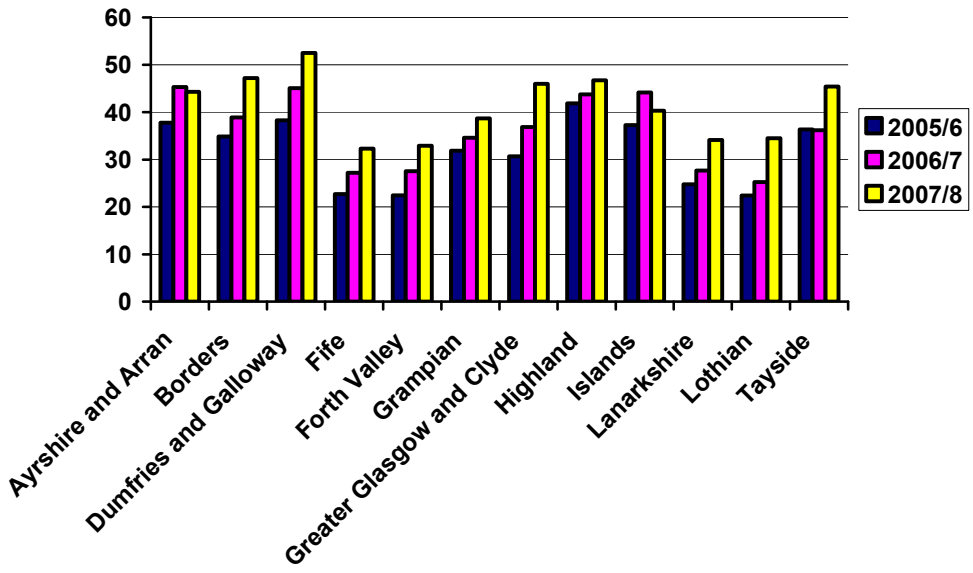

Figure 5: LARC Uptake by NHS board 2005/06 to 2007/08 (ISD Scotland, 2008a)

KEY CLINICAL INDICATORS (KCIS): ACTION 12

As Chapter 4 describes, the Key Clinical Indicators are not targets or standards per se but are intended to highlight priority areas in sexual health that boards and services should be addressing and monitoring. The DASH project regularly publishes data on the KCIs by NHS Boards using information gathered from laboratory returns and clinical data from NHS Boards, as well as that reported nationally. This allows boards to identify areas of best practice and presents the opportunity to share progress, knowledge and experience. The publication of the data also allows Boards to identify possible areas of weakness that may need to be concentrated upon. The KCI reports can all be accessed at www.isdscotland.org/kci.

Although initially identified as specific NSHAC actions, with the ongoing implementation of *Respect and Responsibility* and the *Respect and Responsibility* outcomes 2008 – 2011 (Scottish Government, 2008a) these actions have now become regular outputs of the DASH project and are supported by the Sexual Health Epidemiology Group (SHEG) that is made up of a number of parties including HPS, ISD, sexual health clinicians and the Scottish Government[i]. The information about KCIs is only part of the growing picture of sexual health information in Scotland, which has increased considerably in the last few years in line with the national sexual health strategy and associated service development across Scotland, as the next section explains.

CURRENT INFORMATION SOURCES ABOUT SEXUAL HEALTH IN SCOTLAND

Sexual health information in Scotland is available in a number of regular publications

- Annual Sexual Health Report (SSHI Report)
- ISD Publications on teenage pregnancy, termination of pregnancy, genitourinary medicine (GUM) data and the KCIs
- HPS Publications

- STIs and Blood Borne Viruses (BBV)

Other available sexual health information consists of:

[i] SHEG is the new name for STIEAG as discussed in Chapter 2.

- Information requests from outside parties including the media
- Parliamentary Questions ('PQs') – where information is provided by ISD/HPS for written and oral questions sent by MSPs in the Scottish Parliament to Government Cabinet Secretaries
- Sexual health data obtained through the Scottish Health Survey

See www.isdscotland.org/dash for more information on publications and data that are available.

NEW DATA AND ANALYSES USING A RANGE OF COLLECTION METHODS

Mystery Shopper

As well as systematic data as already described, a number of new data reports have been generated by the DASH project, some based on innovative collection methods. One that has attracted much interest has been the mystery shopper scheme, where volunteers pose as a patient and telephone sexual health services throughout the country to discover waiting times and ease of access. These data are then collated, which allows a national picture to be developed, along with individual reports for each NHS Board (ISD Scotland, 2008b)

DOCUMENTING VASECTOMIES

Another sexual health intervention that has received new attention in data terms has been vasectomies. Vasectomies are increasingly undertaken within sexual health clinics across Scotland in community settings, rather than in acute hospital sites. Because of the changed clinical location, vasectomies are poorly recorded on the Scottish Morbidity Record (SMR) - the national hospital recording system and a new system of accessing the data was needed. Therefore NHS Boards were contacted directly in order to develop an accurate picture of vasectomy in Scotland and this is information is available on the ISD website.

Expanding Existing Data Resources

The annual Scotland's Sexual Health Information (SSHI) Report, produced by the Sexual Health Epidemiology Group (SHEG), brings together sexual health data to build a comprehensive compendium of Scotland's sexual health information. Over recent years, this has expanded from being concerned mainly with STIs towards covering wider aspects of sexual health in Scotland, including teenage pregnancy and contraceptive practice (NHS National Services Scotland, 2008).

Information Benefits

It is essential that information produced and published should be used for benefit rather than being only 'interesting', exemplified by ISD's overall aim to support improvements in sexual health in Scotland by providing high quality health information. To understand its value it is important to understand the potential use for data. This includes;

- Guiding overall policy for public health and service improvement.
- Informing Health Promotion messages, campaigns and social marketing, with particular emphasis on education, such as Sex and Relationships Education (SRE)
- Monitoring changes in population sexual health
- Monitoring changes in service provision and its effects

One of the key areas that rigorous sexual health information can be used to illustrate and illuminate concerns inequalities – both in terms of the impact of social inequalities on health outcomes and inequalities concerning access to health services or good health. For example, data published by ISD shows that in Scotland there are higher rates of teenage pregnancy in areas of greater deprivation (see Figure 6).

Data such as these can be used to highlight an area where a new policy focus or local or national strategy or initiative may be required. Data can and does highlight where action can, and should, be taken. Such data is essential for informing policy and demonstrating where time, effort and resource can best be spent.

FUTURE INFORMATION NEEDS

Scotland has a wide variety of sexual health and HIV information produced by ISD and HPS and by other data collection organisations and methods such as survey data. However, it is important that these national data sources also keep up to date with the ever changing needs and challenges of clinical services. It is also crucial to understand through good lines of communication with clinicians and service providers what further data are required. It is essential to know where such data can be obtained and whether it is truly of value to obtain it, either to the organisations that produces it or to the planners, policy-makers and services that would make use of it. This is achieved through regular communication with groups such as the Lead Clinicians for sexual health, SHEG and thorough the sexual health policy team at the Scottish Government.

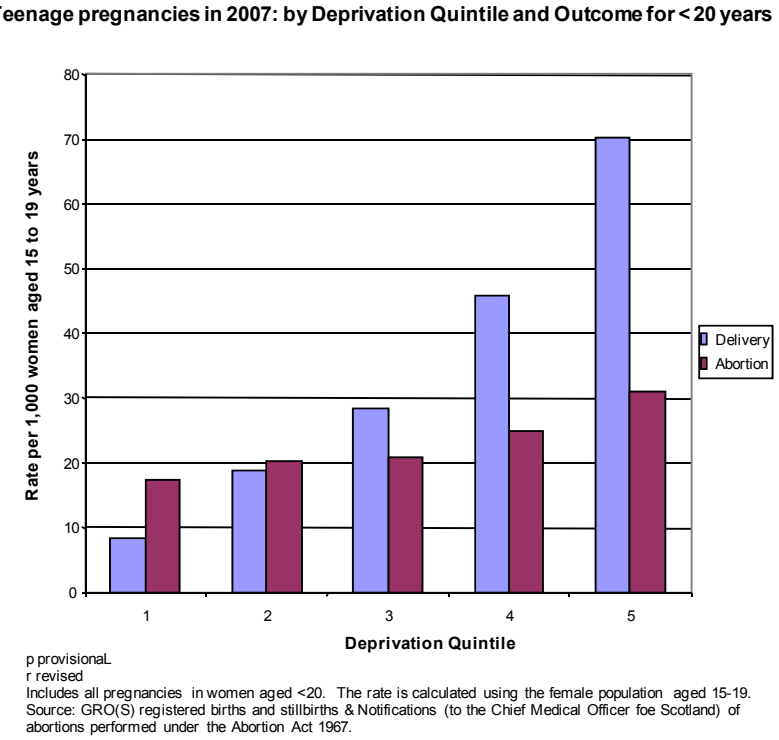

Figure 6: Teenage pregnancy and abortion, by SIMD, in Scotland, 2007 [ii]

There are still a number of data deficits around sexual health in Scotland that need to be addressed. These include:

- Emergency Hormonal Contraception use.
- Contraception Use – such as contraception continuation rates. This can build on information from other sources. For example, data on condom and contraception use and attitudes and behaviours towards contraception and be obtained from NATSAL (National Survey of Sexual Attitudes and Lifestyles) or from the Scottish Health Survey. Similarly, the reasons for failure can be explored without requiring a large new national data initiative, as demonstrated by Lakha and Glasier (2006).

[ii] Source: http://www.isdscotland.org/isd/2071.html#excel_tables_and_charts [accessed on 26 October 2009]

- Sexual health in Primary Care – such as service provision.
- Sex workers – useful national work could be produced through sharing best practice with specialist services such as Base 75 in NHS Greater Glasgow and Clyde (see Chapter 8).

The National Sexual Health system (NaSH) (described in Chapter 6) will provide huge future information resources through the use of secondary data, but again it will be important to use these data carefully and discerningly.

Other examples of useful future data resources include the development of a national prescribing data warehouse, information on Emergency Hormonal Contraception provision from pharmacies, and data from new sexual health questions in the Scottish Health Survey (SHS) as discussed earlier. As the next section identifies, the National Survey of Sexual Attitudes and Lifestyle (NATSAL) Scottish data boost to the 2010 survey will also provide valuable data on trends in sexual health unique to Scotland.

NATSAL BOOST 2010

NATSAL is the most comprehensive survey produced on sexual behaviours, attitudes and lifestyles and as such, there was no need for an entirely new and Scotland specific survey on sexual attitudes and behaviours. The robust methodology and processes required already exist within NATSAL and its content is comprehensive. Therefore, the decision was made to increase or 'boost' the Scottish sample to produce more usable data which looks especially at sexual attitudes, behaviours and lifestyles in Scotland. These data, which will be available in 2012, will provide a broad ranging and invaluable view of sexual health in Scotland, and build on the existing Scottish NATSAL-derived data that Chapter 4 discussed..

CONCLUSION

The publication of *Respect and Responsibility* in 2005 considerably boosted the importance attached to and need for high quality data on sexual health - data which would not only reveal more information about sexual health in Scotland, but that which would also provide essential information on the use of sexual health services, and the behaviours and lifestyles of the public. Sexual health is a public health concern which cannot be understood or addressed without reliable data. As more and more information becomes available we become to understand the population affects of sexual health and the changes that monitoring, services and policy make. The information initiatives ongoing throughout Scotland illustrate the continuing importance of information in supporting improvements in this important area of public health. Only with data can we illustrate the outcomes that all our efforts have made and continue to make.

CHAPTER 6

Managing Patients Differently – The Scottish National Sexual Health IT System (NaSH)

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Sandyford

Abstract: The concluding chapter in this section of the book provides a comprehensive review of the evolution of the Scottish sexual health patient information system - NaSH, and its eventual implementation. With all NHS Health Boards, at the time of writing, either using or about to introduce NaSH, this is a significant achievement, given the previous patchy nature of sexual health patient records in Scotland as the chapter describes. Dr Winter, a GUM consultant and expert in sexual health information management, was part of the group behind the NaSH system, and conveys the multiple strands that NaSH needed to incorporate, and the internal and external challenges that needed to be overcome.

The NaSH system was funded by the Scottish Government to support increased access to services and to bring all sexual health services in Scotland into the 21st century in IT terms in line with the inception of the Sexual Health Strategy. It needed to meet the needs of national governance and local commissioners for robust information about client uptake, service efficiency and sexual health demographics; of clinicians and NHS managers for a workable and efficient system that maximised client outcomes; and of clients for a system that made services increasingly accessible yet protected confidentiality in a highly sensitive clinical area. The commissioning and tendering process for the NaSH system is described, and a range of tables and documents drawn from the development process included that illuminate the complexity of the system, and the issues that had to be addressed.

INTRODUCTION

This chapter will describe the development of the Scottish National Sexual Health (NaSH) e-health system, providing a robust information technology (IT) structure for sexual health services in Scotland that will ensure better patient management and improved national reporting capability. The Scottish Sexual Health Strategy, *Respect and Responsibility* (Scottish Executive, 2005a), called for integration of sexual health services across disciplines and noted that most sexual health services in Scotland lacked any modern IT infrastructure.

At this time in Scotland, the largest Health Board (NHS Greater Glasgow and Clyde) was running near-complete electronic records using a highly customized version of a legacy product (Clinic Pro 2, FMI). This included partial electronic results importing by a bespoke conversion process. Highland had implemented Lilie (Blithe Systems) with limited electronic case notes. Lothian had adopted Clinic Pro 2 for scheduling only, but was developing electronic results delivery with a manual-entry process using Telephonetics (Telephonetics VIP). Other Boards had no electronic scheduling, results delivery or prescribing, and were relying on entirely paper-based diaries, handling all results and patient enquiries manually, and produced all management data by hand.

Epidemiological data about genitourinary medicine (GUM) episodes and sexual infections (STIs) diagnosed in GUM were gathered using a national web-based process, STI Surveillance System (STISS), hosted at ISD Scotland (www.isdscotland.org/isd/4906.html). This had been developed from 2001 in response to a near-complete breakdown in any STI data gathering and continues to work very successfully. No national data was collected from any of the community-based sexual and reproductive health clinics.

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Published by Bentham Science Publishers

DEVELOPING THE VISION

In January 2006 a group of leading sexual health clinicians and national e-health representatives agreed to explore developing a national e-health system to improve this situation. Key to this proposal was the desire of relevant specialties to work together, and most important of all was the evident commitment of clinicians to such a project. After considering options including doing nothing, developing in-house applications, and procuring licenses for existing systems, Scottish Government Health Department (SGHD) eHealth Board approved a process of national procurement. This process was led and supported by NHS National Services Scotland. An outline business case was approved, and the NaSH Project Board met for the first time in June 2006. A summary of the NaSH development can be found at http://www.nash.scot.nhs.uk/index.html, including all the documents from which the examples in this chapter have been taken.

The vision at this stage was for a centrally-hosted web-based full electronic record system that would be accessible from all clinic locations across community sites, it needed to be compatible with Scottish IT products such as SCI store[1] (for sharing laboratory data) and the Community Health Index (CHI)[2] demographic index, and be able to support approximately 1200 staff with 400,000 annual patient attendances across 200 sexual health settings in Scotland.

BENEFITS

The 2006 business case contained a stringent list of expected benefits shown below:

Table 2: Expected benefits from NaSH: specific to NaSH

B1	*Improved Clinical Care by introducing more patient focused processes and modern communication tools.* This benefit is about using the modern communication tools that are used by the main client group and providing them with more care options to encourage better uptake of services and therefore improved care.
B2	*Streamlining of services enabling improved throughput and availability.* This benefit is about making better use of scarce resources to address unmet need.
B3	*More effective use of staff resources.* This benefit is similar to B2 but adds the dimension of using staff more effectively to minimise increases in staff required to handle increased service demands.
B4	*Removal of multiple manual record keeping systems.* This is the one benefit where there is the potential for cash releasing savings in the accommodation required to house manual record systems, in the costs of maintaining these record systems and in the stationery costs involved.
B5	*Ability to address some clinical governance issues more effectively.* There are great many demands for information on the quality and quantity of sexual health service systems and how client guarantees are met. With the existing, disperse manual record keeping systems, addressing these issues is difficult.
B6	*Improved service security.* Highly sensitive information is held in hand written manual records which are transported between various clinics. Risks of loss, legibility and access will be greatly reduced.
B7	*Reduction in resource required to complete STI coding.* Currently STI coding is a manual process requiring special staff duplicating collection of data. The system will provide automatic means of extracting the required data set.
B8	*Ability to introduce use of Community Health Index (CHI) number* where patient choice allows. Due to manual processes, filing and lack of access to suitable technology sexual health services have not made use of the benefits for client care of the CHI number. The introduction of NaSH will make this possible where client consents.
B9	*Improved access to patient clinical information.* Having an electronic record will provide multi location access to legible and complete client information providing improved data quality, reducing risk and improving service to the client.

[1] 'SCI Store' is a national product used across Scotland to exchange information between parts of the health service, most commonly laboratory and other results.

[2] For more information see: http://www.datadictionaryadmin.scot.nhs.uk/isddd/11203.html

Table 3: NaSH: generic e-health benefits applied to sexual health services

B10	*Increased ability to share clinical information.* Client permitting, will enable electronic communication between the sexual health services and the rest of the health service for such services as results reporting.
B11	*Reduced requirement for duplicate entry of patient data and generally better quality of data.* There will be one integrated client record throughout Scotland allowing mobility of clients across boundaries without the need for creating new manual records per location.
B12	*Increased use of national data standards.* The system will use the NCDDP approved data standards for all elements where standards exist.
B13	*Reduction in number of potential diverse clinical systems.* There will only be one sexual health system throughout Scotland which utilises other appropriate, national eHealth products.
B14	*More efficient and increased integration of systems.* Standard interfaces between NaSH and relevant national systems, e.g. SCI Store, will be provided.
B15	*Improved resilience and support for clinical systems.* NaSH will be supported by a managed technical service from the national data centre using a standard support protocol with local NHS Board IT Support services.
B16	*More efficient clinical staff training.* Because a standard system will be in place, sexual health service staff will be able to move more easily between services and locations without having to be retrained in local systems and processes.
B17	*Get more value from national infrastructure products.* NaSH will make its contribution to the uptake of the national infrastructure products and thus increase value for money of these products.
B18	*Increased clinical buy-in and usage of Information Management and Technology (IM&T).* Having an electronic system which is seen to support their clinical service will encourage the increased use of other electronic services and thereby contribute to the eHealth modernisation agenda.
B19	*Better public health information.* With the existing, dispersed manual record keeping systems, it is extremely difficult to produce robust national information of the required standard and quality. Such information will be a by product of NaSH.

PROCUREMENT PROCESS

A Reference Group was formed, chaired by a clinician and with representation from geographic areas, disciplines and interests across Scotland. This group developed a detailed Statement of Requirements (SoR), which is available on the NaSH website (www.nash.scot.nhs.uk). It was recognized that it would be very positive if 80% of requirements were achieved, and the group was careful not to over-specify mandatory items although this provoked significant discussion. It was helpful here to refer to two example cases which illustrated some of the complexity of workflow in sexual health care as a way of identifying who could best meet the needs. These cases contain the type of information that would form a clinical interaction in an integrated sexual health setting and are for illustration. For that reason, clinical aspects will not be defined further here.

CASES USED TO HELP DEVELOP THE STATEMENT OF REQUIREMENTS

Case 1: Acute STI

Gerald is 29 yr old Chinese gay man on holiday in Ayr with a 3 day history of purulent discharge. He wants full check up including rectal and pharyngeal tests + HIV + Hepatitis B vaccine. Is leaving the country in 3 weeks but happy for letter to go to his partner's address while away. Does not want details sent to his GP in London at this point. Has gonorrhea diagnosed by near-patient gram stain and given cefixime directly in the clinic, and a 'blue script' for doxycycline as the clinic has run out. Gives basic details of anonymous contact. Asks for letter to take to local clinic back home. Hepatitis B test comes back showing cAb+, +HBsAg: health advisers need to recall twice by phone. Four weeks later he rings up asking for letter to go to GP after all saying he had used assumed name and date of birth.

Points raised:

- Access to healthcare without Community Health Index number and anonymously, but ability to change that
- Patient choice in recording contact details for personal and GP communication, and handling changes to these
- Recording tests taken and highlighting positive results returning, noting a single test request can generate multiple returns
- Recording near-patient microscopy
- Recording prescriptions given out within the unit and externally
- Printing a patient summary for transfer of care
- Follow-up and recall

Case 2: Emergency Contraception

Mary is 15 yrs old and is seeking emergency contraception for unprotected sex four days ago. She also wants Chlamydia testing. An under 16 proforma is completed and her 'Fraser competence' documented (see Walters, 2008). She does not want her GP or mum to know but is happy for results to go to mobile. Urine and cervical Chlamydia tests are sent, an IUD fitted and prophylactic antibiotics given. Three weeks later she defaults her follow up visit. Her Chlamydia result is positive but she is of course already treated. She is recalled for partner notification, returns and starts Depo-provera injections.

Points raised:

- Documenting procedures completely, including chaperones, device used, anaesthetic
- Documenting under 16 assessment processes and recording relevant communications across multiple disciplines
- Handling lab tests with the same test at multiple anatomic sites
- Recall systems, notification of defaults, recording outcome of positive tests.
- Recording prescriptions to be administered at intervals over a time period

National e-health procurement long-listed interested suppliers with technical scoring, and the clinically-led Reference Group scored the shortlisted suppliers' responses to the SoR.

Table 4: Example 'Statement of Requirements' statements

Key: Each statement is determined to be mandatory (M), desirable (D), or just seeking information(I) about the proposed solution

6.1 The Sexual Health System must be able to extract client demographic information in real time from the national CHI database. If this functionality is not currently available, the supplier must guarantee to meet this requirement in advance of the initial implementation.	**M**
8.1 The Sexual Health system should deliver an electronic client (patient) record (EPR) relevant to integrated sexual health able to be used in front of and with clients permitting entirely paper-free clinical work. The following bullet points are a representative sample of that which is desirable. Suppliers should indicate which of these is currently available, which could be delivered for the initial implementation and expand upon these to give details of other relevant information currently available: • Sexual history: with attention to detailed recording of sexual activity, use of	**M, I**

condoms, HIV/BBV and historic sexual risk factors. • Medical history: with attention to factors influencing contraceptive • prescribing, symptoms of HIV, previous Sexually Transmitted Infections, allergies with alert/block to prescribing, • Family history: with particular relevance to contraception issues e.g. breast cancer, thrombosis • Women's health: smear history, contraceptive history, menopausal symptoms, obstetric history, gynaecological symptoms • Men's health: sexual problems, lifestyle risk factors • Social health: determinants of sexual ill health such as alcohol and drug misuse, domestic violence, injecting drug use, smoking etc. • Examination findings: including ability to use diagrams to indicate lesions, recording chaperones & consent, • Test request and results: see section 9 • Prescriptions: ability to pre-select drugs to create a 'Sexual Health System formulary'; recording dispensing including batch numbers of vaccines and injectables; clear audit trails of prescribers and dispensers with reporting of outliers • Procedures: including record of consent, anaesthetic use, complications of relevance to Implanon, Intra Uterine Devices/Intra Uterine System, biopsies, colposcopy, vasectomy etc., instrument sterilisation codes, batch numbers of inserted devices • Partner notification: detailed recording of all data required by Society for Sexual Health Advisers, including ordered lists of contacts, contact outcome, location and context of contact, outcome, clinical interviews • Preset proformas: additional configurable relevant data items should be requested automatically at each attendance e.g. of anyone aged 15 or under or known to be "looked after" or with a learning disability – this also includes documenting discussion of key items such as pre termination counselling • Correspondence: See section 12	
9.1 The Sexual Health system should provide a clear auditable workflow for reviewing abnormal results, including ability to calculate delays at each step of the process, recording and attributing any clinical comments, record date of treatment linked to the prescribing record. This must be integrated into the recall system with relevant warning messages in case of client attendance (see section 11).	**D**

Four suppliers were invited for demonstrations. These included suppliers of proprietary sexual health systems already in use in UK clinics, a supplier with experience of community health systems but not specific sexual health, and the supplier of the Generic Clinical System for Scotland. It became clear that no current supplier could cover the range of required functionality for integrated sexual health that was specified. This last supplier, AxSys Technology Ltd, emerged as preferred bidder due in part to their proven experience in integrating with existing Scottish e-health systems and running a Chlamydia screening system. The core product, Excelicare, was a fully-featured clinical records system with user-definable special forms but offered limited scheduling options. This meant that a significant amount of functionality to support sexual health work processes had to be developed. The contract was thus awarded subject to completion of a satisfactory phase 1 development. SGHD undertook to fund significant parts of the product development and initial hosting costs.

APPLICATION DEVELOPMENT

Business Analysis

AxSys brought a rigorous business analysis approach, and considerable time was spent defining workflows in sexual health clinics. An 'episode-based' approach to work with time-sensitive information grouped under an episode of care was adopted, and lifetime data recorded in an ongoing record. Specific needs for scheduling within sexual health services were defined. Examples of the business planning flow charts are shown below.

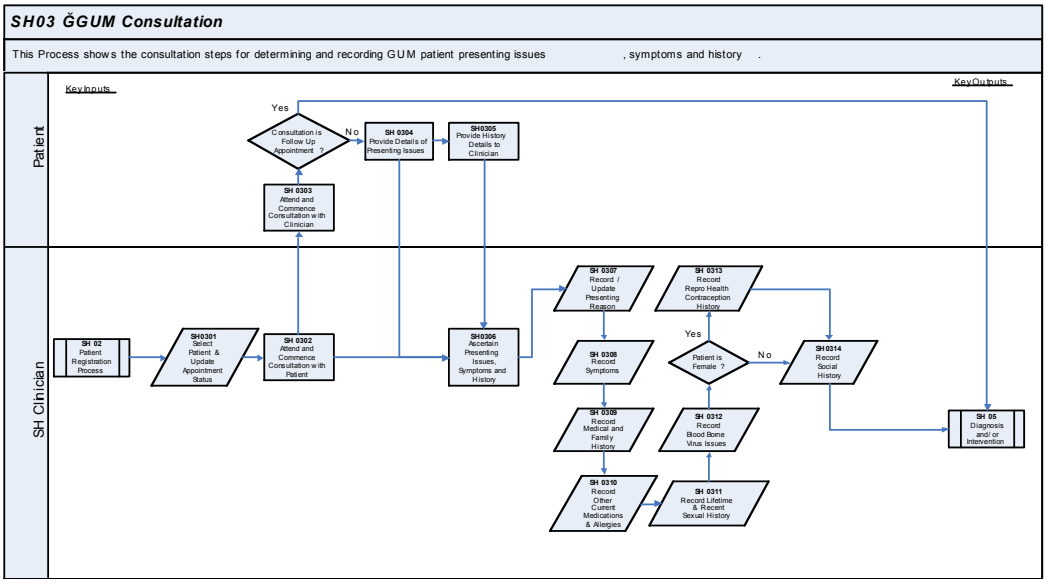

Figure 7: GUM process workflow

FUNCTIONAL AND DETAILED SPECIFICATION

FA functional specification was agreed by the Reference Group and then developed into a detailed specification, listing every special form and data item. Excelicare Special Forms were designed to capture the key elements of a sexual health consultation, with an overall structure as shown, to stand alongside existing Excelicare functionality such as Clinical Notes and Patient Order.

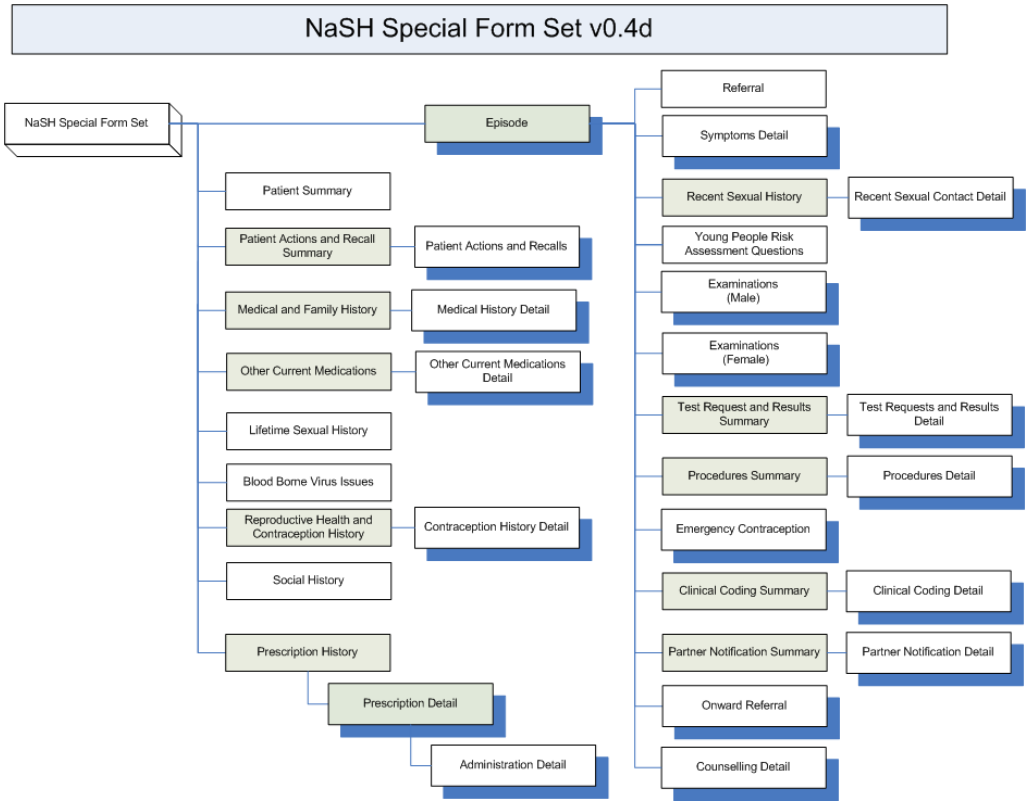

Figure 8: Summary of NaSH form set

In tandem with this process, the National Clinical Datasets Development Programme (NCDDP) (www.clinicaldatasets.scot.nhs.uk) was approached and agreed to assist with a formal process of developing sexual health data standards. This group was chaired by the chair of the Reference Group so there was close integration between the NaSH project and NCDDP. However it drew on a much wider clinical group as the data standards would be applicable to all future information management and technology (IM&T) systems. Eventually two rounds of definitions work were needed, covering everything from recording of detailed sexual behaviour through to partner notification. The major problem with the NCDDP approach was to attempt to keep the operationalisation of the data collection realistic – the ever-present tension between having perfect data collection system used by 10% of the staff or an imperfect system used by 90%. The Reference Group had to decide how best to implement sometimes unwieldy data definitions in a real-world clinical clerking form. The NCDDP work was incredibly useful in populating the extensive series of drop-down menu items. Unfortunately there was a lack of strategic integration at national e-health level so that the data standards were published onto the data dictionary website but are not easily accessible within the NaSH application (for example by context-sensitive help). Thus much of the work of the NCDDP group to standardize definitions remains hidden from end-users, and does not therefore achieve its main purpose of ensuring consistency of data collection.

During the development of the detailed specification the group was also attempting to second-guess the outcome of the Quality Improvement Scotland Sexual Health Standards (NHS Quality Improvement Scotland, 2008a) (see Chapter 4) and ensure that relevant data items could be recorded. It was clear there would be considerable interest in booking delays, hepatitis B vaccine status and uptake, and partner notification among others. So a referral form capturing timeflow of referrals was included, and the group worked with NCDDP to define appropriate data items for Hepatitis B vaccine and partner notification (PN) outcomes.

NCDDP Information			
NCDDP Formal Name	**Definition of NCDDP data Standard**	**Hyperlink to NCDDP item on Data Dictionary**	**Additional or related Information**
Sexual Health - Phase One			
Socio-Environmental Details			
Sexual Activity Status (Current)			
Sexual Activity Status (Current)	**Definition:** A record of whether or not the person has had any sexual contact with another person in the last 3 months.	http://www.datadictionaryadmin.scot.nhs.uk/isddd/ISD_DT_TOP_SMR.jsp?pContentID=23693&p_applic=CCC&p_service=Content.show&	**Further Information:** Sexual contact includes any type of genital or anal contact with another person (includes vaginal, oral and anal sex).
Sexual Activity Status (Lifetime)			
Sexual Activity Status (Lifetime)	**Definition:** A record of whether or not the person has ever had any sexual contact with another person.	http://www.datadictionaryadmin.scot.nhs.uk/isddd/ISD_DT_TOP_SMR.jsp?pContentID=23674&p_applic=CCC&p_service=Content.show&	**Further Information:** Sexual contact includes any type of genital or anal contact with another person (includes vaginal, oral and anal sex).
Sexual Partners (Number of Previous)			
Sexual Partners (Number of Previous)	**Definition:** The person's best estimate as to how many sexual partners they have had.	http://www.datadictionaryadmin.scot.nhs.uk/isddd/ISD_DT_TOP_SMR.jsp?pContentID=23700&p_applic=CCC&p_service=Content.show&	**Further Information:** Sexual contact includes any type of genital or anal contact with another person (includes vaginal, oral and anal sex).

Figure 9: Sample sexual health data definitions

The next major task was to build the dictionaries and ensure they were fit for purpose. This required:

- Defining a systematic list of all tests requested in sexual health services, with appropriate grouping and request sets and agreeing systematic naming conventions
- Agreeing a subset of Read codes for inclusion in medical conditions: level 3 codes (e.g. R59.) were selected amplified by lower-level codes of relevance to contraception (e.g. all UK MEC conditions), HIV, GUM, and sexual reproductive health (SRH).
- Agreeing to use a top-level list of allergies
- Developing a systematic prescribing table for all medications to be directly given to patients.

At all times in building such lists the project team looked ahead to end-user usability and reporting requirements. One of the most difficult issues in the specification was to develop a suitable scheduler, which the vendor chose to do with an Outlook-type diary system. Sexual health clinics have considerable diversity both between disciplines and across Health Boards. For example, some services ran large open access walk-in clinics without fixed appointments, some wished to control bookings to specific sessions; in some Boards different staff with different 'lanes' of work started and ended work at different times. Different boards had different default times for new and return patients. The larger boards have several hundred discrete clinical sessions running in any one week. Perhaps not clearly enough specified was the requirement to search across all these clinics for 'free space' by different categories e.g. showing the first return slot of at least 15 minutes for a specialist gay men's clinic. Significant enhancements have been made during the initial testing and later product development to meet these needs.

TECHNICAL DEVELOPMENTS

A major decision for any project of this scale is how to 'host' the application - should there be multiple installations in each geographic area or should the application be installed in a single central server with all users connecting via web links? One of the reasons for a national project was to ensure equity of access across all Board areas, some of whom had little e-health involvement in sexual health. Lead Sexual Health Clinicians for Boards were in favour of central hosting and this was in line with national e-health policy. Atos Origin Alliance (AOA), under an existing national contract, were contracted to host the necessary environments: the live application, a 'User Acceptance Test' version where upgrades could be tested, and a Disaster Recovery replication site. A thorough memorandum was drawn up to divide responsibility for investigating faults, as errors could broadly be divided into the following four areas, shown in the table below.

Table 5: Division of responsibility for a managed hosted web-based clinical system

Board IM&T	Local hardware speed and functionality Local networks up to N3 outlet Browser configuration and patches (differs between Boards) Antiviral protection (differs between Boards) Local firewall management
Software provider	Application including server-side scripting
Application host	Server hardware Server software, such as SQL Host firewall
National e-health	Elements of the BT N3 contract

This shows at once the complexity raised by an apparently simple helpdesk call such as 'my NaSH has stopped working' - the fault could lie anywhere along this chain, from an inadvertent change in local browser configuration to a failure of the N3 connection to a server failure at the host. A detailed Implementation Pack was prepared and continues to evolve which specifies all the requirements for Boards to run NaSH successfully.

GO LIVE ISSUES

NHS Boards went live in a phased process, commencing with the acceptance test site, NHS Lanarkshire, on 17 March 2008. Key project milestones are shown in Box 1:

TRAINING DEVELOPMENT

A 'Train-the-trainers' approach was adopted, with enthusiastic professional IT trainers working in several early adopting Boards, who did a huge amount to customize generic training material for

NaSH. In the largest Board to go live with over 300 staff (NHS Greater Glasgow and Clyde - NHSGGC) the staff training alone took six continuous weeks of half-day sessions in an IT suite of eight desktops. Separate Clinical and Clerical courses were developed with a common core stem of Excelicare familiarity. Key points to improve in future would be to strengthen understanding of the MCN catchment functionality, and basic understanding of forms (single-record vs. multi-record).

Box 1 Project Milestones:

Jun 06	Project Board established
Jul to Oct 06	Statement of Requirements defined
Aug to Dec 06 and May to Aug 07	Clinical Data standards specific to sexual health developed by NCDDP (two phases)
Nov to Jan 07	Formal EU procurement process
Feb to Mar 07	Phase 1 demonstration project
Apr to Aug 07	Workflow and business analysis
Jun 07	Functional specification
May to Aug 07	Detailed specification development
Nov 07	Contract signing
Dec 07 to Jul 08	User acceptance testing
Jan 08 to Mar 08	Role-based access / security framework developed
Mar 08	Go-live in acceptance site (Lanarkshire)
Apr 08	Phased roll out to further Boards
May 09	Version 2.5 (performance improvement)
Oct 09	Version 3.5 (further performance improvements)
Dec 09	Completion of 'project' phase as all Boards anticipated to be live

MIGRATION ISSUES

NHSGGC had particular requirements, having been working largely paperless for over 5 years when NaSH went live. It was decided to take all live records, defined as anyone who had attended sexual health services since 1 April 2003. A separate contract was negotiated to map pre-existing clinical and demographic data on the CP2 system into the relevant special forms in NaSH. Around 300,000 patients and about 800,000 test forms were migrated over the go-live weekend. Smaller migrations happened in NHS Lothian, where demographic records from the two main services were taken. Migration caused particular issues with duplicate records, for example clients having already attended live clinics in NHS Lanarkshire who then had records migrated with duplicate demographic data from Glasgow, and within NHS Lothian where clients had attended both services. Further migrations are planned for NHS Grampian and Highland. Boards with previous paper records decided not to scan old records, and are faced with running mixed systems for some time, using old paper records as needed. For some this has meant continuing dual numbering systems, or maintaining paper files alongside the new NaSH record.

There were a number of issues relating to staff. All staff had to be created on the system with their User Profile correctly entered to ensure adherence to the security framework. The initial security profiles have worked well with some recent additions as it emerged certain people were unable to fulfil their normal day-to-day functions without holding two user accounts.

ISSUES AND CHALLENGES:

This complex national IT project has faced considerable challenges. Most clinical sites prior to the advent of NaSH were not computerized. Many staff have had to learn about computer-based records, from simple problems with passwords and keyboard skills, through to changes in consultation style brought by having a computer in the room. Departments have had to develop new relationships with local IM&T infrastructure staff, business intelligence, and laboratory technical staff. Clinicians have had to work together across professional and geographic divisions.

i) Technical – Speed and Performance

From Go-Live it was clear that the system faced major performance challenges working across a typical day-to-day NHS environment. There has been unprecedented working together at national e-health level between the supplier AxSys, the Host (AOA) and national e-health and Boards' IM&T departments. There were myriad small improvements to be made at all levels, from running the latest browsers through to detailed firewall and proxy configurations, to allow a feature-rich web-based application to run in real-time to the satisfaction of clinicians. The application has gone through two major upgrades to address some of the observed inefficiencies, including increased caching of local forms and dictionaries. A safety feature asking users to confirm they wished to save data to the clinical form was universally ranked in a user survey as top of the irritations. In the latest version to launch late 2009 can now be inactivated by the user.

Local network bandwidth was an issue in many sites where dozens of users were strung along a daisy chain of vulnerable connections. This required Board IM&T departments to work to define actual network routes and optimize these. At times it was hard to convince Boards that this was a real-time, web-based, centrally hosted EPR system, and that action was required to amend network routes and improve local connectivity. Other boards spent considerable local resource investigating issues. Conflict with PACS (Picture Archiving) systems were a problem, especially in community sites where for example a dental practice adopted a PACS system and downstream NaSH became unusable at times. Late in the project the impact of certain antiviral software script-scanning became clear, which affected NaSH in particular with lots of 'intelligent' web-forms hiding content based on previous selections. Thus the minimum specified bandwidth and processor and RAM to run the system in a stand-alone setting was inadequate in the real world. The autumn 2009 release, v3.5, now in acceptance testing, finally offers users the desired 2-3 s page load even on complex forms in a real-world environment, at least on a well-specified PC.

One key argument about the amount of data collection remains: whether data should be collected via multiple special forms or whether a simple 'minimum data set' should be defined and collected on a single form. NaSH has to serve needs of clinicians in a wide range of services and allows data collection across the whole spectrum of sexual health with few mandatory fields. For example, for recent sexual history the design allows recording of basic 'screening' type questions then, if relevant, a separate window can open to record detailed sexual history for each sexual partnership. The slower-than -expected page loading times can make this cumbersome in certain sites. The key problem to collecting a minimum data set across Scotland is for all NHS Boards to agree what items should be included. There have been misunderstandings that data collection is all about subsequent reporting needs, but the primary purpose of accurate data collection is to allow a better risk assessment for the patient and to make the clinical notes useful to subsequent practitioners.

ii) Confidentiality and Security

Although there were unfounded concerns about scare-mongering stories appearing in the media, most issues regarding confidentiality and security have arisen from within the e-health arena itself. These include patient identification, laboratory function and electronic test transfer, and user roles,

and are discussed below. A first step was to agree who would be the system owner and appoint a Caldicott Guardian[3], a role kindly discharged by the Medical Director of Information Statistics Division. A Lead Clinician not on the Programme Board or User Management Group was also appointed to advise the Caldicott guardian and help investigate and review any confidentiality issues.

All patients registered with a GP in Scotland have a Community Health Index number (CHI)[4] and in recent years considerable national and local effort has been put into '100% CHI' identification of all correspondence and test requests. Anonymous care is however fundamental to sexual health care, where this is desired by the patient, to avoid patients being inhibited from seeking care for fear of discovery. The NaSH project wished to place the choice firmly in the patients' hands as to how they wished to be identified, and adopted a patient-centred approach with specific per-patient consent sought to download and use their nationally-held demographic data. Some laboratories also raised concerns about anonymous identification, although in practice all GUM services had been sending anonymous tests for years. National agreement was obtained to develop a national anonymous identifier with similar characteristics to CHI, including a check digit, commencing with the letters 'AN'. This is system generated and held only on the NaSH application. Three choices are now offered to patients and recordable on the application as below:

Box 2: CHI and Patient Identity Options

Full CHI identity	Patient is identified just as if they were at their GP with CHI identity labels on all tests. Test results may be available via routine SCI store
Confirmed identify/ Anonymous testing	Patient details are downloaded from CHI but all tests are sent with an anonymous identifier number
Assumed identity	No attempt is made to look up CHI, the patient can call themselves what they wish and all test are sent anonymised. No GP communication is possible

The NaSH number is used by patients to access their STI test results from the Telephonetics application even if these tests have been sent with a CHI number as the NaSH number is private and known only to them.

Each Board has customized its use of SCI Store with different Boards using different versions and all using slightly different matching rules. Laboratories across Scotland varied in their approach to broadcasting sexual health tests, with some labs not sending any such 'sensitive' tests to SCI Store at all. One of the key benefits of NaSH is to obtain test results electronically and use machine interpretation, which requires all relevant test data to be obtainable via SCI Store. A lot of work has been required to work with Boards to persuade them of the great impact of this benefit.

The NaSH Project Manager oversaw a key process which was to determine for each staff group their level of access to various parts of the system. A key principle which will be maintained is that no single person with one log-in can see the national patient index and view clinical data. Clerical staff in general had rights to see all patient demographics but no clinical data, and clinicians were to be prevented from registering new clients and restricted to patients within their own catchment. This has subsequently required modifying as some clinicians run single-handed clinics with no clerical support, and some clerical staff such as medical secretaries require to register patients and see some clinical data, such as clinical letters and test results. The risk of

[3] Caldicott Guardians are responsible for agreeing and reviewing internal protocols governing the protection and use of patient-identifiable information by the staff of their organisations.
[4] See http://www.datadictionaryadmin.scot.nhs.uk/isddd/9733.html

creating duplicate patients in extremis to allow a clinical service to be given to someone has therefore been accepted. More recently the development of a formal managed clinical network (MCN) in the West of Scotland involving five NHS Boards working closely together raises a fresh consideration about the exact boundaries placed around clinical data, especially with considerable evidence of 'border-hopping' as patients seek the most suitable service for their needs. Developments here may include creation of a single catchment for the whole of this MCN area, or certain users being given rights to see multiple catchments. Some staff already work across Board areas and require multiple user accounts, one for each Board area they work in.

CENTRALISATION OR DIVERSITY?

NaSH is one of the first centrally-hosted live clinical electronic records system to run across Scotland. Other applications such as PACS have local hosting with downloads of data to a central data store. Other national applications such as the Scottish cervical screening system (SCRRS) deal with a tiny part of the patient journey, with just a few pages to be completed by the user compared to NaSH. In this case, it was decided to develop a single application for all centres in Scotland, serving an area of around 5 million people. This is a similar size to the Strategic Health Authority areas in England, but a greater challenge due to the number of different Health Boards and degrees of service development. Arguments remain about which is better: a centralized (web-hosted) solution nationally specified and delivered, or local diversity with some element of central data extraction from a common data specification, and these are set out below.

In favour of centralized developments are:

- Efficiencies of central procurement driving down cost
- Common approach to other central e-health products e.g. CHI lookup; Lab results (SCI Store); SCI Gateway; STISS coding extract, integration with SCRRS
- Perceived desire for all sexual health services to adopt a common approach to working
- Efficiencies saved in set up: drug dictionaries / past medical history / updating clinician list
- Meta-outcomes – the process of working together itself promotes integrated working; cross board working especially with the emerging West of Scotland MCN
- Boards are at different stages and have different resources – all can share in development and use best skills to contribute, but few would be able to implement a successful solution and gain all the benefits on their own
- Common approach to reporting

Against centralized development:

- Some loss of local control to develop local initiatives – e.g. self-clerking / new forms – as changes to NaSH require to be agreed nationally
- Historically local centres would have customized clerking forms relevant to their own ethos and practice. A local IT development might allow more incorporation of this local flavour
- Central e-health solutions turn out to have lots of local differences, for example each Board has configured SCI store differently and every laboratory IT output is different so local work is needed for each Board implementation.

Boards remain free to use what parts of the NaSH system they wish. Some parts of the solution are customizable, particularly the extent of desired lab integration, the extent of CHI identification, and the method of communicating results to patients.

REPORTING

One of the main intentions of NaSH was to facilitate robust reporting of client and service activity and clinical outcomes. Work commenced on specifying reports in 2007. Reports can be broken down into four main areas:

- 'Safety' reports: e.g. exception lists of patients with positive results
- Management reports: activity data (attendance, tests, scripts) split by various categories
- Clinical audit reports: record completeness, proportions of patients exhibiting characteristics, prescribing audit, personal activity data
- Nationally required: extracts of data for STI coding, Key Clinical Indicators (e.g. hepatitis B vaccine or HIV test uptake)

Significant challenges have arisen in developing a suitable reporting framework, including:

- Creating and agreeing reporting specifications across such a large range of work with Boards at very different levels of experience in sexual health electronic systems.
- Communicating reporting specifications to developers, for the set of contracted developer-led 'safety' reports
- Delay in preparing and quality assuring a full data schema for such a complex system
- Getting standard reporting tools such as Crystal to work with the proprietary reporting product while maintaining the system-controlled security environment.
- Variable skills in using reporting tools among the user base

However, from late 2009 NaSH release 3.5 offers significant enhancements, not least the Excelicare PRISM reporting system that allows dynamic filtering by virtually any data collected on the system in real-time, and tools which allow NaSH report developers to load complex reports developed in Crystal back onto the system for users to run within NaSH. In time there is no doubt that NaSH will provide a unique data source for research projects as the system can link information on sexual behaviour, social risk (e.g. alcohol excess), diagnosed STIs, and demographic variables such as ethnic status and deprivation category of residence. There are already over 5 million special forms completed, each containing multiple data items. Such work would need careful approval and strict anonymisation.

PROCESS RE-DESIGN AND BENEFITS

Significant benefits have already been obtained with NaSH in spite of some of the difficulties outlined above. Most significantly for NHS Boards without previous record systems has been the new ability to centralize booking, searching for free space for a particular service across the whole Board area. Centralised results processing ensures failsafe systems compared to the old pattern of all results being returned to the local requesting site of origin and languishing in an unopened envelope for a week until the next occurrence of the clinic. Senior staff can access and view records, annotate comments, interpret results and contact patients who have been seen in community-based sites. Patients can obtain their results from electronically-processed results via the Telephonetics VIP interface. Results are imported against a robust and explicit matching system ensuring no clerical errors, and are available within a few hours of the lab report being electronically dispatched. Integration with CHI and QAS address software has greatly improved accuracy of demographic data.

However challenges to adopting a full EPR remain. Only a few NHS Boards are now running near-paperless. There has been some reluctance to part with old paper notes and numbering

systems, to scan correspondence and discard paper copies. Each Board has its own local benefits realization plan and all will move at different speeds. Influential factors include local senior clinical leadership and engagement; the involvement and support of local IM&T departments, including business intelligence, IT training and networks specialists and the growing informal support networks among system administrators

WIDER IMPLICATIONS OF NaSH

The challenges involved in delivering such a state of the art comprehensive IT system on a national basis while still allowing local flexibility are documented above. The fact that these have been largely achieved over a 4 year period is testament to the enthusiasm and passion of those involved. These characteristics form the basis of strong team working between clinicians and IT experts even in times of great challenge. The direct benefits for quality and efficiency of the services in the future are huge. In addition NaSH has and will support the underlying ethos of *Respect and Responsibility* in more subtle ways. Health Boards remain free to use electronic patient records to support local priorities and standards. However, benchmarking between Health Boards will make it clear the extent to which services are client-centred, communicate effectively and explore underlying behavioural determinants of health. The use of anonymised data will greatly support partnership working and service design, both within and outwith specialist sexual health services. For these reasons alone the complete national rollout of NaSH is awaited with great anticipation by many individuals and bodies such as Scottish Government, NHS Health Scotland and various voluntary organisations. Anonymised data from NaSH will have an important role together with the key clinical indicators (see Chapter 5) and QIS's Sexual Health Standards (see Chapter 4) in supporting local and national strategic and operational planning. It is expected that local Health Boards will be supported by ISD in comparing and commentating on areas of data relevant to national priorities.

CONCLUSION

As of September 2009, NaSH is live in eight boards with rollout across Scotland due by the end of December 2009. It is already in use in 89 locations by over 870 users with over 800 separate clinics running weekly. More than 430,000 patients are now registered, with over 5 million special forms created containing sexual health specific patient data. This is the largest single installation of a sexual health system in the UK and possibly in the world. The project has only been possible due to the incredibly hard work of committed clinicians, clerical staff, developers at AxSys Technology Ltd, AOA staff, national e-health personnel, and political and financial support from the Scottish Government.

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CHAPTER 7

Scottish Sexual Health Services: Cinderella Starts Making her Way to the Ball

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Abstract: A central objective of *Respect and Responsibility* - Scotland's first national sexual health strategy - was to improve sexual health services through developing strong local and national alliances. This chapter by two of Scotland's sexual health clinical leaders, Dr Alison Bigrigg of the West of Scotland Managed Clinical Network and Professor Anna Glasier of NHS Lothian, reviews the resulting organisational arrangements and the key roles given to the NHS in Scotland and their local authority partners to take a holistic view to the Scottish sexual health landscape.

Summarising the previous structures of sexual health care, and the players involved, the chapter charts the shift to a more innovative environment by describing examples of good practice from across Scotland that have resulted from these opportunities, and from the funding that came to local areas through the Strategy. This includes work to support young people in Lothian; innovative developments in the West of Scotland; a managed sexual health clinical network Grampian; an enhanced sexual health role for community pharmacists; a national campaign to raise awareness of long acting reversible contraception (LARC), and partnership working in Dumfries and Galloway.

The sexual health strategy aimed to reduce inequalities in access to sexual health services, and the authors argue that these, and other examples of sexual health care in the 21st century go a long way to improving the previous landscape of sexual health services in Scotland.

INTRODUCTION

Prior to 2002, the then Scottish Minister for Health and Community Care commissioned a National Sexual Health Strategy - *Respect and Responsibility* (Scottish Executive, 2005a). At that point, Scottish sexual health services were similar to those in the rest of the United Kingdom. Family planning services were largely community based and staffed by part-time clinical staff with no formal training or career structure in the specialty. Genitourinary medicine at least had a specialist training and career structure but was mostly located in the acute hospitals and often hidden out of sight. Both services had little funding or political profile and were hardly noticed by strategic planners within the NHS Health Boards.

A decade later, specialist sexual health services are a small but important element of Health Board strategic agendas, mostly consultant-led, mentioned in all annual reviews of Health Board performance by the Scottish Government and firmly established as a specialist service within the NHS. Furthermore, the importance of sexual health in other NHS and local authority services, such as addictions, learning disabilities, education and community safety is widely recognised, as a number of contributors to this collection, notably Chapters 10 and 11, discuss. The Scottish Government has made only a modest financial investment in sexual health, £10million over 6 years from 2004-2011 across the whole of Scotland, so how has this happened? This will give examples of how investment in local leadership, supported by high profile political backing, led to partnership working and commitment by many different agencies. This in turn has resulted in substantial impacts from a small financial investment.

RESPECT AND RESPONSIBILITY – THE NATIONAL HEALTH STRATEGY FOR SCOTLAND

The achievements in sexual health in Scotland are all the more notable considering that in 2003 Scotland appeared to lag behind the other countries of the UK. England had already published its

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Teenage Pregnancy Strategy – see Chapter 3 and http://www.dcsf.gov.uk/everychildmatters/-healthandwellbeing/teenagepregnancy/teenagepregnancy/ for more information, and the Strategy for Sexual Health and HIV (Department of Health, 2001). There were some doubts that Scotland would ever produce the Strategy as it struggled with the political difficulties due to a relatively strong conservative and religious lobby as others have described, and a recently devolved government. The slow start did however enable Scotland to learn from the English experience and the challenging environment necessitated the engagement of politicians from the start of the process. *Respect and Responsibility* emerged with a three pronged approach (clinical, cultural and life long learning), and as Chapter 3 commented, was arguably a much broader and inclusive strategy than the English one, particularly in acknowledging the needs of people of all ages, not just young people

In retrospect, the recommendations from the Expert Reference Group which drew up the draft Sexual Health and Relationships Strategy in 2003 (Expert Reference Group, 2003) have been key to its success. The five broad recommendations were to:

- Provide national leadership (covered in Chapter 3)
- Set clear national and local targets and goals (covered in Chapter 4)
- Provide local leadership
- Use existing mechanisms (thus ensuring sustainability)
- Monitor progress to ensure delivery (covered in Chapters 4 - 6)

IMPLEMENTATION OF *RESPECT AND RESPONSIBILITY*

Respect and Responsibility required each Health Board to appoint a Lead Clinician and Lead Commissioner for Sexual Health and each Local Authority to appoint a Lead Director for Sexual Health to ensure that the holistic and partnership approach was present from the start. The Lead Clinicians came from within the specialist sexual health services, but had a remit to provide leadership across Acute and Primary Care services as well as within family planning and genitourinary medicine. It was expected that the Lead Commissioner would have seniority within the Health Board.

Funding of £5 million over three years to be shared according to the established Arbuthnott formula (a method for allocating government funding in Scotland according to local health and social need) across the then 14 Health Boards was announced in March 2004. Importantly the funding was ring-fenced and passed directly to the Health Boards (i.e. the frontline) with instructions to invest locally to achieve the aims of *Respect and Responsibility*. Local autonomy was preserved but a common strategic direction was set. The local champions (Lead Clinicians, NHS Lead Commissioner and Local Authority Directors) knew they would be held accountable for the investment, but had the ability to direct it according to local circumstances. Those Health Boards where services had been developing before or simultaneously with the Strategy were able to boost investment in their successes and fill in gaps in their activities. Sandyford in Greater Glasgow and Clyde was an example of this, as Chapter 8 sets out. Other Health Boards which had no, or little, investment in sexual health were able to develop local Strategies for the first time.

Involvement of local Clinicians in the National Sexual Health Advisory group and its various sub groups ensured that local Strategies stayed true to the aims of the National Strategy and that there was shared learning. Development of the Key Clinical Indicators, as Chapter 4 documents, to monitor implementation of the various strands of the strategy relevant to clinical services and later the QIS standards, described in Chapters 4 and 5, designed to monitor the key activities of these services enabled clinicians to focus on common goals. Very early and on-going involvement of NHS Scotland's Information and Statistics Division (ISD) in devising ways to collect new data

and analyse existing data sets has facilitated the collection of evidence to inform national and local progress with implementation of the Strategy as Chapter 5 details.

The National Annual Reports on *Respect and Responsibility* published in 2006 (Scottish Executive, 2006b) and 2007 (Scottish Government, 2007a) as well as local Health Board Annual Reports, highlight many achievements and innovations. These are far too numerous to describe systematically and all continue to adapt and change to meet the needs of the local populations they serve. Due to *Respect and Responsibility*'s integrated approach, a few examples of good practice come solely from its ring fenced funding but are achieved from partnership work made possible by local enthusiasm using the Strategy's principles and funding as a catalyst. Developments continue, due to embedding of the Strategy within existing organisations and processes. This is illustrated by examples of multi-agency working and developments described below. Examples have been chosen to show the extent and variety of outcomes initiated by local champions but developing due to wide spread ownership and enthusiasm. They demonstrate work to support young people in Lothian; innovative developments in the West of Scotland; a managed clinical network (MCN) for sexual health in Grampian; an enhanced sexual health role for community pharmacists; a national campaign to raise awareness of long acting reversible contraception (LARC), and partnership working in Dumfries and Galloway.

HEALTHY RESPECT – EXAMPLE OF JOINT OF WORKING BETWEEN LOCAL AGENCIES

Healthy Respect was one of four national health demonstration projects outlined in the Government White Paper *Towards a Healthier Scotland* (Scottish Office, 1999). Funded by the Scottish Executive and hosted by NHS Lothian, the aim of the Healthy Respect Project was to create an environment that would lead to long term improvements in the sexual health and wellbeing of young people in specific areas of Lothian – see http://www.healthyrespect.co.uk/. A multi-faceted, evidence-informed approach of linking education, information and services for young people aged 10-18 years was developed. Partnership working with local agencies including both the statutory and voluntary sectors was central to delivery of the project. Some of its key outputs are as follows:

Education: A training and support package of sexual health and relationships education (SRE) included a specific 22 week programme for secondary schools (SHARE) and a Zero Tolerance programme based on Respect in relationships aimed at primary 7 pupils (RESPECT).

Information: This included the development and publication of training manuals for professionals, resources for young people and parents, a website, a branding component and social marketing of key messages:

- A parents' campaign highlighting 'quality family time'
- Increasing knowledge of young people's services and confidentiality
- Respect difference: to raise awareness of the importance and value of respect for self and others in relation to building healthy, respectful relationships

Services: A network of local, easy to access young person friendly services was developed to increase young people's access to services. The 24 'drop-ins' became 'Healthy Respect accredited' by assessment against the 'all I want-LIVE Standards' developed by young people in collaboration with Healthy Respect (Healthy Respect, 2007) to offer quality and consistency across the network. Work was also developed in primary care, pharmacies and within specialists sexual health services.

Healthy Respect is committed to, and dependent on, partnership working to deliver the multi-faceted approach. Close-working facilitates links and communication, empowers those already

working in local areas, and demonstrates good practice. Ultimately the network aims to facilitate a culture change. The partnership network comprises:

- A forum for debating, sharing information and to influence strategies/policies in relation to sexual health
- A targeted Sex and Relationships Support Network for a range of professionals working with 'vulnerable' young people
- A network for multidisciplinary staff delivering young people's drop-ins across Lothian
- A professional network for those working with young people with learning disabilities (commenced March 2009)

Healthy Respect started in 2001 and following both internal and external evaluation, (University of Aberdeen and SPCERH, University of Edinburgh, 2005; NHS Health Scotland *et al*., 2008) core components of the project have now been mainstreamed into the work of NHS Lothian and closely relate to the Respect and Responsibility Delivering Improvements in Sexual Health Outcomes 2008-2011 (Scottish Government, 2008a). The next example refers to work within Glasgow and the West of Scotland to improve access and quality of sexual health services taking a population health approach.

SANDYFORD – EXAMPLE OF JOINT WORKING BETWEEN CLINICAL SPECIALTIES

Sandyford has been operating as a cohesive sexual and reproductive health and counselling service since 2001, serving the geographical area of Greater Glasgow and Clyde and a population of over 1million. It was the first integrated sexual health unit of significant size within the UK, and by focusing on the needs of clients, not the departments or staff, a truly integrated and holistic approach has been developed and maintained. Sandyford is fully discussed in Chapter 8 (and see also http://www.sandyford.org) so this section refers to some of its community activities.

The city centre Sandyford service (known as Sandyford Central) was established prior to the launch of *Respect and Responsibility* but funding and strategic input from the Strategy allowed the establishment of nine small Sandyford units in community settings in Greater Glasgow and Clyde – known as Hubs. These are integrated sexual and reproductive health units operating 3-5 days a week, offering men, women and young people walk-in and appointment services. They provide comprehensive STI and contraceptive services as well as most of the complementary services found at Sandyford Central such as information services and counselling.

There is one Hub per Community Health and Care Partnership CH(C)P. CH(C)Ps are integrated community health, primary care and social work organisations servicing geographical areas of Greater Glasgow and Clyde that provide services for populations ranging from 50,000 to 170,000 individuals. They are part of the Health Board but set local priorities according to local need and after consultation with local people. Each Sandyford Hub is led by a Lead Nurse who is responsible for liaison with other health and local authority services. Each Nurse works with the CH(C)P Management and Clinicians to support the sexual health component of local services by facilitated in-reach, out-reach, training and joint planning.

Examples of initiatives undertaken by Lead Nurses include :

- the incorporation of youth workers, alcohol screening and smoking cessation into Hub youth clinics
- the provision of specialist sexual and reproductive health services to a post-natal depression unit based in a local hospital
- working with addiction teams to provide both outreach services and an enhanced Hub-based clinical service including needle exchange for their registered users.

The Hubs work closely with local teachers, support workers for looked after and accommodated children and an array of voluntary groups. The Hubs are well used by all sectors of the sexually active population including gay men, despite many of the sites having developed from traditional family planning services used predominately by women. Hard to reach groups such as looked after and accommodated young people, those who are homeless or seeking asylum or have learning disabilities may be referred to additional services for other forms of support, and / or attend with their support workers. Developments initiated within Sandyford as part of *Respect and Responsibility* include new local services with pro-active partnership working to support the delivery of sexual health by other clinicians and organisations. This is expected to increase access to sexual health, particularly amongst hard to reach groups, a philosophy which is consistent with the ethos of Sandyford and the aims of *Respect and Responsibility*. In the next example, work within the Grampian region, in the North of Scotland, provides evidence of improving links between services to achieve better outcomes.

GRAMPIAN SEXUAL HEALTH NETWORK – EXAMPLE OF ADDED VALUE ACHIEVED BY LOCAL MANAGED CLINICAL NETWORKS (MCN) IN SEXUAL HEALTH

The Grampian Sexual Health Network was established in July 2008 following previous consultations with heads of service for genitourinary medicine, sexual and reproductive health, and workforce and learning development, and in the light of the production of NHS Grampian's Sexual Health Strategy implementation plan (NHS Grampian, 2007). One of the principal drivers behind any decision to develop a network is to improve patient care. For a sexual health network another principal driver is to work with schools and colleges/universities, the youth service, and particularly with organisations that work with young people. However, and as we know, sexual health pervades all other areas of health and social wellbeing and the Grampian network has been established to develop multi-agency and cross service working around linked risks such as drugs, alcohol, sex and smoking.

The work of the network is being governed by national and local strategies together with standards regarding delivery of care which drive the work plan. Members of the multi-agency Sexual Health Network Project Board contribute to the strategic objectives and work plan with every effort being made to balance aspirations with financial limitations. With sexual health being such a pervading topic, the network is developing links with many healthcare professionals and colleagues working in local authorities and voluntary organisations who are coming across, and tackling sexual health issues within their day-to-day work and particularly in the remoter and rural areas of Grampian.

The work of the network is often broken down into more manageable pieces. There are various sub groups and working groups feeding into the Network Project Board such as a community STI group; a group looking at sexual health and pregnancy and the year after delivery; a training sub group, sexual health implementation groups for Moray, Aberdeenshire and Aberdeen City; an operational and performance group; a communications steering group, and a steering group to address the remote and rural issues for sexual health. The network is still developing, and its impact will be of interest to other parts of Scotland. A range of health professionals and others, as other chapters have discussed, are involved in sexual health work, as the next example of the work of community-based pharmacists indicates.

HEALTH SERVICES DELIVERED BY PHARMACISTS – PARTNERSHIPS BETWEEN HEALTH PROFESSIONALS

Sexual health services in community pharmacies were limited prior to the reclassification of levonorgestrel (emergency hormonal contraception) as Pharmacy medicine in 2001; mainly concentrating on dispensing prescribed contraceptives, the sale of condoms and the provision of advice. The move of levonorgestrel from "Prescription Only Medicine" to Pharmacy medicine provided the first opportunity to provide emergency hormonal contraceptive (EHC) services from

a community pharmacy. Some Health Boards have developed local schemes for provision of EHC using a patient group direction (PGD) but this was not widespread across Scotland and there still remained the issue of access or supplies to young people under 16.

Since the publication of *Respect and Responsibility*, the role of community pharmacy in provision of sexual health services has increased and allowed improved access to young people in a confidential, less threatening environment. Health Boards began to look at more innovative ways of delivering the sexual health strategy and this included the role that community pharmacists could provide in terms of advice, information, referral and signposting as well as free provision of EHC and condoms in order to improve access for all patients. In addition, work has been ongoing in improving premises in terms of installation of consultation areas within the pharmacies which has aided the opportunities to offer services such as these in a private and confidential area. As these services began to embed into normal community pharmacy practice, Health Boards then turned to look at possibilities of addressing STIs and piloting of Chlamydia testing began in different areas in Scotland in conjunction with local Lead Clinicians. This ensured that pharmacy services complemented local specialist services and ensured appropriate testing and treatment protocols were implemented.

In August 2008, the Scottish Government announced the expansion of the community pharmacy contract to include sexual health services. These new national services included the provision of free emergency contraception to all women aged 13 and over and implementation of Chlamydia testing and treatment service; both in line with local arrangements and with the support of the Lead Clinicians. This joint working approach has benefited patients in line with underpinning principles of *Respect and Responsibility*. Community pharmacists are now developing their prescribing roles, and becoming independent prescribers in sexual health remains one of the key areas where they can further contribute to these principles. Progress in public awareness campaigns is the subject of the next part of this chapter, where attempts to increase uptake of long acting reversible contraception is highlighted.

PUBLIC HEALTH AWARENESS CAMPAIGN – EXAMPLE OF JOINT WORKING BETWEEN HEALTH IMPROVEMENT, CLINICIANS AND THE COMMERCIAL SECTOR

For some years, the effectiveness of longer-lasting contraception has been well evidenced and more recently in the NICE guidance published in 2005 (NICE and the National Collaborating Centre for Women's and Children's Health, 2005). But less than one in four women in Scotland are using longer lasting contraception methods and whilst the rates of unintended pregnancies in under 16 year olds is falling, the number of repeat terminations in women aged 16-30 are rising. In anticipation of the implementation of the first set of Scottish sexual health standards promoted by NHS Quality Improvement Scotland, in early 2007 with support from Organon (now Schering Plough and soon to be Merck), the Raising Awareness Group (RAGS), in Scotland commissioned research with young women on their views on contraception and how best messages around contraception could best be delivered (NHS Health Scotland, 2009b; Glasier *et al*., 2008).

This work set out a clear direction of travel but there was no national avenue at that point to develop this further. However, with the Scottish Government's refocused *Respect and Responsibility* outcomes of improving a) access to services and b) public knowledge and awareness of effective interventions and contraception added to the Quality Outcomes Framework for GPs, NHS Health Scotland was asked to take forward a social marketing campaign to promote longer-lasting contraception and through this, open up contraceptive choices for women. Building on the earlier RAGS work and drawing on the expertise of clinical leads, health improvement staff and fpa, further qualitative research with women and health professionals led to the development of a Scotland-wide campaign, *Giving You More Choice*, launched in July 2009 (NHS Health Scotland, 2009c), with the main poster below.

Aimed at encouraging women aged 18 to 44 years to explore their contraceptive options when next visiting their GP or family planning services, this campaign has its own look and feel and is supported by an information leaflet (translated in nine core languages), posters and other publicity materials in women's retail outlets, viral links from social networking sites to the national sexual health website – http://www.sexualhealthscotland.co.uk Work is now underway to develop this campaign further including exploring how the pharmaceutical industry can again jointly collaborate with key stakeholders in Scotland on this work. Returning again to young people, the next example sets out work in a rural part of Scotland to increase service access and reduce barriers.

DUMFRIES AND GALLOWAY: JOINT WORKING BETWEEN AGENCIES IN A RURAL SETTING

Dumfries and Galloway is a rural area in South West Scotland. The sexual health work with young people consists of:

- C2U drop-ins in most towns with a secondary school
- C4U condom card scheme region wide
- School nurse drop-ins in every secondary school
- Outreach to hard to reach groups with designated departmental link worker e.g. looked after children, learning disabilities etc
- Condom and postal testing kit provision to hard to reach and other groups
- Multi-agency Sexual health training for staff (NHS and non NHS)
- Annual 'Let's talk about sex' sexual health week
- Sexual health services provided by community pharmacies

Across the region there is a network of C2U's for people under 20, staffed by school nurses who are trained in sexual and reproductive health. They offer a range of services including counselling,

advice and information on diet and exercise, alcohol consumption, menstrual problems, relationships, contraception, pregnancy testing, emergency contraception, free condoms, referrals to specialists in all aspects of sexual health, sexuality and body image. C2U's are held in non health settings mostly youth or community centres and are open either over lunchtime or after school. School nurses hold a health drop in their designated secondary school. These offer young people sexual health information, advice, signposting, Chlamydia and pregnancy testing, and C4U cards

The C4U scheme (for under 20s) is more than the distribution of condoms. It involves NHS, statutory and voluntary staff, trained in child protection, exploring the values and principles of sexual health, sexual health behaviour and updated in contraception and sexually transmitted infections. Time is spent with young people, who sign up to the scheme, and this provides an opportunity to explore relationship issues as well as increasing young people's knowledge on sexual health issues. Although the school nurses and sexual health service staff have a pivotal role in the youth services in Dumfries and Galloway, partnership working and consultation with young people contributes more widely to the success and integration of this work. Full information about all the sexual health services in NHS Dumfries and Galloway is available at http://www.nhsdg.scot.nhs.uk/dumfries/10649.html

LEADERSHIP AND SEXUAL HEALTH – AND LOOKING TO THE FUTURE

Respect and Responsibility is achieving its aims through strong national and local leadership. A unity of purpose between local champions and Scottish Government has been an essential ingredient of success. This has been achieved by mutual respect and dialogue. The Government recognition of the need for local clinical and non-clinical champions was a starting point. The willingness of specialist clinicians to listen and work with, and value the input of other professionals has also been essential. This comes from an understanding that sexual health outcomes designed for Scotland will not be achieved by clinical services alone, but that clinical services are an essential component.

Good intentions about working together would never have been enough. A mechanism had to be found whereby local leaders (Health Boards) retained their autonomy but worked together on issues where a national approach was beneficial. The Lead Clinicians group was established in 2005. Representatives from Scottish Government and NHS Health Scotland meet with the Lead Clinicians for each Health Board four times a year. The Lead Clinicians share knowledge and experience as well as raising areas of policy they wish to progress. Wherever possible, consensus is agreed and clearly communicated to the Scottish Government and other services, maintaining an active influence on policy direction. The Scottish Government benefits from direct contact with clinicians delivering the services and is able to discuss policy prior to its formation, as well as having a route to ensure implementation is rapid and consistent. It is hoped, for example, that the Lead Clinicians will ensure that the implementation of policies around sex and alcohol, as well as gender-based violence, are implemented in an effective manner which reaches the frontline clinical services.

The principles by which *Respect and Responsibility* are being implemented need to be sustained to ensure the longer term goals are achieved and service improvement sustained. Continual development of co-operative working and partnership will keep the Strategy fresh and robust. The future looks bright if the appetite for change and development amongst clinicians is as great as ever and if government, and hopefully ministerial, interest is maintained. Plans are advanced for the greater involvement of local professionals at a national level, with the establishment of groups of Lead Nurses and Lead Health Improvement experts. A national information strategy and website has recently been launched as Chapter 3 explained, and work has commenced on a national identity for clinical services.

CONCLUSION

Strategies only work if ownership is taken by those who must deliver and if they are given substantial high level political and organisational backing. *Respect and Responsibility* has made a good start in improving sexual health services within Scotland by using a model that promotes local diversity within a central performance management framework. The key elements have been local and national leadership with robust links and respect between all parties. It is acknowledged however, there is still a long way to go before establishing universal excellent practice, as well as achieving positive impact on culture and education. The size and structure of the population and of health services may limit transferability of the Scottish model to other settings. However consideration of adopting the model for other countries, maybe beneficial as it has helped to produce measurable improvements in Scotland, despite the historical challenges of Scottish history and culture.

Sexual health is not an easy subject. In contrast to cardiovascular health for example, among the general public (including faith groups) everyone has a view, and often these views are extreme and incompatible. The media grasps every opportunity for shocking headlines and often undermines attempts at widening access to services particularly to young people. The government has to be courageous if they are to adopt sensible approaches to improving the sexual health of the population. Time will tell if sustained efforts being made in Scotland have achieved their ambitious aims of sexual health and wellbeing, but in the meantime, there is a sense of optimism and energy within those responsible for sexual health services.

CHAPTER 8

The Story of Sandyford – Developing Accessible Sexual Health Services in the West of Scotland

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Abstract: The second chapter in the section covering contemporary sexual health services focuses on the largest sexual health service in Scotland, the Sandyford Initiative in Greater Glasgow and Clyde. This service pre-empted the first national sexual health strategy for Scotland in its integration of family planning and genitourinary medicine in 2000, and the chapter details the local conditions that led to this development, much of which are linked to previous multi-agency working concerning inequalities and health.

Written by one of the founders of the Initiative (also one of the book's editors) the chapter reviews thinking that informed the merger between family planning, GUM and a women's health service in Glasgow. It describes how integrating understandings of health and social inequalities into the planning and delivery of the service was seen as critical, and employed as a vision in bringing staff together to form one cohesive unit.

Drawing on internal documents and early evaluations of the views of staff and service users at the start of the service, along with a summary of activity and outcomes since then, the chapter sets out to discover how successful Sandyford has been in embedding an inequalities sensitive approach since its opening. It concludes that organisational culture has a high level of understanding about inequalities, and the service has reached a wider range of service users than before integration, yet the current economic climate may prove increasingly challenging in ensuring that the ethos continues to remain central.

INTRODUCTION

This chapter will describe changes to the delivery of sexual health services in the Greater Glasgow and Clyde area of the West of Scotland through the inception of the Sandyford Initiative from previously separate services in 2000. This large region of Scotland has urban and rural aspects and covers a population of approximately 1.1 million, many of whom experience health and social inequalities. The chapter will highlight management and organisational changes, planning and consultation processes, and community and staff engagement. Its main purpose is to consider whether, nearly ten years on, Sandyford's stated aims to embody a social model of health care have been met, and how successful the integration of services, in what was effectively a merger, has been. The term 'social model of health' means that wider social, economic and cultural determinants are considered when understanding and responding to people's health and wider population health. These factors include faith and belief systems, socio-economic status, housing, education opportunities as well as the environmental, political and socio-economic conditions in which people live. Social and community networks also have an impact on health, as do personal experiences of age, disability, gender, race and sexual orientation.

Sandyford is the largest integrated sexual health service in Scotland, (www.sandyford.org) and although its development and activity is of interest, some of the experiences described are particular to these circumstances. Other sexual health developments in Scotland and the rest of the UK have trajectories and histories that differ from those that are described here. A number of chapters in this collection, including Chapters 7 and 10, provide information about such developments in other areas of Scotland.

GLASGOW AND WEST OF SCOTLAND SERVICES BEFORE SANDYFORD

The word 'integration' comes from Latin, meaning 'to complete', and a sense of coming together to create a whole that is greater than the sum of its parts. From both a patient and health service perspective, the less services and systems are integrated, the more fragmented the patient journey, the more complex the administration for clinicians and managers, the less cost efficient is the system, with its ability to be person-centred and holistic extremely compromised. For Kodner and

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Spreeuwenberg, 'integration may be seen as a step in the process of health systems and health care delivery becoming more complete and comprehensive' (Kodner and Spreeuwenberg, 2002).

Prior to the development of Sandyford, the shortcomings of having separate reproductive and sexual health services were apparent. The services that came together were in different physical, organisational and structural spaces. They were subject to the historical lack of funding for sexual and reproductive health care as Chapters 1 and 7 mention; the lack of a national policy framework in Scotland (although as Chapters 2 and 7 discuss, this was in development), and societal views of sex and reproduction (and gender and sexual orientation, and other aspects of equality and diversity) were significantly different from now. Health service organisation in Scotland, with NHS Health Boards as the main commissioning agency, was also different, as Glasgow and the West of Scotland fell within two Boards – NHS Glasgow and NHS Argyll and Clyde. This changed in 2006 when Clyde integrated with Glasgow, and Argyll with NHS Highland, after the Argyll and Clyde Board disbanded.

At the start of the 1990s, within Glasgow, reproductive health services were available at the main family planning centre in a Victorian town-house in the West End of Glasgow; in part-time well woman and family planning clinics in health centres in deprived neighbourhoods (Craddock and Reid, 1993; Wilson, 2004) and via general practitioners (GPs). Genitourinary medicine (GUM) options were part-time clinics at the Glasgow Royal Infirmary, east of Glasgow's city centre, or the Southern General Hospital a few miles out. There were no GUM community based sites, and people had limited access to drop-in or self-referral services. Within the Clyde area, reproductive health services were available in the Russell Institute in the centre of Paisley, supported by a range of part-time well woman services in health centres in local com-munities. Inverclyde Hospital had a long standing GUM service that attracted clients from a wide area, but there were no other community based services. Although Sandyford developed before the major changes to Health Board geographies, some GUM consolidation had occurred, as Glasgow-based GUM clinicians recommended the closure of the Southern site in 1999 with a move of all services to the Glasgow Royal. After the Southern General service shut in 1999, additional GUM sites developed at the Royal Alexander Hospital in Paisley and in the Russell Institute in Paisley town centre to support clients in that area who had previously accessed the Southern.

RESPONDING TO CLIENT NEED

Despite this fragmentation, thinking from the women's health movement and from gay men had improved accessibility for some groups. As Chapters 2, 7 and 9 describes, health improvement approaches incorporating these understandings have been positively applied to sexual and reproductive health in various places, and Glasgow has been no exception. For example in the 1980s, the Family Planning Directorate opened a drop-in service for women involved in prostitution jointly with Glasgow City Council, Base 75, (Carr *et al*., 1996) as well as open access services for young people, and clinics for disabled women. Genitourinary Medicine had developed a service for men who have sex with men, the Steve Retson Project (SRP), in collaboration with local gay men who challenged GUM services as not only inadequate but further stigmatising their users. Like other gay men's sexual health services in the UK that developed in response to HIV and AIDS in the 1980s, SRP was non-judgemental and did not embody negative values about sexual behaviours (Knussen *et al*., 2008; Nandwani, 2005).

Glasgow had other services that aimed to address the wider social context of health and much of this had been generated through systematic attempts towards service improvement in public health. From the late 1980s onward, Greater Glasgow Health Board (as was then called) had established a strategic health improvement unit to encourage and support change concerning health inequalities across the local NHS system with women's health as the starting point (Laughlin, 1998a). The Health Board's Women's Health Team was instrumental in advocating for an innovative centre that later became part of the Sandyford story as, in 1995, after years of planning, and funded by Greater Glasgow Health Board, Strathclyde Regional Council and Glasgow City Council, the Centre for Women's Health opened to offer new thinking about women's health for planners and practitioners and to provide a range of services that recognised the impact of gender inequality on women's life experience and health. This service, under the

Glasgow Healthy City umbrella [i], was based on the top floor of the Eye Infirmary site in the city centre, with the opthamology services underneath. The Centre, although within the NHS, was effectively a stand-alone unit, but had established some joint initiatives with family planning and GUM including Scotland's first sexual health service for lesbians (Carr *et al*., 1999) combining two of the Centre's priorities – women's experience of reproductive health services and the recognition that the needs of women were not homogenous.

IMAGINING A NEW MODEL AND EMBEDDING PUBLIC HEALTH PRINCIPLES

As discussed, Glasgow sexual and reproductive health services had undergone some service modernisation, were within a local environment that prioritised health improvement, alongside policy-making through the devolved Scottish Government that required the NHS to address health inequalities more systematically within a wider public health model. Public health strategies use a range of interventions and approaches to tackle complex population health issues and inequalities, with health improvement as part of that (Griffiths *et al*., 2005). Sandyford was created with an intention to improve client outcomes and reduce the inevitable fragmentation of separate services through adopting this approach.

In the mid 1990s senior officers and clinicians from Greater Glasgow Health Board, led by the Women's Health Team and supported by colleagues in Glasgow City Council began to develop a proposal to bring together various women-centred services within a one-stop shop. This embedded aspirations of the Glasgow's Women's Health Policy (Laughlin, 1998b) that statutory services should be more gender-sensitive and understand the impact of gender inequality on women's health - and family planning, breast screening and the Centre for Women's Health (CWH) were initially seen as possible partners. However, in February 1998 family planning and GUM services proposed to the Health Board to move into the Eye Infirmary, supported by CWH, and provide services together (Family Planning Directorate and GUM Directorate, 1998).

It was known that the whole Eye Infirmary site in Sandyford Place, at the end of Sauchiehall Street, one of Glasgow's main city streets, would be available as the opthamology service (below CWH) was moving. This proposal was also motivated by the belief that convergence and co-location brought major opportunities, as more services could be offered for clients, resources and management could be shared, and there could be enhanced collective effort in addressing local strategies such as the Glasgow Women's Health Policy and the Glasgow Sexual Health Strategy. This latter strategy produced in 1997 was one of the first emerging in Scotland, before the later requirement through the national sexual health strategy for local plans, as Chapters 2, 4 and 7 comment. From then on Family Planning, Genitourinary Medicine and the Centre for Women's Health began a process of internal discussion and user consultation.

In June 1998 the Health Board described their vision for what was already named the 'Sandyford Initiative'. Although there were later staff consultations on the right name for this venture, this suggestion stuck, chiming with other evidence that 'non-descriptive titles' work best for clients using integrated sexual health services (Sonnex, 1995). There were clear expectations that the development was not just an expansion or a merger, but could realise national and local public health intentions, and 'implement a city-wide initiative to enhance the promotion of health and the quality of health care using a social model of health'. (Laughlin, 1998b) This was reinforced by the Sandyford Planning Group, involving staff across disciplines and services, that confirmed that Sandyford should incorporate a social model of health, be gender sensitive, accessible, participatory, devolved and bring added value and the Planning Group should 'identify standards and markers which translate the general ethos of the Sandyford Initiative into practice' (Sandyford Planning Group, 1998). This explicit notion – to embody a social model of health – was both the vision and the flag around which staff could gather, and set the tone for expected outcomes.

Open meetings, events and consultations were held with staff from the services throughout this period to inform the proposals and to help create a unified culture. Various studies and evaluations

[i] Glasgow has had 'Healthy City' status for a number of years, as part of a WHO: Europe programme that has led to various partnership developments since the late 1980s.

were commissioned by the Health Board to chart the impact of the development on the services and staff, as well as on existing, and potential, clients, and all had similar findings concerning staff attitudes before integration (Kinn, 2002; Lawson *et al*., 2002; Scott *et al*., 2000). Although many saw opportunities for service improvement, reducing stigma in using sexual and reproductive health services, and developing closer links between clinical and non-clinical services, in other words to achieve the benefits of health service mergers and integrations that Kodner and Spreeuwenberg describe, there were some reservations. Advantages of the social model in realising equity and encouraging diversity were recognised, but there were conflicting views that bringing clients together might disenfranchise firstly, women, who had previously used women-focused family planning services and the CWH and who may not attend, and secondly men, who had been previously more identified with GUM, may feel less anonymous with more women around. There were also views that more resources were needed to fully realise the integration, that extensive role changes for staff might be needed and that the identities and cultures of separate services could be lost.

However, this needs to be seen in context. At that point there were few integrated services locally or nationally, there was no sexual health strategy in Scotland (or in the UK), there had already been much innovative development within the services, as well as ongoing changes to NHS structures that had affected operational and governance systems. A large UK survey of the perceptions of GUM, family planning and sexual health staff of service integration undertaken at the time had similar findings - staff were positive, especially regarding anticipated client outcomes, but concerns around professional status, career development and skills were evident and, as the authors comment, such reservations need to be anticipated and accounted for when planning integrated sexual health services (Kane and Wellings, 1999).

INTEGRATING THE SOCIAL MODEL

A new organisation needs a vision and a 'framework of social, cultural, technical, economic and political conditions that will help them achieve that vision' (Mitleton-Kelly, 2004), and from the end of 1998 until the opening in 2000, significant work took place to realise the vision. Staff working groups - including Administration, Services, Outreach and Promotion, and Social Model of Health and Concepts - informed plans for the refurbished building and the design of shared areas including reception, library and crèche, as well as thinking on staffing arrangements, operational and governance issues, and service delivery and development.

It is important to consider the physical nature of the space that Sandyford occupied, that was designed to provide modern, light and accessible surroundings for all those attending the services, very different from the environments that clients of family planning and genitourinary medicine particularly, had accessed before. Openness combined with confidentiality was the underpinning principle and there was much user and staff involvement in the architecture and designs that developed, albeit constrained to some extent by the fact that the physical space was within a listed building. As Gillespie commented, in a fascinating article about architecture and power in healthcare settings, family planning services per se have been liberalised over time, yet may not have always considered issues of space and meaning:

> *Despite the increasing liberalisation of sexuality associated with time, and the greater accessibility of contraceptive services, buildings for the provision of these services may be seen to represent a metaphor for a backlash against the sexual liberation of the 1960s.*
>
> (Gillespie, 2002, p. 214).

In her study of the impact of physical space on a family planning service in England at the time that Sandyford was beginning, she suggests that unequal power relations and reinforcements of social norms will continue if so little thought is given to the buildings in which such sensitive and personal matters are addressed. She goes on to suggest that family planning clinics are not the only sites where such issues are paramount, and 'where architecture and spatial organisation may impact upon social relations in ways that discipline and control' (ibid, p. 218) and departments of

geni-tourinary medicine in hospital settings are also likely to embed messages of judgement through the materiality of their structures, as Chapter 4 also indicates. Clearly those involved in developing Sandyford were aware of these issues and set out to negate them through the way that space and its meaning was considered.

These activities both symbolised, and tested, partnership and integration. Community consultations had indicated that publicity about the Initiative and its services, easy access, and developing community outreach were crucial, and staff wanted to realise these wishes (Sandyford Initiative, 1999a). Continuing strategic thinking within the local Health Board was also embedding broadened understandings of the links between gender and health within the NHS, and supporting improved responses to issues such as domestic violence and abuse, and the need for Sandyford to encompass that perspective was also paramount.

However, resourcing was finite, and as well as efficiencies through convergence, there was an expectation that other income streams could add value and further developments. For example, partnership working took place to propose as a Healthy Living Centre - 'not to provide or top-up existing clinical and other health services . . . but to resource the 'added value' part, to maximise its impact on Glasgow's health' (Ilett, 1998). Local partners, including Body Positive, Meridien, Rape Crisis and PHACE West, represented many of the user groups viewed as experiencing less access to services and critical in sexual health terms – namely people affected by HIV and AIDS, black and ethnic minority women, women experiencing gender-based violence, and men who have sex with men. Although the bid did not progress because of lack of eligibility, the process of operationalising the integration and having the social model as a central focus was productive in reinforcing purpose, partnership working and client outcomes.

COUNTDOWN TO 2000 AND OPENING OF SANDYFORD

By the time Sandyford opened in one site in 2000, there had been extensive planning, and adaptation to changing structures. In April 1999, in response to a Government White Paper (Scottish Office, 1997) an NHS Primary Care Trust (PCT) was established in Glasgow that brought the three separate services that comprised Sandyford under the same corporate management, and proposals for working relationships and governance developed over the next few months. In summer 2000, Sandyford opened services to the public with existing management arrangements. Shared information technology (IT) and client referral processes were being planned, but staff and stakeholder consultations had indicated that establishing the services in one site to encourage client access and to allow staff to work collaboratively was the first step. The new PCT proposed that shared management continued for the first stages of the development, with service heads maintaining old roles and sharing new tasks, with consultation to develop a new clinical directorate with appropriate management to later occur (Carron, 2000). A Sandyford Advisory Group, representing stakeholders and client groups, would provide links to primary and secondary services, voluntary agencies, geographical communities and communities of interest (Ilett, 2000) and was later set up. The new management team, with input from staff from the Health Board's Women's Health Team, presented the values of the Initiative at the time of opening - see below.

Box 3: Sandyford original values (Sandyford Initiative, 2000).

The aim of the Sandyford Initiative is to develop a system of health care, which promotes reproductive and women's health, which embodies an agreed set of principles:

A social model of health, in which the determinants of health are recognised and taken in to account, will be applied

The Initiative will be co-ordinated and effective in both its clinical and non-clinical work

Consultation with current and potential service users will form an ongoing part of the work to ensure equity and access in the delivery of service

The Initiative will recognise and actively address the various needs of different groups within the population

The initiative will be gender sensitive and anti-discriminatory in its practice

Services will take the needs of individuals into account in their delivery

DELIVERING HEALTH IMPROVEMENT, MEETING CLIENT NEEDS AND INFLUENCING CHANGE – NEARLY A DECADE ON

To test out the original aspirations of Sandyford against current activity and that which was the subject of external evaluation and assessment during the period between 2000 and 2002, reference will be made to each statement in turn and evidence presented. As a number of activities and processes could fall within more than one section, these are illustrations, rather than concrete allocations.

1. A SOCIAL MODEL OF HEALTH, IN WHICH THE DETERMINANTS OF HEALTH ARE RECOGNISED AND TAKEN IN TO ACCOUNT, WILL BE APPLIED

Progress by 2002:

The opportunity offered by the convergence began to be realised through the integration of organisational and administrative systems after Sandyford's opening. The need to make the service as accessible and barrier-free as possible meant that previously separate medical records needed to merge – initially in paper and later in electronic form (see Chapter 6 for the extensive progress across Scotland since then). This gave a focus to expand the opportunities provided by the new service, and clinical staff from family planning and GUM backgrounds, health improvement specialists and managers, worked together to develop an integrated social health assessment tool – the Sandyford Health Screen – that could be offered to clients that accessed any part of the clinical service (Bigrigg *et al*., 2005).

This tool asked clients questions about their experience of drugs and alcohol, of sexual and physical violence, about buying or selling sex and other health aspects like eating and smoking, along with sexual history and health issues as might be expected. This important milestone shifted the service away from clinical diagnosis and treatment as the first entry point, recognised the wider determinants of health, and also identified those who may benefit from other Sandyford services such as counselling and emotional support. It also evidenced unmet need and helped the development of new services. For example, in the first year of the Health Screen, a significant number of men who had been sexually abused as children disclosed for the first time to a health professional when using Sandyford. Although childhood sexual abuse of men and its detrimental impact was known within family planning and GUM, the needs of male survivors had not been systematically met, and this data led directly to the successful funding of a counselling and befriending service in Sandyford for male survivors - Thrive (*Daily Record*, 2005; Haslam, 2006).

Thus, the health screen helped to support disclosed client need as part of an aim to mainstream understandings of the impact of inequalities, and to help inform future service creation. Beside this, targeted services for specific client groups such as men who have sex with men, and women involved in prostitution, continued. To deliver this, Sandyford job descriptions required all staff to understand the delivery of a social model as the environmental context in which they worked, and a multi-disciplinary training programme to support that began, alongside clinical training on a weekly basis that brought together staff from throughout the organisation, and contained a high level of input about inequalities and diversity – often offered by specialist voluntary organisations.

Progress by 2009:

The Sandyford Health Screen has had positive outcomes in the service and more widely. Along with similar tools developed within Addictions and Maternity services, the Screen influenced the adoption across NHS Scotland of various methods of routine enquiry that focus on inequalities sensitive practice and appropriate responses. The suitability of the screen for asking sensitive

questions in sexual health settings was also applied in The Place, the young people's service run Sandyford where a scheme to discuss problem drinking through systemic questions was successfully introduced (Keogh *et al*., 2008). The questions that formed the original screen are also now embedded within the NaSH client management system that Chapter 6 describes, and allow rich information to be gathered about the experiences and needs of clients accessing sexual health services across Scotland concerning a range of health and social issues. Evidence is already emerging from Sandyford of the continued comfort that clients have in disclosing highly sensitive issues in this setting through the information that is being revealed as below:

Box 4: Examples of Information identified by routine enquiry between April - Sept 2009

- Nearly 2000 of under 16 attendees regularly drink alcohol, of which 25% exceed recommended adult units
- 91 cases of Gender Based Violence were identified
- 18% of male attendees had sex with men
- 302 number of clients identified as homeless
- 290 cases of Intravenous Drug Use were identified
- 373 individuals reported receiving payment for sex

At the time of writing, targeted services are still offered for groups experiencing the consequences of inequality – such as men who have sex with men, and women involved in prostitution – but the tendency has been to ensure that all services are accessible and inclusive, and to reduce the number of 'ring-fenced' services. This has also been linked to enhanced joint working with services like homelessness and addictions, and as Chapter 7 noted, there have been some new developments in this area to reach people who may not access sexual health services.

As commented earlier, and as Chapters 7, 9 and 10 also suggest, before the integration of family planning-focused and GUM services, many staff had little experience of working with a wide range of users, and fears and knowledge gaps existed amongst staff in Sandyford about client needs that they felt ill-prepared for. The early training has developed and systematic training for all staff in the social model and health inequalities has been developed, supported by the Health Board's Corporate Inequalities Team (that emerged from the Women's Health Team, mentioned previously) and sexual health improvement staff (Ilett, 2008). This has helped to shift organisational culture towards mainstreaming approaches and for all staff to understand the importance within their work and to feel confident in their role.

2. THE INITIATIVE WILL BE CO-ORDINATED AND EFFECTIVE IN BOTH ITS CLINICAL AND NON-CLINICAL WORK

Progress by 2002

Sandyford overall management roles and functions were not fully integrated until 2001, and separate operational and administrative systems continued in many parts of the service at this stage, although with plans for integration. Clinical staff, although linking together through training and partnership working, maintained their original focus most of the time, whilst plans developed for bringing teams together over time. As Chapter 10 describes, this is a complex process, and required sensitive handling, with the aim to support change through continuing to develop a shared identity and client focus.

Progress by 2009

Nearly a decade on, a single management and integrated operational system exists with staff working as one team. Over time, staff departures and new starts mean that many staff now have no previous experience of working in the separate services, and consequently identify with Sandyford. This has been aided by the creation in 2006 of a Sandyford 'brand' that extended the generic name across all the community sites that are part of the service, so each is prefixed by

Sandyford. Clients and staff can therefore refer to Sandyford as a catch-all term, which provides anonymity for clients about the services they might be using, and a shared identity for staff. It also recognises that clinical staff, as well as administrative and management, work across all services, not to only one section.

3. CONSULTATION WITH CURRENT AND POTENTIAL SERVICE USERS WILL FORM AN ON GOING PART OF THE WORK TO ENSURE EQUITY AND ACCESS IN THE DELIVERY OF SERVICE

Progress by 2002

Many of the intentions expressed in the Healthy Living Centre bid mentioned were progressed early in the development. A full time Community Access Co-ordinator post was created, to involve service users and the public in the development of the service, and to ensure that opportunities were there for genuine partnership. This led to some important developments, including the set up of a scheme of lay health guides in the reception area of the main site. Here, members of a local Asian women's group, with a longstanding link to the Centre for Women's Health, undertook a training programme on sexual health, led by Sandyford and health improvement staff, to provide them with the knowledge to support Asian people using the service, as well as to break down barriers in the local community and publicise sexual health. The Community Access Worker also began to establish a range of user feedback schemes and approaches, including open days, feedback boards and satisfaction surveys. The position of the Sandyford Library and Information service in the main Sandyford site, its function as a public library and part of the Glasgow City Council system, brought many people into Sandyford from the start who wished to use facilities, such as the Internet (funded by the Council), rather than clinical services.

Progress by 2009

This engagement with the sexual health setting by members of the public has proved important over time in continuing to break down stigma and to raise awareness, and the continuation of the Community Access Co-ordinator post has been important in maintaining this approach. Over recent years, there has been a need to mainstream this approach more widely, as the service has grown, and many more staff now carry out user evaluations and other means of ongoing client involvement across all parts of the service. Volunteers continue to play a role in the delivery of Sandyford, and to take part in innovative activity, with an interesting example being the successful Transgender support group in Sandyford. This group emerged from what had previously been a clinically-oriented 'gender dysphoria' service in Sandyford, that combined with a growing counselling and support component, began to provide space for transgender clients to meet together and to share experiences about service access and equality issues. The group, supported by the Community Access Co-ordinator, is led by volunteers who are transgender themselves, and has achieved much in influencing national and local policy and service planning.

4. THE INITIATIVE WILL RECOGNISE AND ACTIVELY ADDRESS THE VARIOUS NEEDS OF DIFFERENT GROUPS WITHIN THE POPULATION

Progress by 2002

As stated, the ambition from the start was to deliver a service that was generic in its application of understandings about the impact of inequality and discrimination, but that was sensitive to individual need. Targeted services – like SRP and Sappho, the service for lesbians and bisexual women (Carr *et al*., 1999) – offered safe space but with the overall aim to widen accessibility of all services to all population groups.

The variable experience across staff of dealing with all population groups was being addressed through training and working across different clinical areas, but there was knowledge that services were not available equally across the community.

Some of the early staff consultation stated that more time was needed for full service integration and for other aspects of the social model to be realised (Kinn *et al*., 2003). This was recognised,

and integrating family planning, GUM and CWH services in communities was seen as essential, as stated in a staff newsletter during the time of the integration, 'one possibility is a pilot clinic whereby a nurse for Genitourinary Medicine works alongside staff in a Well Woman Clinic setting, it is recognised that this might not be the ideal point of access for men and health needs assessment as to their preference is planned' (Sandyford Initiative, 1999b).

Progress by 2009

As highlighted in Chapter 7, developing integrated community services, later termed Sandyford Phase 2, was not fully realised across the whole of the geographical area covered by Sandyford until 2009, nearly a decade after the Initiative first opened. There are now mini-Sandyfords – known as Hubs - in all parts of NHS Greater Glasgow and Clyde that offer STI testing and treatment, contraception, community gynaecology, counselling and health information in a wide range of health settings, typically located in areas of high social deprivation, providing easy access to people in their own communities, Some of these services evolved through the integration of part of the geography, services and staff of NHS Argyll and Clyde, as mentioned earlier, into Sandyford in 2006. This had huge repercussions in terms of ensuring a consistent delivery ethos and model, absorbing staff and organisational restructuring, and ensuring that the Sandyford service was appropriate to the needs of the expanded population. However, once established, the services have been successful. The information following demonstrates their ability in ensuring that interventions are readily available where needed. Table 6 and Figures 10 and 11 show data from the first six months of 2009 on the insertion and removal within Sandyford of long acting reversible contraceptive (LARC) implants by deprivation quintile.

Table 6: Data from the first six months of 2009 on the insertion and removal within Sandyford of long acting reversible contraceptive (LARC) implants by deprivation quintile, by number of procedures and number of individuals, Sandyford (2009).

Key: 1 = least deprived; 5 = most deprived.

		Implant Insertion	Implant Removal & insertion	Total
5	**Procedures**	923	310	1233
	Individuals	884	287	1169
4	**Procedures**	298	84	382
	Individuals	288	83	371
3	**Procedures**	195	61	256
	Individuals	187	59	246
2	**Procedures**	146	41	187
	Individuals	141	37	178
1	**Procedures**	119	26	145
	Individuals	118	24	142
N/A	**Procedures**	223	67	290
	Individuals	216	58	274
Total	**Procedures**	1904	589	2493
	Individuals	1834	548	2382

Sandyford has also continued to be seen as an example for other services in delivering innovative client-centred work within a public health construct, and has worked closely with NHS Greater Glasgow and Clyde, particularly the Corporate Inequalities Team, in influencing thinking about addressing and investing in inequalities. Decisions have been made to site innovative new services, such as the Archway for those who have been recently raped or sexually assaulted, that Chapter 9 describes, within Sandyford, in acknowledgement of its experience in supporting this client group through its sexual health clinics and its ability to provide clinical expertise within a gender-sensitive context.

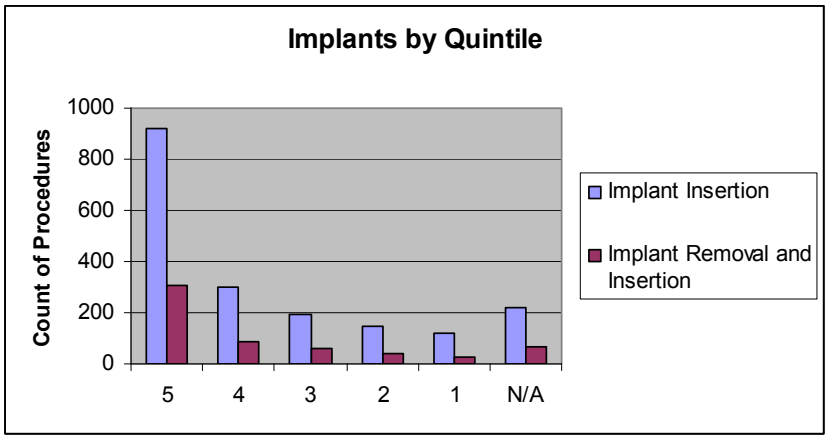

Figure 10: Insertion and removal within Sandyford in the first six months of 2009 of long acting reversible contraceptive (LARC) implants by number of procedures and deprivation quintile (key as above)

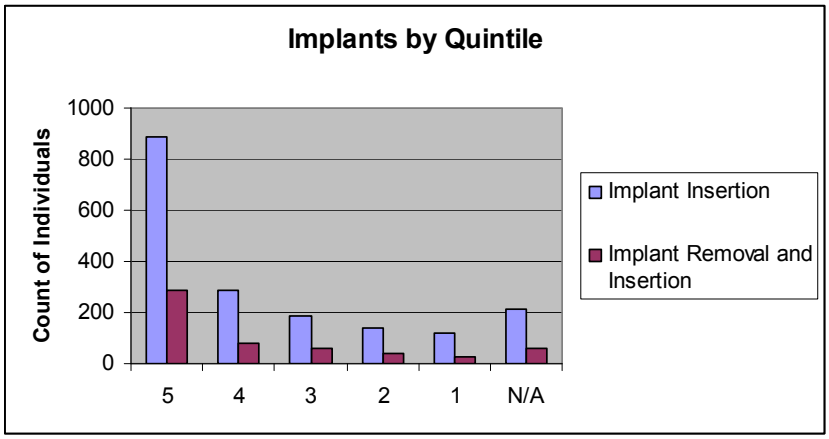

Figure 11: Insertion and removal within Sandyford in the first six months of 2009 of long acting reversible contraceptive (LARC) implants by number of individuals and deprivation quintile (key as above)

5. THE INITIATIVE WILL BE GENDER SENSITIVE & ANTI-DISCRIMINATORY IN ITS PRACTICE

Progress by 2002

As discussed, there were initial fears from staff that the mixed environment in shared areas of Sandyford, and its overall size, would disadvantage some service users who had been familiar with previous single-sex environments in all the services that formed the Initiative, and reduce anonymity. However, after the Initiative's opening, Kinn found reduced stigma in those attending sexual health services, no reduction in the number of men attending as some staff had feared, increased satisfaction with the new service and facilities offered in the refurbished building, and increased numbers of referrals between services (Kinn *et al*., 2003). Lawson *et al.* had similar findings, with interestingly GUM clients commenting that having separate male and female waiting areas in the new building (that had never been possible in previous sites) was an important factor in privacy, and 'an acknowledgment to the sensitivity of the GUM staff towards individuals who use the service' (Lawson *et al*., 2002).

Besides recognising the need for separate spaces, the new Sandyford also sought to integrate understandings of the impact of gender into its planning and delivery, and especially in the way that staff conceptualised how the different experiences of women and men affected their health.

This was undertaken through the training and education programme as discussed, as well as through the use of tools such as the Sandyford Health Screen. Having the Centre for Women's Health as one of the Sandyford partners also brought expertise on gender and health issues into the overall system, as did work with the Health Board's Women's Health team, and Sandyford's membership of a number of multi-agency women's health networks.

Progress by 2009

Since the inception of Sandyford, wider legal and social reforms have occurred in the UK[ii] that have given additional focus to many of the understandings developing within Sandyford, as well as across the wider NHS system, about gender and other factors. This has required Sandyford, and other parts of the NHS in the UK, to produce Equality Plans that embed thinking about the needs of all population groups – including disability, gender, race, sexual orientation – within service planning and delivery. Although this process is still in its early stages, it has heightened awareness within Sandyford, as in other sexual health settings, about the need to consider all user groups, and has led in this context to new pieces of work taking place, such as an audit of the experiences of LGBT users and staff in accessing and working at Sandyford respectively, and in considering the wider equality aspects of the termination services that Sandyford offers.

6. SERVICES WILL TAKE THE NEEDS OF INDIVIDUALS INTO ACCOUNT IN THEIR DELIVERY

Progress by 2002

As already stated, from its onset Sandyford aimed to respond to individual's needs through the accessibility and sensitivity of the services offered, in the attitudes and approaches of the staff, and by ensuring that user views were incorporated into decision-making about services and their content and development. This approach, whilst being client-centred also intended as discussed, to recognise and respond to the social determinants of health in an individual, as well as in terms of wider population health concerns.

Progress by 2009

As discussed the full time Community Access Co-ordinator post at Sandyford has continued, as has client involvement and consultations with the public across the organisation. There have also been other developments concerning changing population demographics in Glasgow, which have required new responses from Sandyford. For example, as Chapter 3 in this collection comments, the epidemiology of HIV has changed over time. For example, people from Africa have come to Glasgow and the West of Scotland as refugees and asylum seekers in the last decade. Many of them are from countries with a very high incidence of HIV and AIDS, and some have acquired HIV through rape or sexual assault during civil war. This has meant that Sandyford (working closely with staff at the Brownlee Centre in Glasgow for infectious diseases) has needed to gather knowledge and intelligence about the particular needs of this group, understand the social context of their experiences before they came to Glasgow, and since they came, as part of developing an appropriate response. In this instance, partnership working with the newly settled African communities, and with voluntary groups that work with African people (for example Waverley Care – a local agency - has an African Health Project working with African people living with, or affected by HIV and AIDS [iii]), has informed the work, and also raised awareness of sexual health services amongst the communities.

The services continue to rise in popularity and uptake, and as the table and figure below shows, the number of appointments and the number of individuals attending continue to rise. The information shows a 370% rise in appointments and a 350% rise in individuals attending the services provided by Sandyford in the period from before its creation (with figures taken from the previously separate services) until then end of 2008.

[ii] See Equality and Human Rights Commission website – www.equalityhumanrights.com – for more information
[iii] See website - http://www.waverleycare.org/content/africanhealthproject/117/

Table 7: Sandyford attendances by calendar year 1999 – 2008

Appointments	Individuals	Year
35356	19314	1999
35443	19623	2000
56209	27483	2001
60170	29505	2002
63018	31399	2003
65060	33421	2004
89735	46845	2005
102825	51234	2006
117587	59713	2007
130406	69882	2008

CONCLUSION

The creation of the Sandyford brought together previously separate services to benefit service users through integrated working, and appears strongly to have fulfilled the potential that Wilkinson, Hampton and Bradbeer had in mind in 2000, when they suggested that 'integrating family planning and GUM services offers the potential to develop the range of sexual health services that men and women want to use as clients in 21st Century' (Wilkinson *et al*., 2000). Thinking from feminism and the gay community had influenced the NHS and others in Glasgow in how they understood and acted upon inequality, discrimination and exclusion, and a specific set of conditions greatly affected the origins and realisation of this development. There was evidence that services could respond creatively and sensitively to meet client need and there was an appetite for change amongst local planners and services providers. Events were facilitated by histories of local partnership working and creative approaches to planning and delivering health care, the explicit integration of notions concerning health inequalities, as well as specific factors that created synergies and new opportunities.

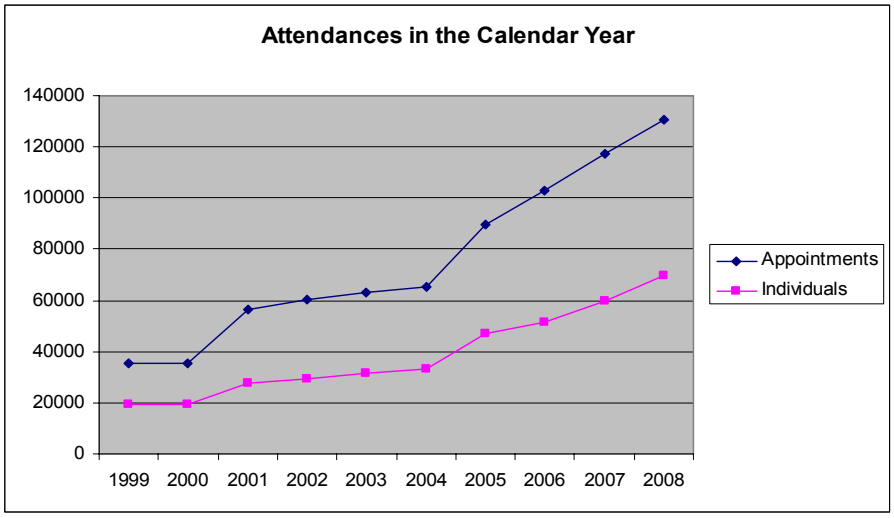

Figure 12: Sandyford attendances by calendar year 1999 – 2008

The initiative can be regarded as successful in its attractiveness to users, the roles that many of its senior management and clinical staff have in sexual health bodies and education across the UK, and its ability to provide a wide range of services to clients in now nearly two dozen settings. It has a national and international reputation and receives much interest from clinical and policy

colleagues as a place of excellence (Laughlin *et al.,* 2001). This has been achieved arguably because many of the place-specific factors discussed facilitated the development of an exportable ethos that has become established as the norm, that has allowed creative responses to continue and for sexual health in all its facets to be addressed. The size of the geography, and the number of clients, whilst clearly proving a challenge is also likely to have been an advantage in improving staff skills and knowledge, in expanding joint working and links with other services, and in destigmatising sexual health services through introducing an inclusive and non-threatening brand.

The development has needed to respond to external factors as well as to maintain services, instigate new developments and respond to increasingly complex client needs. Although the development occurred within a volatile political period, the possibility of very unexpected and important occurrences happening, like the need to suddenly take over and run services for another geographic area and its population, was not projected, and arguably, there was little thinking from a risk management perspective of these kind of unforeseen events. Such eventualities use up huge resources and cut across other planned developments.

The expansion of Greater Glasgow Health Board to cover the adjacent Clyde area tested Sandyford's ability to respond, and to continue to expand, and significant management time was spent on ensuring that services were provided appropriately and that the organisation itself operated as one unit. At the same time, extensive service development was needed that had not been anticipated when Sandyford had been first mooted and as the Clyde integration took place 6 years after Sandyford opened, a more sophisticated service needed to be planned and delivered through the Community Hubs that also attracted a lot more clients. This required flexibility in mainstreaming the Sandyford ethos into new territories in a short time period, faster than had been the case in the original Sandyford inception and required extensive efforts in team building and staff training.

This chapter demonstrates that bringing together previously separate services can have positive outcomes for clients, staff, the newly created organisation, other agencies and the wider policy and service environment. However the importance of planning and managing radical change, making it genuinely inclusive, identifying outcomes and indicators for ongoing assessment and evaluation, and committing to staff training and education especially around inequalities and diversity cannot be underestimated. The need for any such service to continue future proofing is essential especially in an increasingly complex financial and political environment, when the lack of ongoing development funding may no longer provide opportunities for growth.

ACKNOWLEDGEMENTS

Many thanks to Sue Laughlin, NHS Greater Glasgow and Clyde, for her contribution to, and comments on, this chapter, and for her extensive support in developing Sandyford.

CHAPTER 9

Health Improvement Perspectives: Transformation Within Services Through Reaching Out

Phil Eaglesham

NHS Health Scotland

Abstract: The final chapter in this section - Chapter 9: Health improvement perspectives: transformation within services through reaching out – continues to explore the importance of taking a broad model of sexual health into conceptualising sexual health and in targeting activity to those most vulnerable to poor sexual health outcomes. The first sexual health strategy for Scotland emphasised the need for this approach, and in this chapter Phil Eaglesham from NHS Health Scotland describes the significant role of health improvement in promoting good sexual health in Scotland and reviews its contribution to population health.

Mr Eaglesham gives an overview of the tenets of health improvement practice in Scotland and the UK, and provides evidence of work from a health improvement perspective to address the needs of those most at risk of poor sexual health outcomes and to advocate for improved outcomes. These include men who have sex with men, as well as young people as a group, and examples are given of good practice in sexual health improvement especially in relation to partnership working, linked to specialist services and supporting multi-agency approaches.

Two examples from Greater Glasgow and Clyde, Archway – for those who have been recently raped or seriously sexually assaulted, and Open Road – for men involved in prostitution, are given as useful case studies. The chapter ends by suggesting that sexual health improvement approaches contribute to broader population health in Scotland by often providing the only routes for rapid access to healthcare and support for those marginalised in our society.

INTRODUCTION

Health promotion is the process of enabling people to increase control over, and to improve their health (WHO, 1986). In Scotland this has largely been superseded by health improvement (Tannahill, 2003) across a range of programmes and practices which include several approaches that are both behavioral and clinical, and move beyond individual lifestyle choices. Practitioners in this field must therefore take account of social, economic, physical and cultural factors in health while acknowledging equity, diversity and the power within communities to address their own health.

This chapter discusses key health improvement activities in Scotland to develop sexual health and wellbeing, initially triggered by *Respect and Responsibility* (Scottish Executive, 2005a) - Scotland's first sexual health strategy. This strategy initially focused on service access and improvement to ensure that the consequences of ill-health were addressed promptly. This has since developed through *Respect and Responsibility: Delivering improvements in sexual health outcomes 2008-2011* (Scottish Government, 2008a) and been strengthened by implementation of the first range of Standards for Sexual Health Services (NHS Quality Improvement Scotland, 2008a). This ensures a cohesive approach across the field and improved accountability (see Chapter 4 for further information). In particular, these documents and strategies have highlighted the need to minimise barriers to HIV testing, to tackle the incidence of sexually transmitted infections (STIs) among high risk or socially excluded groups, and to use media and marketing communications at a local and national level as a means of promoting behaviour change in identified target groups, including men who have sex with men.

SEXUAL HEALTH AND SCOTTISH SOCIETY

Sexual health has biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual influences (WHO, 2002). While most health issues have a

Rosie Ilett and Alison Bigrigg (Eds)

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manageable number of key stakeholder relationships to foster, sexual health influences every professional and public sector and hence, all facets of Scottish life. Health improvement approaches recognise the link between emotional wellbeing and health behaviours (Seedhouse, 2002), holistic perspectives on health (Swinton, 2001) and the social determinants which reinforce health inequalities (Dahlgren and Whitehead, 1992). Health improvement practitioners within sexual health can often therefore find themselves on the frontline of debates on political equality and social justice. These provide useful opportunities for ethical discourse, and recognise cultural influences which shape gender and sexual identity and impact either positively or negatively on sexual health outcomes. Attitudes and societal values are crucial factors in sexual health interventions, which challenge behaviours within human relationships to improve health outcomes. These also occasionally prove to be a barrier to their delivery within NHS resources and financially may reinforce the assumption that such activity might appear to be ultimately unrewarding (Lefebvre and Flora, 1988).

Such thinking has been evident in Scotland in attempts to improve the sexual health of young people and one which the Healthy Respect Project in Lothian has experienced (see Chapter 5 for full account). This national demonstration project aimed to reduce teenage pregnancies by 20% and terminations of pregnancy by 50% by 2010 from 1995 baseline figures, to achieve a decrease of 50% in Chlamydia among young people, and more importantly recognised the promotion of self esteem and confidence which would contribute to achieving these targets (University of Aberdeen and SPCERH, University of Edinburgh, 2005). However, the overtly protective and at times patronising culture of 'preserving innocence' towards young people's sexuality was in this case trivialised and the project was widely attacked by the Scottish media as these examples below demonstrate:

> *Sordid sex packs aimed at pupils as young as 11* (*Daily Mail* on NHS Lothian produced 'Pathways to Sexual Health', 2001)
>
> *A case of too much, too young? Gay play for Edinburgh schools sparks debate on age of innocence as children are exposed to daily diet of sex and sleaze (Edinburgh Evening News on* Healthy Respect/LGBT Youth Scotland's anti-homophobic bullying initiative, 2002)

These attempts to undermine essential health improvement work did not detrimentally affect attitudes among parents, school staff and young people who were in the main supportive of the work, understanding the participative and child-centred approach that was being taken. Scottish society however seemed to struggle with these principles and in creating this extra level of stress, Healthy Respect has had to be vigilant of any reactionary confounding of such essential work (Ball and Sturgeon, 2004). This has not however, deterred them from offering comprehensive, accessible and evidence informed approaches to young people's sexual health. It may also be that Scottish society and its values have progressed considerably since devolved powers on health and wellbeing were created through the Scotland Act 1998[1] and after several achievements in enshrining equality in law across the UK as other chapters have discussed, legislation now finds itself in less conflict with advanced health improvement strategy and practice. [2]

Until recent years, as other authors in this collection note, Scotland had a relatively poor political record on sexual health, illustrated by a pervasive culture of homophobia, fostered by patriarchal institutions and some forms of organised religion (Cant, 2008; Whyte, 1995). For example, while the decriminalisation of homosexuality between men over 21 in England and Wales occurred in 1967, it took 13 years of debate and political struggle before Robin Cook MP amended the Criminal Justice Bill in 1980 for an equal law in Scotland (Kellas, 1989). During this time however, LGBT Centres, Gay and Transgender 'Switchboards' offering telephone support to often

[1] See http://www.opsi.gov.uk/legislation/scotland/scotact for more information

[2] See Equality and Human Rights Commission website – www.equalityhumanrights.com – for more information

isolated individuals, gay community bookshops, support projects and a vibrant LGBT art and culture emerged to meet the needs that mainstream society (and core health and social services) were unable or unwilling to support.

Health improvement practitioners have collaborated with and directly supported many of these mechanisms in recognition of their cultural significance and the opportunity that they provide to reach oppressed and excluded minorities, whether in relation to gender, sexuality, ethnicity, disabilities or age. Such work has developed their skills in a variety of key equality areas that have become increasingly important in the development of statutory duties concerning equality and diversity within Scotland and the rest of the UK as mentioned. More importantly, such focused work and the learning associated with it has informed the wider mainstream provision of sexual health services and combined with the political weight and financial investment which Scottish Government has provided in the last five years for sexual health, has transformed the sector.

TRANSFORMATION IN SCOTTISH SEXUAL HEALTH SERVICES

Health improvement perspectives have over many years provided evidence for change and have supported genuine partnership approaches, acknowledging that much of the poorest sexual health in Scotland coincides with exclusion and experiences of stigma and oppression. The legacy created by the social activism of the 1990's has advanced equality strands within a 'mainstream' health approach. Scottish society has also progressed over this time and this is reflected in legislation which acknowledges diversity, as discussed above, although there still remain many challenges to address.

The experience gained through over 20 years of HIV prevention is one example where experiences of collaboration and challenge have provided useful applied learning to improve sexual health services. This approach has also attempted to address health inequality which this epidemic appears to have recently amplified in Scotland, with ongoing HIV infection rates among men who have sex with men standing at 4% in the last 5 years (Williamson and Hart, 2007). This is despite the apparent low prevalence of under 0.1% within the general population (Health Protection Scotland, 2009). Inequalities in health and the co-ordination of both prevention and treatment are also acknowledged in the recent draft Scottish Government HIV Action Plan (Scottish Government, 2009a) where health improvement approaches have provided the evidence, prioritised the actions and promoted a cohesive and collegiate way forward.

The health improvement perspective recognises that in sexual health, poor outcomes that are associated with gender, sexual identity and orientation also coincide with social exclusion, stigma and oppression. This has also chimed with Scottish Government policy to tackle inequality and its underlying causes through the national Equally Well programme to systematically tackle health inequalities (Scottish Government, 2008b) and the overarching purpose of the Scottish Government to create a more successful country through increasing sustainable economic growth (Scottish Government, 2007c). While this is considered paramount, principles of a 'fairer' and 'healthier' Scotland are acknowledged as fundamental to realising this goal. In improving services, a range of mutually beneficial health improvement initiatives have developed in collaboration with voluntary sector and local authority partners, some of which Chapter 11 also describes. Many were fuelled by social and political activism on gender equality and identity, the rights of young people, sexual orientation, anti-racism and to combat HIV-based phobia and discrimination.

Informed by a sense of social justice, these provided the impetus for research and evidence to support the design, improvement and funding of a number of services which were piloted, evaluated and expanded to make up the diverse range of sexual health drop-ins, clinics and outreach that now exist in Scotland. Services for young people such as The Corner in Dundee and Healthy Respect in Lothian, the Steve Retson Project for gay men and the Glasgow Centre for

Women's Health at the Sandyford Initiative in Glasgow (as Chapter 7 describes) plus the services below (Archway and Open Road) developed to meet specific needs but also informed the inclusive ethos of such core NHS Services for sexual wellbeing. Health improvement professionals have also developed close collaborative working on issues of trauma, prostitution, gender based and sexual violence and ethnicity, including asylum seekers and refugees. In this regard, such outreach approaches epitomise 'going the extra mile' to promote sexual wellbeing for ALL in Scottish society, not only those who can most easily access services.

Spearheading such services which appear to benefit a small and marginalised sub-community can provide learning on process and outcomes that not only inform the health improvement work concerned, but inform mainstream health, social care, and treatment more widely. This is where the delivery and commissioning of independent evaluation has been a crucial health improvement function; sharing good practice and positive outcomes but also importantly learning from errors, unexpected outcomes and process failure. Such reflective partnership work and use of evaluation has been crucial in the development of the first project which will now be focussed on in more detail.

ARCHWAY: REACHING THOSE WHO HAVE EXPERIENCED SEXUAL VIOLENCE AND ABUSE

Action by the multi-agency Glasgow Violence Against Women Partnership sparked, after many years of discussion, formal negotiation and planning, a proposal for a rape and sexual assault referral centre in Glasgow –which led to the development of a pilot in the Greater Glasgow area, called Archway. Archway was created as a Sexual Abuse Referral Centre (SARC) for both men and women in the Glasgow and Clyde area supported by multi-agency partnership and funded initially by Scottish Government, with NHS Greater Glasgow and Clyde, Strathclyde Police and Glasgow City Council providing continuing funding after the initial pilot period. Meeting the needs of those who have been subjected to sexual assault, rape and may also be survivors of sexual abuse is a common aspect of clinical and sexual health improvement interventions in Scotland. The objective of Archway was to improve the level and quality of service provision and to promote change across agencies in Scotland. SARCs are acknowledged as having tangible benefits to victims, police and health services and have been evaluated by the UK Government's Home Office (Lovett *et al*., 2004). An independent evaluation was carried out of Archway during its pilot period, and reported on the Home Office findings that were felt to be most relevant to Archway:

- Flexible support and advocacy are the most vital forms of victim support offered by SARCs;
- Both male and female service users express a preference for female forensic examiners;
- SARCs ensure high quality and consistency in forensic examinations;
- SARCs increase access to services and support for a proportion of those who do not report rape to the police;
- Service users request greater out of hours access and more support groups.

  (Schonbucher and Kelly, 2009)

As well as the forensic and clinical needs which those subject to abuse require, there is evidence in Lovett *et al*.'s 2004 review that those receiving good immediate care and counselling are less likely to need ongoing supportive mental health care. As it was paramount to achieve such outcomes, it was agreed that forensic, health and support services would be brought together in one central location to provide an integrated 'one-stop' location particularly for women and men who had been recently raped. With expertise in collegiate partnership, working for health improvement and skill in managing the strategic challenges which this brings, clinical and non-clinical staff worked hard to achieve an eventual consensus. Archway brought the NHS,

Strathclyde Police, Crown Office and Procurator Fiscal Service, the Scottish Government, Glasgow City Council and voluntary sector partners such as Rape Crisis with different interests and expertise together to meet the needs of highly vulnerable individuals who may previously have received inappropriate or inadequate provision.

Schonbucher and Kelly's 2009 project evaluation of Archway funded by the Scottish Government, cited occasional breakdown in communication, misinterpretation and the over-riding passion to tackle the issues which gender-based violence raise as challenges which Archway overcame through effective partnership work. This has provided essential learning in the development of projects such as Archway which tackle health inequalities. By embracing both the holistic (Swinton, 2001) and social models of health (Wilkinson and Marmot, 2003), Archway tried to meet the expectations of the range of partners who have invested in its development, and to support client's emotional, housing, finance, cultural, religious, physical, and psychological needs. Despite some fear voiced that in engaging with the NHS, a biomedical approach was bound to predominate, Archway has managed to found and develop an ethical, holistic service which has transformed practice by reaching out to challenge a taboo health issue. Full information can be found at www.glasgowarchway.com/.

While considerable work in Scotland on women's involvement in prostitution has evolved, as Chapter 7 comments on, there has been a more limited focus on men selling sex until this second project which will now be described.

OPEN ROAD: REACHING OUT TO MEN WHO SELL SEX

Although rarely appearing in published literature, by taking account of research and evidence on the health impact of Scottish men's involvement in prostitution, Glasgow's Open Road project has developed effective support for a stigmatised population in Scottish society. While the much larger population of women who sell sex has received considerable focus from services and strategists alike, little focus on men has emerged until this recent project developed both clinical and strategic mechanisms to bring partners together.

Homelessness, youth and vulnerability have long been associated with selling sex by men in 'on-street' settings (Zuilhof, 1999). Initiation into male sex work has a variety of routes; recruitment through 'pimps' and paedophiles, initiation through partners, friends or acquaintances and by planned or chance encounters as part of the 'gay scene' (Connell and Hart, 2003). Health outcomes in this group of men are exceptionally poor, with depression, suicidal ideation, attempted suicide, addiction, and sexual ill health including risk of exposure to HIV and other STIs frequently reported. Initial evidence from social work practice on the lived experience of men who sold sex (de Croy, 1990) and street-based outreach interventions (de Croy, 1991) in Glasgow demonstrated the benefits of engaging with this group.

Further focus on harm reduction and risk behaviours associated with HIV transmission (McKeganey *et al*., 1990) compared interventions between men and women selling sex in street-based settings in Glasgow and the lived experiences of men in dealing with purchasers of sex (Bloor *et al*., 1990). Further research then compared the experiences of men in Glasgow and Edinburgh exploring health issues beyond harm reduction (Connell and Hart, 2003). Through use of outreach services, this study identified strong links between substance use, poor mental health and homelessness among street based men selling sex in both cities. The mental and physical health consequences for the men, their family and social backgrounds and the nature of their entry into prostitution were acknowledged as 'survival behaviour' and has become the main focus in how services meet these complex needs and supports the imperative of collaboration in this process.

The Open Road Project was developed by West Glasgow Community Health and Care Partnership (CHCP), with monies from NHS Greater Glasgow and Clyde's Blood Borne Virus prevention fund and the Scottish Government *Respect and Responsibility* fund to respond to these findings.

The purpose of the project is to identify the hidden population of men currently involved in prostitution and to ensure that this population receives appropriate service provision from services across NHS Greater Glasgow and Clyde. The project recognises the impact of social determinants and poor health outcomes which occur in selling sex and uses the following definition of prostitution:

> *Males who engage in sexual activity in exchange for some form of payment such as money, drinks, drugs, consumer goods or a bed or roof over their head for a night. This may take place in a variety of settings including private accommodation, brothels or on the street.* (Open Road, 2007)

The project's aims are established as:

- To identify the men involved in prostitution through effective processes and partnership working,
- To assess the needs of men currently involved in prostitution,
- To address the needs of men involved in prostitution by appropriate service delivery across a range of partners,
- To ensure that mainstream services provide appropriate services to address the clients needs,
- To contribute towards establishing an evidence base to inform future policy and services,
- To evaluate the effectiveness of the project and it's approach.

Although this is a hard to reach group, the project has developed ways of identifying men involved in prostitution through partnership working and other means, and is currently supporting a number of men from the Glasgow area and beyond. Since 2007 the Open Road Project has also chaired and developed the Glasgow Male Prostitution Network, an ongoing forum to strengthen multi-agency work, share research interests and integrate prostitution within a wider health improvement context. The project champions health improvement for a marginalised population, information flows between research and practice to improve access and quality of services, challenging the accepted political and theoretical status quo on this issue.

CONCLUSION

Sexual health improvement approaches contribute to broader population health in Scotland by often providing the only routes for rapid access to healthcare and support for the marginalised in our society. This occurs through arguing for and providing evidence of the need for change and investment of resources where clinical experience can be insufficient and media concerns can be obstructive. In consistently reinforcing a holistic approach to sexuality, sexual identity and sexual orientation, a range of physical and emotional health needs, social and spiritual entitlements and human rights in Scotland have been met in partnership with clinicians, professionals allied to medicine, civil servants, politicians, activists and advocates.

This has occurred through leadership of and contribution to local strategic partnerships, providing the evidence to inform sexual health service development and improvement. This process is also underpinned by strong, credible and mutually beneficial professional relationships. Connecting and often supporting a range of local and national partners from a range of sectors simultaneously requires enormous skill, diplomacy and courage when balancing the rich but emotive sexual health theme. In outlining such examples of the sexual health improvement approach; whether through active health promotion, strengthening of health protection or informing of public health policy it is apparent that its contribution to a more equal, equitable and ethical health and social care provision in Scotland is increasingly significant.

CHAPTER 10

Modernising a New Workforce Fit for Purpose in Sexual Health

Lorraine Forster, Martin Murchie and Urszula Bankowska

Sandyford

Abstract: This chapter continues the book's theme concerning partnerships and integration, and focuses on the implications for the clinical workforce of service integration within sexual health. Written by three clinicians from a range of sexual health disciplines, based at the Sandyford Initiative - Lorraine Forster, Dr Urszula Bankowska, Martin Murchie – it reviews the clinical environment before integrations took place and the training needs of specialities and disciplines, and the role of recent government policy in influencing the shape of the sexual health workforce.

The chapter describes the new skills and competencies required by medical and clinical disciplines to deliver integrated sexual health services. It suggests examples of good practice to effect that change from nursing, medical and health advising perspectives. The responsibility of national training agencies in supporting staff training, such as NHS Education Scotland (NES), Royal College of Nursing (RCN), the Faculty of Sexual and Reproductive Health (FSRH) and the British Association of Sexual Health and HIV (BASHH) is described.

The chapter concludes that there are a number of challenges ahead that will impact on sexual health care and maintaining a skilled workforce, including the availability of budgets to continue developing sexual health services, responding to changing population health needs and workforce issues. The authors argue that strong networks, professional identities and accredited clinical skills can only help to ensure that the sexual health workforce continues to make a valuable contribution to public health in Scotland.

INTRODUCTION

Modernised sexual health services in the twenty-first century require staff who can meet the increasingly complex needs of clients and deliver a wide range of interventions. Previous models of delivery offering either contraception and well-woman services in a family planning setting or the diagnosis and treatment of sexually transmitted infections (STIs) in genitourinary medicine (GUM) clinics have changed, in response to client need, changing social mores and sexual behaviour, clinical opportunities and national policy-making, and brought previously separate specialisms closer together. Well trained clinical staff in multi-disciplinary teams, often in integrated sexual health environments, are now the norm with work also being undertaken to enhance the roles of clinical and support staff beginning across Scotland. This chapter will look at the changing nature of the Scottish sexual health workforce in relation to clinical staff working within specialist sexual health settings. Firstly, it will briefly review the clinical environment before integration took place and the training needs of specialities and disciplines, and then look at the role of recent government policy in influencing the shape of the sexual health workforce. The responsibility of key training agencies such as NHS Education Scotland (NES), Royal College of Nursing (RCN), the Faculty of Sexual and Reproductive Health (FSRH) and the British Association of Sexual Health and HIV (BASHH) will be described. The changing role of nurses in sexual health will be discussed, as will the contribution that the health advising workforce makes to the specialist environment. In addition the chapter will look at the future for the sexual health workforce in the light of changing service and client needs.

WORKFORCE ISSUES PRE-MODERNISATION

As a number of other chapters point out, the services that have increasingly become part of an integrated sexual health delivery model across Scotland and the rest of the UK had very different trajectories. Historically family planning was community based, with doctors and nurses

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delivering and developing contraceptive services and training with very limited funding and aimed typically at female clients. Genitourinary Medicine (GUM) was hospital based, male dominated, and delivered from 'hidden premises' in basements and annexes. Since legislative and policy changes in the 1960s and 1970s as Chapter 3 describes, and most importantly within the last 15 years, the impetus has been to de-stigmatise services and to make services accessible in terms of increased visibility, improved premises and longer opening hours.

Pre-modernisation, nurses' role in providing traditional family planning services to clients within community settings involved reproductive health history taking, advising and supporting clients to make appropriate contraceptive choices and undertaking pregnancy testing and cervical smears. Medical staff were responsible for diagnosis, prescribing and undertaking contraceptive procedures and cervical smears, and training was pioneered in the charitable sector as a certificate of contraception. Within GUM services in hospital based settings, medical staff led the service, supported by nurses who were involved in a range of activities, typically involving specimen labelling, chaperoning, venepuncture and supplying medicines to clients. There would be little patient contact other than for isolated activities, in contrast with the historical reproductive health model. Many registered nurses and midwives with experience in a discipline such as women's health or health visiting worked sessionally within family planning services. In Scotland they would be required to undertake and pass the National Board for Scotland recognised theory course. Clinical practice sessions were undertaken within the specialist area where nurses would be assessed as to their communication, knowledge and practical skills.

Historically the education and learning needs for nurses working within the speciality of genitourinary medicine was met by accessing training within England via a variety of courses run and validated by the English National Board (ENB). There was no training provision within Scotland for nursing working in this speciality. At this time the role of sexual health advising was provided by trained nurses who were qualified health visitors with the belief that their knowledge of population health and of working with sensitive issues was vital in providing this role.

Medical doctors specialising in GUM trained initially as general physicians and had a recognised career structure similar to other hospital consultants. Training was under the auspices of the Royal College of Physicians. There was no equivalent career or training structure for doctors involved in family planning. Prior to 1974 they were employed by the Family Planning Association, an independent charitable body, rather than the NHS, as Chapters 1 and 2 discuss. When the family planning clinics were transferred into the NHS no arrangements were made to equalise the training career opportunities. This would only begin to change with the establishment of the Faculty of Sexual and Reproductive Healthcare (FSRH) in 1993 and the appointment of consultants to lead services in the 1990s. The early consultants were formally trained in general obstetrics and gynaecology but received no formal supervised training in the speciality of sexual and reproductive health. Their appointment did however allow the development of a modern specialised training programme.

Towards the latter part of the twentieth century, training for both doctors and nurses was affected by changing circumstances. The onset of the HIV epidemic from the early 1980s, alongside thinking concerning potential service integrations in the early 1990s, required a workforce with different skills around diagnosis and treatment, around a broader model of sexual and reproductive health – and with a wider understanding of client issues (Irwin, 1997). Debates within the medical press in this period, including responses to Stedman and Elstein's pivotal editorial in the British Medical Journal in 1995 about integrating family planning and GUM with appropriate clinical training, indicate the tensions that existed between specialities and the need to better provide for clients (Stedman and Elstein, 1995). Nunns and Mandal for example pointed out that many GUM doctors had relevant family planning training (Nunns and Mandal, 1995) whilst Donovan *et al.* gave initiatives in Australia and New Zealand as examples of converged services where clinical training had been expanded to fit the new challenges:

> *As well as providing services for sexually transmitted diseases and broad family planning under one roof – a common practice for state funded sexually transmitted disease clinics for over 20 years - the clinical staff increasingly receive training in such diverse topics as sexual and relationship counselling, sexual assault, sexual dysfunction, and promotion of sexual health* (Donovan et al., 1995).

Whilst the specialities and the separate disciplines continued to review appropriate clinical responses and workforce issues, the policy environment also began to respond to increasingly visible public health imperatives concerning sexual health through the development of national strategies across all parts of the UK – see Chapter 3. As Chapters 3, 4 and 7 describe, *Respect and Responsibility* (Scottish Government, 2005a), the Scottish sexual health strategy document, set out a framework for improving sexual health in Scotland and increasing access to information and services, whilst allowing flexibility for local services to respond to local needs. This led to the development of standards to support service delivery and the training and development of staff (see Chapter 4). As Dr Nandwani describes, the NHS QIS Standards in Scotland for sexual health services aims to ensure that all clinical staff are appropriately trained, and the next section will consider the bodies and accredited training that maintain and develop clinical staff within specialist sexual health.

EDUCATION AND TRAINING – THE KEY AGENCIES IN SEXUAL HEALTH

Several key agencies have provided education and training to support the modernisation of the sexual and reproductive health service workforce. NHS Education for Scotland (NES) is the Scottish Health Service's own training organisation. It has statutory functions to fulfil its remit of promoting best practice in the education and lifelong learning of all NHS staff and supports NHS Scotland Boards and their staff to deliver better patient care through targeted, effective training and education. Information is available at http://www.nes.scot.nhs.uk/

Their work is based on fundamental principles including patient-centred outcomes, equity of access to educational support for all NHS Scotland staff, appropriate balance between uni-/multi-disciplinary approaches to education, valuing diversity and striving for a culturally competent workforce. Although they have developed and published several competency frameworks to support the workforce providing sexual and reproductive health in Scotland, these can be used across all countries in the UK.

The Royal College of Nursing (RCN) is the largest professional organisation for nurses in Scotland, and across the UK. It provides development and education opportunities for nurses, building professional expertise and leadership. Several recent RCN publications have specifically supported sexual and reproductive health nursing; sexual health standards, contraceptive implant and intrauterine contraceptive device guidance. The RCN accredits a range of study days and conferences that take place across the UK which ensures the event meets the RCN's quality standards, promotes best practice and provides effective education outcomes. Full information is available at http://www.rcn.org.uk/

The Faculty of Sexual and Reproductive Healthcare (FSRH) - http://www.fsrh.org - of the Royal College of Obstetricians and Gynaecologists - http://www.rcog.org.uk/ - was established in 1993 as the Faculty of Family Planning and Reproductive Healthcare. It changed its name in 2007 to the Faculty of Sexual and Reproductive Healthcare to reflect the speciality's current functions. Diplomas, certificates, fellowships and equivalent recognition of specialist knowledge and skills are granted in sexual and reproductive health care. Since its inception, the Faculty has offered general and higher training programmes. The basic training is based on the Diploma of the Faculty of Sexual and Reproductive Healthcare (DFSRH) which represents, through theoretical and practical training, a core standard for doctors involved in offering sexual and reproductive health services including aspects of communication with clients, and confidentiality as well as clinical aspects. Higher training leading to Consultant level is offered through a four year sub-speciality

type programme offering jointly through Royal College of Obstetrics and Gynaecology (RCOG) and the Faculty of Sexual and Reproductive Healthcare. Special skill modules in abortion care, menopause, vasectomy, sexual problems and ultrasound are also available.

Towards the end of 2009 the Postgraduate Medical Education Training Board is expected to announce the establishment of a new speciality of sexual and reproductive health which will replace the previous sub-speciality. Responsibility for the new 6 year training programme will be with the FSRH who will ensure it meets the needs of specialists working in the modern integrated environment of sexual health. These practitioners will be recognised specialists but not accredited in general obstetrics.

In 2003 the Medical Society for the Study of Venereal Diseases (MSSVD) and the Association of Genitourinary Medicine (AGUM) merged to form the British Association for Sexual Health and HIV (BASHH). BASHH provides general training and advises the RCP on specialist post graduate training and education for sexually transmitted infections and HIV within the UK. Along side this training BASHH aims to develop, monitor and maintain standards of governance in this field and full information is available at http://www.bashh.org/. In response to the English sexual health strategy in 2001 BASHH developed a 2 day training course, the Sexually Transmitted Infections Foundation course (STIF), with the aim to expand sexual health provision in primary care by training staff within primary care with the appropriate knowledge and skills in relation to sexual health. This course is now run across all parts of the UK, including Scotland, and is well evaluated (Melville *et al*., 2003).

These training agencies and professional bodies have a central function in ensuring that specialist sexual health clinical staff receive the right training, professional development and support to work in the modern environment, in the right numbers, as the next section discusses in more detail.

WORKFORCE NEEDS OF INTEGRATED SERVICES AND HOW EDUCATION IS RESPONDING

Between 1995 and 2009 the number of Consultants in Sexual and Reproductive Health (SRH) in Scotland increased from 2 to 22. There has been a steady increase in the total number of doctors and nurses and in those working in more substantive posts, as opposed to sessional staff. This undoubtedly reflects the fact that sexual and reproductive health has raised its profile and offers many more career opportunities than in the past. More doctors are taking up full or part time posts instead of the very large number of sessional doctors employed in the speciality previously.

Doctors in training programmes to become consultants in Genitourinary Medicine or Sexual and Reproductive Health are supported through the curriculum of their specialist training programmes to have a wider flexibility of roles whilst retaining their specialist focus. Extended competencies for those doctors working at non consultant grade within specialist services have been developed with the expectation that an individual doctor should be able to work across contraceptive, reproductive and sexual health services. Retention and recruitment of staff at this grade continues to be a challenge – competing with higher pay scales in general practice. Though combining work in sexual health with general practice is a popular option, and brings additional skills to a specialist service, but maintenance of communication within a team and specialist skills is difficult unless protected learning time is retained.

One of the roles of specialist sexual and reproductive health services is to take a strong lead in education as well as developing new service models and initiatives that improve quality, access, and services. Collaborative and innovative work with other providers such as pharmacies, healthy living centres, schools and youth settings has increased the settings and access to contraception and sexual health services within Scotland, and in other parts of the UK, and clinical staff need to be able to perform in this context.

Maintaining links with specialist services through easy access to protocols and referral pathways has been important for general practice settings. Locally agreed Enhanced Service agreements (LES) for general practitioners for sexual health screening and for IUD and contraceptive implants has increased the access to and uptake of long acting reversible contraception (LARC) and screening in a general practice setting. Across the UK, additional training has been developed to support this through the availability of the Sexually Transmitted Infection Foundation courses (organised by BASHH) offered to general practice colleagues. The Royal College of Nursing (RCN) have also developed standards to support nurse fitting of all LARC methods and provide a benchmark for competence.

A new web-based Sexual and Reproductive health care e-learning project is currently being developed in partnership with e-learning for Healthcare and in collaboration with general practice and sexual health as well as HIV e-learning projects. There are a range of modules designed to match the needs of a variety of healthcare professionals. The e-learning development will form the initial part of the training for the Diploma of Sexual and Reproductive Health and part of the training for practical procedures for LARC. This resource will be freely open to all healthcare professionals and to compliment this project a revised programme of face to face workshops and work based assessment are also being developed. This training will be piloted in two Primary Care Trusts in England to provide a baseline knowledge and information for nurses in the absence of an agreed national entry level qualification to specialist services. The next section will highlight nurses in sexual and reproductive health as a case study of a sub-group within the specialist workforce that has undergone significant change.

NURSES IN SEXUAL AND REPRODUCTIVE HEALTH

The Scottish sexual health strategy, *Respect and Responsibility* (Scottish Executive, 2005a), advocated a central role for nurse leadership in sexual and reproductive health services reflecting *Delivering for Health* (Scottish Executive, 2005b) which articulated a similar vision of nurse leadership at the forefront of initiatives designed to improve the patient journey and experience. *Modernising Nursing Careers* (Department of Health, 2006b) also recognises a role for nurses with advanced practice skills and competencies to undertake a range of client care and emphasises that opportunities should be developed within organisations to support this.

Recent years have seen a growing involvement of nurses in the direct provision of sexual and reproductive health services (both integrated and not), with nursing staff able to work as autonomous practitioners in providing a full range of services to clients including client consultations, case management and interventions including testing and provision of treatments and onward referral to specific services where required. Many nurses have developed clinical skills such as ultrasound scanning and fitting of long acting contraceptive methods and undertaking cervical cytology.

QUALIFICATIONS AND COMPETENCIES

Independent nurse prescribing is an additional qualification now being taken up by a number of sexual health nurses across Scotland, recordable with the Nursing and Midwifery Council, which gives nurses the scope to prescribe widely within their specialist area (Tyler and Hicks, 2001). This has contributed extensively to service developments and improved access to services and reduced waiting times for clients. Sexual and Reproductive Health nurses in specialist services have extended and expanded their role through education and training and the demonstration of competence through the utilisation of competency based workbooks.

Specific national sexual health competencies developed by the RCN in 2004 (Royal College of Nursing, 2004) provided a useful benchmark but were based on a model of care that was largely weighted towards a specialist GUM model and not transferrable across most Scottish generic service provision. In order to ensure competent practice in nurses working across a wide spectrum

of health care settings, alternative competencies were developed. Discussions with nurse leaders and higher education providers in Scotland led to the development of a national competence framework for post registration / pre specialist sexual and reproductive health nursing (NHS Education for Scotland, 2007). This provides nurses, midwives and their managers with guidance as to appropriate competencies. This published document was distributed to Lead Clinicians and Lead Nurses across Scotland, with service leads encouraged to adopt these competencies as a basic skill set for nurses working within specialist sexual and reproductive health services. There has not been any monitoring of the uptake or use of these competencies, although this is expected to be developed through the new Scotland Managed Clinical Network in Sexual Health which was launched in 2009.

In Scotland, nurses working in specialist sexual health services are required to undertake post registration modules in sexual and reproductive health provided by Higher Education Institutes. This is supported by practice placements within the specialist service area where nurse mentors are responsible for signing off service competence or will refer for further training/supervision. Additional specific competencies have been developed across the UK to support access to services such as LARC with Implanon and IUCD/IUS fitting, ultrasound scanning to support early access to termination of pregnancy and prescribing nurses working within menopause services. Independent nurse prescribing has provided a robust framework for the provision of nurse led services as has already been mentioned (Scottish Executive, 2006c).

Nurses and midwives provide a range of generic sexual and reproductive health advice and services within their specialist areas such as general practice and schools. There is currently no identified benchmarked/post registration education requirement in the UK for non-specialist nurses or midwives wishing to provide sexual health services.

CAREER FRAMEWORK

Members of the Scottish sexual and reproductive health Lead Nurse Network have lobbied for nurses receiving formal recognition within the strategic planning arena and leading on local service developments and delivery. Working in partnership with NHS Education for Scotland, a national career framework for nurses working within sexual and reproductive health services was launched in 2009 (NHS Education for Scotland, 2009). This provides a toolkit for nurses and managers to benchmark roles and career pathways throughout a range of services ensuring standards are consistent with agreed professional and educational standards. Incorporating aspects of the Agenda for Change [1] knowledge and skills framework has ensured validity for the future and has avoided duplication of structures (Department of Health, 2004a).

Like other clinicians working in specialist sexual health, nurses need to be aware of the importance of promoting equality within care provision and of providing an inequalities-sensitive practice. This should be supported through induction and education sessions, and many sexual health services in Scotland have begun to develop in-house multi-disciplinary training programmes to ensure that nurses, and other colleagues, are fully aware of the wide-ranging needs and experiences of clients (Ilett, 2008). One professional group with long experience of taking a public health approach within sexual health are sexual health advisers, and the following section sets out to consider this specific group within the workforce and their training and development needs.

PUBLIC HEALTH AND SEXUAL HEALTH ADVISING

It is recognised that sexual health advising has a core role in the control of sexually transmitted infections and HIV. There are approximately 400 sexual health advisers (SHA) in the UK, with a

[1] Agenda for Change is the agreed national framework to harmonise job evaluation, terms of conditions and development and review for NHS staff – see http://www.nhsemployers.org/PayAndContracts/AgendaForChange/Pages/Afc-Homepage.aspx for full information.

varying role from clinic to clinic but generally one that includes partner notification, sexual health promotion, risk reduction and support. A revised model of sexual health advising is being developed across Scotland to meet the needs of clients who are accessing integrated sexual and reproductive health services. This model comprises of a core group of nursing staff specialising in sexual health advising providing governance, training and support. This supports the integrated model of sexual health nursing where nurses have additional competencies in relation to partner notification and risk reduction strategies. Appropriate knowledge and skills are achieved through completion of a competency framework which is supported by supervised practice and mentorship by practitioners with sexual health advising competence and experience. This ensures continuation of care in the wider provision of the sexual health advising role.

The public health role of partner notification has been the constant core role of sexual health advisers, with advisers being primarily responsible for partner notification management. The aim is to break the chain of transmission of sexually transmitted infections and blood borne viruses by supporting clients with these infections (known as index clients), to identify their sexual contacts and partners, to facilitate testing and treatment if appropriate, and to undertake health promotion and risk reduction work on a one to one basis (Society of Sexual Health Advisers, 2004).

Although individuals working as sexual health advisers come from a multi-disciplinary back ground of nursing, social work, counselling and psychology, the majority are from a nursing background. Like sexual and reproductive health nursing, there has been no national recommended programme of training and education for sexual health advisers within the UK. There has however been discussion in England which would necessitate all nurses involved in sexual health advising to be registered as Specialist Community Public Health Nurses on Part 3 of the Nursing and Midwifery Council (NMC) register (Nursing and Midwifery Council, 2007). This will not be a requirement in Scotland as it is not thought to confer additional protection for the public.

A significant part of workforce redesign and development in relation to the development of integrated sexual health services has been to integrate the role of sexual health advisor into the sexual health nurse role. The majority of SHAs in Scotland have a recordable nursing qualification and by virtue of this are governed by a formal regulatory body, the NMC. This helps to ensure public safety in addition to having governance and professional responsibility mechanisms in place within the individual's workplace. Having the roles separate can cause fragmentation of care for some clients. The view of the profession in Scotland is that it is preferable that one individual manages the care episode and this has allowed nursing staff to gain additional skills and competencies to ensure that they can provide risk reduction and partner notification advice when required without the need for referral.

In response to wider concerns in respect of unregulated staff groups within health care, there is ongoing work nationally to develop a regulatory pathway for non-nurse sexual health advisors (Society of Sexual Health Advisers, 2007). There may be a need to review the existing workforce in some services depending on the outcome of this national work. In response to the need to support the integrated service model and nursing role development, ensuring that the core public health functions of STI management are maintained, some areas have developed local Sexual Health Advising (SHA) Competencies. In Scotland, the sexual and reproductive health Lead Nurses are working with SHA and higher education partners to develop a nationally agreed framework to support integrated services.

CONCLUSION

This chapter has described the specialist sexual health workforce - namely doctors, nurses and sexual health advisers – in relation to their training needs and other considerations in the light of increasingly modernised services across Scotland. The major challenge across UK-wide services

has been to develop the existing workforce from what was for many a single system of either GUM or family planning with its associated work ethos and culture, and this has been achieved to some extent through partnership working and national support.

Sexual health services need to have a highly skilled, flexible partnership of clinicians working across a range of specialist and generic providing accessible, equality sensitive services. This should be supported by recognised post registration education and competency frameworks, appraisal and personal development planning. This uniform national approach is supported by the Agenda for Change knowledge and skills framework, personal development planning and consultant appraisal. Progress has been made with the development of these tools and ongoing dialogue between senior clinicians to ensure strategic objectives are achieved. There are a number of challenges ahead the availability of budgets to continue developing sexual health services, and responding to changing population health needs and workforce issues are likely to become increasingly topical. The existence of strong networks, professional identities and accredited clinical skills can only help to ensure that the sexual health workforce continues to make a valuable contribution to public health in Scotland.

CHAPTER 11

Partnership Working and Multi-Agency Approaches

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NHS Grampian

Abstract: The final chapter in this section of the book, and of the overall collection, turns its attention to the role of other agencies beyond the NHS in affecting sexual health improvement and the nature of partnership arrangements to deliver desired change. The clear expectations in *Respect and Responsibility* (Scotland's first national sexual health strategy) of multi-organisational working, especially between the NHS, local authorities and the voluntary sector, to address sexual health needs in Scotland have needed creative responses. These are reviewed by the chapter's author, Andrew Gardiner from NHS Grampian, and structures that have been put in place to facilitate partnership working across Scotland are described. These include recent requirements, through the introduction of Single Outcome Agreements and Community Planning, by Scottish Government of local authorities in Scotland to ensure that health improvement is addressed in partnership.

Examples of successful joint working from across Scotland are given that suggest where lessons could be learned for the future, especially concerning the most vulnerable population groups and indicate where useful groundwork has started.

INTRODUCTION

This chapter seeks to explore the nature of partnership working and its contribution to improving sexual health in Scotland. Of particular importance is the way in which local planning structures have developed and how these have been enhanced in relation to sexual health and wellbeing, following the introduction of *Respect and Responsibility: Strategy and Action Plan for Improving Sexual Health* (Scottish Executive, 2005a). Partnership working in relation to health improvement in general and for sexual health in particular was well established prior to the publication of *Respect and Responsibility*. It is important, therefore, to set sexual health work in the context of the wider health improvement agenda and consider the partnership working that exists between local authorities, the NHS and voluntary sector within the local arrangements for community planning. A range of practice examples will be described from different areas in Scotland to highlight some of the work that is currently in place, in recognition that a full review of practice would require a much wider study than is offered here.

JOINT PLANNING STRUCTURES AND THE ROLE OF LOCAL AUTHORITIES IN HEALTH IMPROVEMENT

Working together to improve health is not a new concept and links between the NHS, local authorities and voluntary agencies have seen a wide range of services evolve over the years, whether through joint initiatives, grants to voluntary agencies or the direct purchasing of services by statutory agencies through service level agreements. In the sexual health arena the development of agencies such as Sandyford, as discussed in Chapter 8; Brook, currently providing a young person's sexual health and counselling service in Inverness; Midlothian Young People's Advice Service, providing clinical and counselling, and The Corner, and Caledonia Youth (formerly a Brook Advisory Centre), offering similar services in Dundee, the Lothians and Falkirk respectively are clear examples of partnership funding between the NHS and local authorities, predating the publication of *Respect and Responsibility*. In relation to partnership working for health, earlier legislation underlined the commitment of organisations working together for the benefit of individual patients and communities and as Chapter 1 discusses, tendencies towards collaborative working have long existed within Scotland. The Scottish Health Plan, outlined in the *White Paper Our National Health: a plan for action, a plan for change* (Scottish Executive, 2000), required the NHS and Local Authorities to work together to improve community services and the patients' journey through health and social care systems. The process was further

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developed in the *Partnership for Care* White Paper (Scottish Executive, 2003d) which served to restate the commitment to working in partnership and joining up activity. Crucial to translating this terminology into action, though, is the degree to which real change can be identified in methods of working on the ground.

Local Authorities in Scotland are well placed to impact on the health of the population they serve through the provision of direct services to communities on a day to day basis. In common with the NHS, Councils are complex bureaucratic organisations with multi-faceted roles and responsibilities. Clearly, we can identify high levels of commonality where service provision is determined by statute, for example, through Environmental Health and Trading Standards, Housing and Homelessness legislation and through Education and Social Work. Standards of practice are set by regulation determined at national level with public accountability ensured through the publication of inspection reports, for example, by Her Majesty's Inspector of Education, the Social Work Inspection Agency and the Office of the Scottish Housing Regulator. Reports from these inspection bodies are published on their websites. (www.hmie.gov.uk, www.swia.gov.uk, www.scottishhousingregulator.gov.uk)

DEDICATED HEALTH IMPROVEMENT POSTS IN LOCAL AUTHORITIES

A paper from the Convention of Scottish Local Authorities (CoSLA)[i] acknowledges the important role that Local Authorities have in relation to health improvement. (CoSLA, 2002). This publication coincided with the introduction of the Health Improvement Officer posts in Local Authorities, jointly funded by the Scottish Executive, NHS Boards and the Local Authorities themselves. These posts were designed to build capacity for health improvement in Councils and to promote the health improvement agenda at a strategic level by linking in to the community planning process as will be described later in this chapter.

A major priority for these posts was a co-ordination role for Joint Health Improvement Plans which were designed to reflect the contribution of local authorities and their partners to local health improvement activity and provide a strategic framework for future service development. A key aspect to this process was the opportunity to set priorities based on local need within the context of national priorities for health improvement such as those outlined in *Improving Health in Scotland: the Challenge* (Scottish Executive, 2003b).

The task facing colleagues in health improvement at officer and manager level varied due to the size of the organisation, the historical priority that the authority had accorded health improvement and the continued commitment to health improvement partnership working over time. Local autonomy, whilst affording an opportunity to tailor activities to local need, created a mixed economy in relation to the position that officers occupied within departmental structures. Whilst health improvement was often highlighted as a corporate priority for councils this frequently failed to be matched with additional budgetary provision, and the competition for resources between non-statutory health improvement and statutory responsibilities often saw health improvement lose out. Through time a number of authorities chose to leave posts unfilled or cut them from the establishment on grounds of financial prudence. An organisational development report in 2007 for the Association of Local Authority Health Improvement Officers noted that 26 of the 32 authorities had officers in post - 24 of whom completed a questionnaire on the development of the Association within the allotted timescale, reflecting a high level of commitment to a co-ordinated approach to health improvement across the country (Hexagon Research and Consulting, 2007).

CHALLENGES TO LOCAL AUTHORITY ACTION ON HEALTH IMPROVEMENT

If we consider the resource implication of health improvement work in respect of other corporate priorities in local authorities we should also consider the competing priorities that exist within health improvement. As a health topic, sexual health takes its place beside issues such as physical activity, healthy eating, mental health and wellbeing, smoking, alcohol and health and homelessness – all defined as requiring special focus within the *Improving Health in Scotland: the*

[i] The representative body for elected members of local authorities across Scotland.

Challenge document (Scottish Executive, 2003b) – in the competition for funding. This underlines the importance of embedding sexual health provision in the context of community planning through the joint planning processes for health improvement.

It is important to note that across Scotland's 32 local authorities, differences in scale are inherent, given the variation in population served - ranging from Glasgow City Council with 584, 240 at June 2008 to Orkney Islands Council with 19, 890 (General Register Office for Scotland, 2008). Challenges are also faced in the provision of equitable, accessible services when comparing densely populated urban areas with remote and rural populations. This is significant in relation to the provision of health services in general, but becomes increasingly important when considering the confidentiality necessary for people to feel comfortable in seeking advice and treatment for their sexual health. If we consider the demographics of Health Board areas, even those with the large centres of population (such as Greater Glasgow and Clyde, and Lothian) display an urban and rural mix which has implications for service planning and delivery.

The current mechanism by which joint planning is progressed in Scotland is through Community Planning, a process which is 'initiated, maintained and facilitated' by local authorities (Scottish Executive, 2003e). Legislation governing community planning is contained within the Local Government (Scotland) Act 2003 and requires the participation of Health Boards, police and fire service and enterprise and transport authorities, in addition to local authorities. Further guidance highlights the need for community planning to engage with the community and to develop relationships with the voluntary sector, community councils and the local business sector (Scottish Executive, 2004). Community planning has been defined as:

> *A Framework for coping with the great variety of different agencies and sectors that can influence the future of an area, by giving Local Authorities the lead role in bringing them together in partnership to develop a plan. This sets out a shared vision of the priorities facing the area and the contributions that each partner can make in attaining that vision.*
>
> (Health Education Board for Scotland, 2002)

In practice, the degree of complexity has become apparent with the need to consider the social, economic and environmental issues facing an area, and the challenge of bringing the relevant representatives together from the different sectors in a way that allows for both productive discussion and legitimate decision making.

The 2003 Act also introduced the concept of the 'power to advance wellbeing' for local authorities stating that:

> *A local authority has power to do anything which it considers likely to promote or improve the wellbeing of –*
>
> *a) its area and persons within that area; or*
>
> *b) either of those*
>
> (Scottish Executive, 2003e)

Whilst regarded by many as a key legislative departure, it is beyond the scope of this paper to provide an analysis of its impact; suffice to say that the option of using this mechanism depended on the availability of existing rather than additional resources and the non specific nature of 'anything . . . it considers likely to promote or improve the wellbeing' mitigated against widespread change or benefit to communities or individuals within them.

In 2007 the Scottish Government and CoSLA signed an agreement (the Concordat) which saw the introduction of a new relationship between central and local government in Scotland (Scottish

Government, 2007b). This Concordat [ii]has significant implications for local government finance through reducing ring fenced specific grants and requires Community Planning Partnerships to submit a new joint planning document, the Single Outcome Agreement (SOA), reflecting strategic priorities for local areas. The SOA outlines actions across the Partnership, both collectively and for partner organisations, demonstrating how the outcomes from these actions will contribute to the Scottish Government's National Outcomes.

RESPECT AND RESPONSIBILITY – NATIONAL AND LOCAL RESPONSES

The publication of *Respect and Responsibility* (Scottish Executive, 2005a) marked a significant milestone in relation to national guidance for improving the sexual health of the Scottish population. Despite the good work that had been developed through the introduction of Sexual Health Strategies across some NHS Health Board areas in the 1990s and early 2000s, recognition had been given to the need for consistency across Scotland to build on the productive partnerships already in place. The introduction to the document highlights the concern over Scotland's poor sexual health record both in terms of sexually transmitted infections and teenage conception rates. Furthermore, it recognises the inequalities dimension by acknowledging that teenagers in the most deprived areas are three times more likely to become pregnant than those in the more affluent areas (Scottish Executive, 2005a).

Respect and Responsibility reflects the value of working together in partnership whilst outlining the responsibilities for the agencies involved in sexual health promotion and treatment. This included outlining the role of the Scottish Executive, including Health and Education Departments, the Local Authority role, the responsibility of local NHS Boards through their nominated Executive Director and Lead Clinician and the role of Special Health Boards. It further comments on the role of the Scottish Prison Service and suggests the positive part that parents can play in supporting the sexual health education process for their children (Scottish Executive, 2005a).

At national level, as well as recognising the wider influences on sexual health, promoting inclusion and challenging stereotypes, the document highlights the need to integrate sexual health in the wider Executive policies and initiatives. At NHS Board level, the challenge is laid down to deliver a co-ordinated approach whereby community and health improvement plans address the issues that impact on the sexual health of the population.

Recognition is given to the role of schools in sex and relationship education and the important part that parents have to play as well and this runs alongside the development of health promoting schools and the Curriculum for Excellence on which education services will be based in the coming decades. (Curriculum for Excellence Scotland, 2009). *Respect and Responsibility* concludes with the following statement:

> *The challenge now for us all is to turn words into action…the pursuit on the part of all of us – whether statutory or voluntary organisations, faith groups or individuals – of the principles of respect and responsibility, which underpin this strategy, will help us along the way to improved sexual health and wellbeing in Scotland.* (Scottish Executive, 2005a)

The model used in the NHS Lothian Health Board area to co-ordinate planning for sexual health services saw the establishment of the Sexual Health Project Board (SHPB) which reported to the full NHS Board. The SHPB was made up of representatives from reproductive health, genitourinary medicine, public health, health promotion, the local authorities and voluntary sector and included the chairs of the more local Sexual Health Promotion Groups covering the four local authority areas of the City of Edinburgh, East, Mid and West Lothian. The Chair of the SHPB was the lead clinician in NHS Lothian. Opportunity existed at the Sexual Health Promotion Groups to link to the Joint Health Improvement Planning process and thence to the community planning partnerships.

[ii] (See information about the Concordat at http://www.scotland.gov.uk/Resource/Doc/923/0054147.pdf).

The existence of the overseeing body allowed for the development of an overall Lothian Sexual Health Strategy and for the creation of Sexual Health Action Plans for the four local areas. In Midlothian, a framework which provided a focus for addressing health inequalities had been developed through the joint health improvement plan, with the understanding that future strategic documents would utilise this mechanism as part of their deliberations. By using the Venn diagram over the areas of social deprivation, age stages and health related topics, some examples of which are included, the intention was to view the planning process through the lens of health inequalities.

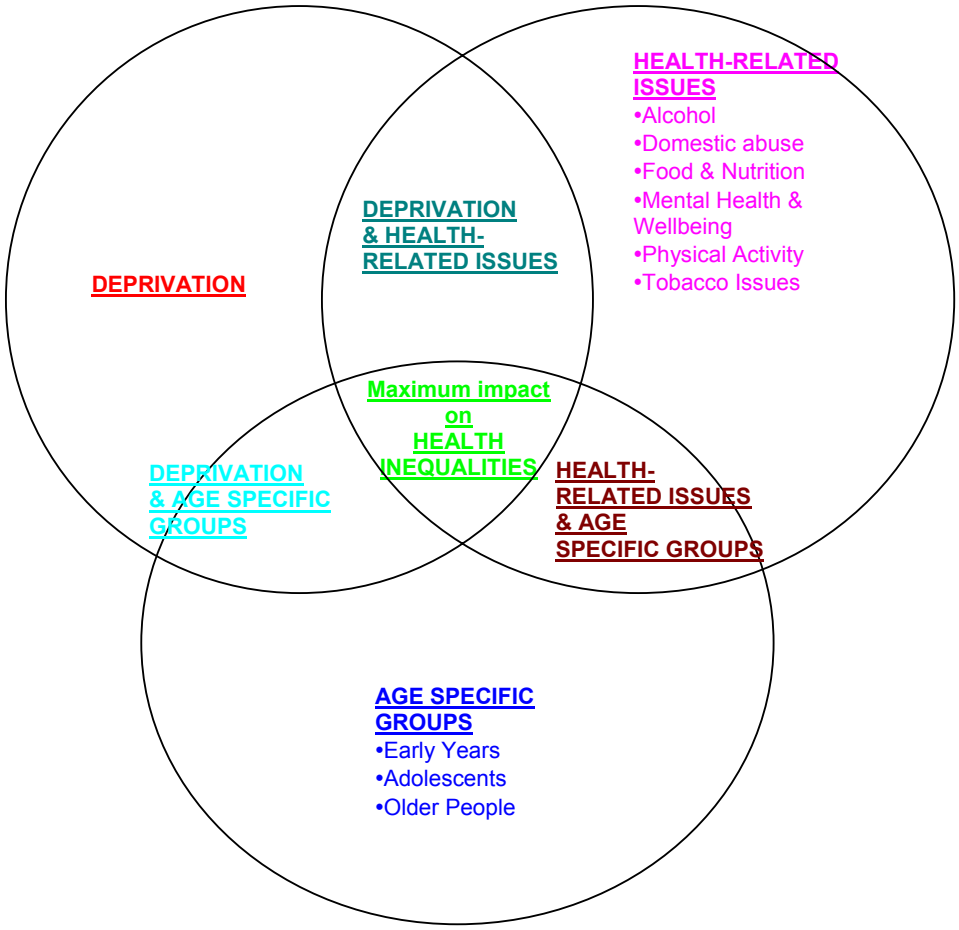

Diagram 1: Priority areas for targeted action on health improvement and to reduce health inequalities in Midlothian.[iii]

Sexual health was not formally included as a priority area as there was already a programme of work underway to develop a new Action plan for the area. The Midlothian Sexual Health Action Plan 2009 – 2011 (NHS Lothian, 2009), however, has been developed with recognition of the need to have this perspective of health inequalities at its core.

PRACTICE EXAMPLES

Respect and Responsibility annual reports (Scottish Executive, 2006b; Scottish Government, 2007a) contain examples of practice which reflect good partnership working in terms of both service design and accessible practice. The implementation of *Respect and Responsibility* guidance

[iii] From Midlothian Joint Health Improvement Plan 2007 – 10
http://www.midlothian.gov.uk//Article.aspx?TopicId=0&ArticleId=21356

> *…involves a wide range of groups and agencies, including schools, health services, the voluntary sector and parents. Across Scotland progress is being made in encouraging different agencies to work together more closely to improve sexual health.*
>
> (Scottish Government, 2007a, p. 34).

The development of Sexual Health and Relationships Education (SHARE) in Highland was acknowledged through the introduction of a 'Training for Trainers' course which significantly improved the numbers available to provide SHARE across the region. Staff from health promotion and health promoting schools, including school nurses and youth development officers, benefited from this training. It operated alongside enhanced school nurse-led drop-in facilities across the region which improved local access to sexual health advice for young people in line with national expectations (Scottish Government, 2007a).

Other developments have also encouraged new ways of partnership working to progress sexual health and relationships education. For example NHS Health Scotland have produced a leaflet in partnership with parents using the 'Writeshop' method whereby the target audience, topic experts, editors and designers collaborate to produce the finished article in a short space of time (NHS Health Scotland, 2007). At a local level, a young parents group in West Dunbartonshire in the West of Scotland have produced a DVD called '9 Months After' targeted at secondary school children to promote understanding about what it is like to be a parent (Scottish Executive, 2006b).

At the service end, improvements in nurse practitioner-led clinics in Fife and service redesign in Dumfries and Galloway, bringing the family planning and sexual health service together with genitourinary medicine (GUM) have served to increase patient throughput and improve accessibility of a wider range of services for rural areas respectively (Scottish Executive, 2006c). In Aberdeen, an integrated sexual health service was created in 2006 whereby sexual and reproductive health and GUM services were transferred to the management of Aberdeen City Community Health Partnership (CHP). This move was designed to promote closer working relationships with the ultimate aim of benefiting both patients and the organisations involved. (Scottish Government, 2007a).

In response to the concerns of the National Sexual Health Advisory Council (NSHAC) funding was made available to local authorities to improve resources and capacity to delivery SHARE training. This funding was made available through Learning and Teaching Scotland, and Argyll and Bute benefitted with an award of £13,200 for 2007/08 and 2008/09. The aim of the project was two-fold. Firstly, to facilitate the delivery of SHARE training to key personnel in Education and Health, and secondly, to ensure the delivery of high quality SHARE education consistent with national guidance to all secondary pupils in the area.

The delivery of the training was undertaken in partnership between the Education Support Officer from Argyll and Bute Council and the Senior Health Promotion Officer of NHS Highland. Reflecting the dispersed population of the area, courses were run in Inveraray, Oban, and on the island of Islay. In addition to mainstream SHARE activity, a resource for pupils with special needs entitled SHARE Special has been purchased, with training provided by NHS health promotion staff and educational psychology. At primary school level a copy of Channel 4's 'Living and Growing' is being provided for all Primary Schools. Future plans include the training for trainers course which NHS staff will attend. This example is a clear demonstration of local multi disciplinary partnerships delivering services to schools for the benefit of pupils and communities in the present and in the future.

East Dunbartonshire has been able to incorporate their Sexual Health Action Plan within their Joint Health Improvement Plan. The Action Plan was developed following an extensive parents survey carried out by the NHS, East Dunbartonshire Council and parents themselves. Several

priorities that emerged from this exercise have been included in the joint health improvement process. Work will focus on improving sexual health and the development of healthy relationships for young people in East Dunbartonshire by implementing the Sexual Health Action Plan (2009 – 2011). This will include:

- A new youth priority sexual health clinic in the area
- Engagement with parents in developing guidelines for schools
- Work with staff who support looked after children and young people

Plans are in place to engage young people in the development of a youth health drop in service to complement the Youth Priority Sexual Health Clinic. This will be achieved by the development of a partnership steering group and the recruitment of young people to participate in the service development, creating a health information service for young people by spring 2010.

The model of sexual health provision within a holistic health setting has also been highlighted in Renfrewshire where the 'Stop In, Drop In' project offers a weekly health drop in service for young people. The sessions take place after school in Linwood Health Centre and are run by a school nurse and school support worker. Activities have included Homelink delivering sessions around relationships, the health improvement team discussing issues such as smoking cessation, sexual health, body image and emotional health and specific awareness raising sessions such as the position of young carers with the help of the Renfrewshire Young Carers organisation.

In North Ayrshire, resources have been made available to pilot enhanced school nurse drop in services in two schools. These will offer advice on lifestyle issues as well as sexual health issues such as Chlamydia testing, pregnancy testing and contraception. In addition to the multidisciplinary approach to SHARE training which is evident in many areas, NHS Ayrshire and Arran have developed a training programme for professional and other staff following a training needs analysis which included local authority staff, parents and carers in addition to NHS staff. A collaborative exercise with school pupils, teachers and school nurses has resulted in the production of a DVD on puberty for use in Ayrshire schools.

The holistic model is also in evidence in West Lothian where the 'Chill Out Zone' (COZ) – a healthy living centre supported by the Big Lottery Fund – offers young people a range of services from sexual health, mental health, lifestyle and relationships issues to an internet café and cooking skills courses. There is also provision for groups who have been identified as requiring more support such as LBGT young people and looked after children or those at the point of leaving care. COZ is managed by Children 1st [iv] in partnership with West Lothian Council and NHS Lothian.

In recognition of the close link between substance misuse and sexual behaviour, the WEB Project run by CAIR Scotland has developed in Dundee, Perth, Kinross and Angus in Central and North-East Scotland to intervene with at risk young people between the ages of 10 and 25. The aims of the WEB Projects are:

- To encourage community involvement of young people and support their development of responses to key issues affecting their own health, lives and those of their peers
- To encourage and support young people in their gaining understanding of local community health needs and risk behaviour issues
- To provide support to young people involved in risk behaviours in relation to drugs/alcohol and sexual health
- To develop programmes to support young people involved in risk taking behaviour in relation to drugs/alcohol and unsafe sexual activity.

[iv] A large voluntary organisation in Scotland providing services for children, young people and their families.

The WEB projects offer options ranging from streetwork in targeted areas, outreach programmes, groupwork, one to one support and counselling, pregnancy testing, Chlamydia screening and participating in the C-Card scheme. (The C-Card scheme, a targeted distribution for condoms, is popular across Scotland and runs in many areas). The WEB projects reflect a partnership approach between the voluntary sector, NHS Tayside and the local authorities of Angus, Dundee and Perth and Kinross.

In Midlothian in Scotland's Central Belt, the Sexual Health Promotion Group in collaboration with Community Learning Disability Nurses are taking forward a project to develop a visual map of sexual health services in the area to enable those with low literacy levels, people with a learning disability or people who do not have English as their first language to easily access services on offer in the community. (NHS Lothian, 2009)

The advent of the technological age has also served to increase opportunities for advice and information to the computer literate and has been particularly productive in supporting young people in accessing services. Organisations such as HIV Scotland[v], Healthy Respect[vi], LGBT Youth[vii], Brook[viii] and Caledonia Youth[ix] all have well developed websites which give information and signposting to services. More general websites such as Young Scot[x] also have portals which allow access to relationships and sexual health advice. As other chapters have highlighted, the new Scottish Government-funded website on sexual health and relationships prioritises young people as one of its target groups.

CONCLUSION

This chapter has set out the governance and administrative frameworks that underpin much of the health improvement partnership work on sexual health across Scotland. It has set out a range of practice examples, existing across the country, that demonstrate a high level of commitment to the sexual health improvement of the Scottish population. Only a few have been included here but the enthusiasm of professionals and volunteers contributing to the development of innovative services in sexual health shines through. The success of these and many other examples is underpinned by the philosophy of partnership working and the recognition that no one organisation on their own can tackle all the complex components involved in the provision of an accessible sexual health service which meets the needs of all members of our communities.

Community Planning Partnerships have a key role to play in the provision of services and allocation of funding and for professionals working in local authorities, the NHS or voluntary sector a major challenge in the coming years will be to impact on the Single Outcome Agreements through identifying local champions to embed sexual health provision as a high level priority for local communities. This is particularly important in the current financial climate when public services need to make efficiency savings leaving non-statutory but very worthwhile initiatives in a vulnerable position. Good foundations have been built through *Respect and Responsibility* and through the development of joint health improvement planning processes. Let us hope that these are the building blocks for future partnership working, for developments in tackling health inequalities and for continued health gain through service improvements and innovative practice.

[v] www.hivscotland.com
[vi] www.healthyrespect.co.uk
[vii] www.lgbtyouth.org.uk
[viii] www.brook.org
[ix] www.caledoniayouth.org
[x] www.youngscot.org

REFERENCES

Alexander, M. (2009), Commission in Scotland calls time on consensus that threatens Scotland's future. *Equality and Human Rights Commission website* http://www.equalityhumanrights.com/scotland/equality-news-in-scotland/commission-in-scotland-calls-time-on-consensus-that-threatens-scotland-s-future./ [accessed on 13 October 2009].

Ball, W. and Sturgeon, F. (2004), *Towards Creating a Culture: A report about Healthy Respect's work demonstrating the development and implementation of mass media campaigns, its brand and Communications Strategy*. Healthy Respect, NHS Lothian.

BBC (2004), Sex education plan angers faiths *BBC News website* http://news.bbc.co.uk/1/hi/scotland/3609736.stm [accessed on 13 October 2009].

BBC (2005), Love Hurts: Panorama. First broadcast on 16 October 2005 on BBC1 [Transcript available at: http://news.bbc.co.uk/1/hi/programmes/panorama/4358384.stm].

Bigrigg, A., Nandwani, R., Ilett, R., Thow, C., Lamont, M., Bankowska, U. and Brechin, S. (2005), 'Use of a staff administered structured questionnaire to identify relevant life-style issues and social-health determinants in a sexual and reproductive health service'. *European Journal of Contraception and Reproductive Health Care,* vol. 10, no. 1, pp. 66-72.

Bloor, M. J., Gannon, M., Hay, G., Jackson, G., Leyland, A. and McKeganey, N. (2008), 'Contribution of problem drug users' deaths to excess mortality in Scotland: secondary analysis of cohort study'. *British Medical Journal,* vol. no. 337, pp. 478-481.

Bloor, M. J., McKeganey, N. P. and Barnard, M. A. (1990), 'An Ethnographic Study of HIV-Related practices among Glasgow Rent Boys and their clients: a report of a pilot Study'. *AIDS Care,* vol. 2, pp. 17-24.

Bradford, E (2008), Cultural views affect STI rates. *BBC News Scotland website, 11 September* http://news.bbc.co.uk/1/low/scotland/7610783.stm [accessed on 13 October 2009].

British Association for Sexual Health and HIV (BASHH) (2009), BASHH Clinical Effectiveness Group Guidelines. *BASHH website* http://www.bashh.org/guidelines [accessed on 16 August 2009].

Cant, B. (2008), *Footsteps & Witnesses: lesbian and gay lifestories from Scotland*. Wordpower Books, Edinburgh.

Carlisle, S. and Hanlon, P. (2007a), 'The complex territory of well-being: contestable evidence, contentious theories and speculative conclusions'. *Journal of Public Mental Health,* vol. 6, no. 2, pp. 8-13.

Carlisle, S. and Hanlon, P. (2007b), 'Wellbeing in a consumer culture'. *Health Promotion International,* vol. 22, no. 3, pp. 261-268.

Carlisle, S. and Hanlon, P. (2008), "Well-being' as a focus for public health? A critique and defence'. *Critical Public Health,* vol. 18, pp. 263-270.

Carlisle, S., Hanlon, P. and Hannah, M. (2008), 'Status, taste and distinction in consumer culture: acknowledging the symbolic dimensions of inequality.' *Public Health,* vol. 122, pp. 631-637.

Carr, S. V., Scoular, A., Elliott, L., Ilett, R. and Meager, M. (1999), 'A community based lesbian sexual health service - clinically justified or politically correct?'. *British Journal of Family Planning,* vol. 25, no. 3, pp. 93-95.

Carr, S., Goldberg, D. J., Elliott, L., Green, S., Mackie, C. and Gruer, L. (1996), 'A primary health care service for Glasgow street sex workers - 6 years experience of the 'Drop-in Centre' 1989-1994'. *AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV,* vol. 8, no. 5, pp. 489-498.

Carron, C. (2000), *The Sandyford Initiative - proposed management arrangements*. March 2000, internal document.

Carstairs, V. and Morris, R. (1989), 'Deprivation: explaining differences in mortality between Scotland and England and Wales.'. *British Medical Journal,* vol. 299, pp. 886-889.

Claire, C (2008), Catholic church moves into Pole position. *The Scotsman,* 25 May [Available at: http://scotlandonsunday.scotsman.com/latestnews/Catholic-church-moves-into-Pole.4118420.jp].

Published by Bentham Science Publishers

Connell, J. and Hart, G., 2003. *An overview of male sex work in Edinburgh and Glasgow: the male sex worker perspective*. Medical Research Council, Social and Public Health Sciences Unit, Occasional Paper 8, University of Glasgow, Glasgow.

Convention of Scottish Local Authorities (2002), *Local Authorities as Health Improvement Organisations*. CoSLA, Edinburgh.

Cook, A., Petch, A., Glendinning, C. and Glasby, J. (2007), 'Building Capacity in Health and Social Care Partnerships : Key Messages from a Multi-Stakeholder Network'. *Journal of Integrated Care,* vol. 15, no. 4.
[Available at: http://www.dhcarenetworks.org.uk/_library/JIC-15.4_Cook_et_al.pdf].

Cowing, E (2008), Sex and the Scottish. *The Scotsman,* 12 February
[Available at: http://thescotsman.scotsman.com/features/Sex-and-the-Scottish.3766459.jp].

Craddock, C. and Reid, M. (1993), 'Structure and struggle: implementing a social model of a well woman clinic in Glasgow'. *Social Science and Medicine,* vol. 36, no. 11, pp. 67-76.

Craig, C. (2003), *The Scots' Crisis of Confidence.* Big Thinking, Glasgow.

Curriculum for Excellence Scotland (2009), *Curriculum for Excellence: health and wellbeing, principles and practice*. [Available at: http://www.ltscotland.org.uk/Images/health_wellbeing_principles_practice_tcm4-540091.doc] (accessed on: 16 September 2009).

Dahlgren, G. and Whitehead, M. (1992), *Policies and Strategies to Promote Equity in Health*. WHO Regional Office for Europe, Copenhagen.

Daily Mail (2001), Sordid sex packs aimed at pupils as young as 11. *Daily Mail*, December 5 2001.
[Available at: http://findarticles.com/p/news-articles/daily-mail-london-england-the/mi_8002/is_2001_Dec_5/sordid-packs-aimed-pupils-young/ai_n36473430/]

Daily Record (2005), Abused men get new hope. *Daily Record,* September 20 2005.

Davidson, R. (2000), *Dangerous Liaisons: A Social History of Venereal Disease in Twentieth Century Scotland.* Rodopi, Amsterdam/Atlanta.

De Croy, D. (1990), *Pilot Study - Male Prostitutes, Glasgow (Phase One - Overview of services in the UK)*. Adult Care Team, Strathclyde Regional Council, Glasgow.

De Croy, D. (1991), *Pilot Study - Male Prostitution, Glasgow (Phase Two - Street based outreach work in Glasgow)*. Adult Care Team, Strathclyde Regional Council, Glasgow.

Dehani, R (2009), Lost Generation: Are modern HIV campaigns failing younger gays? *Pink News*
http://www.pinknews.co.uk/news/articles/2005-13590.html
[accessed on 13 October 2009].

Department for Schools, Children and Families (2009), National teenage pregnancy strategy *Department for Schools, Children and Families website*
http://www.dcsf.gov.uk/everychildmatters/healthandwellbeing/teenagepregnancy/about/strategy/
[accessed on 23 October 2009].

Department of Health (2001), *Better prevention, Better services, Better sexual health - The national strategy for sexual health and HIV*. Department of Health, London.
[Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003133].

Department of Health (2004a), *Agenda for Change: Final Agreement*. Department of Health, London.
[Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4095943].

Department of Health (2004b), *Choosing Health: making health choices easier*. Department of Health, London.

Department of Health (2006a), *Competencies for providing more specialised sexually transmitted infection services within primary care - Assessment Toolkit*. Department of Health, London.
[Available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_089730.pdf].

Department of Health (2006b), *Modernising nursing careers - setting the direction*. Department of Health, London.

Department of Health, Social Services and Public Safety (2002), *Teenage Pregnancy and Parenthood: Strategy and Action Plan 2002-2007*. DHSSPS, Belfast. [Available at: www.healthpromotionagency.org.uk/Resources/strategies/mythsandreality.htm].

Department of Health, Social Services and Public Safety (2008), *Sexual Health Promotion: Strategy and Action Plan 2008*. DHSSPS, Belfast. [Available at: www.dhsspsni.gov.uk/dhssps_sexual_health_plan_front_cvr.pdf].

Donovan, B., Neilsen, G., and Mindel, A. (1995), 'Australia and New Zealand have taken the lead.' 6 May. *British Medical Journal,* vol. 310, no. 6988, p. 1194.

Dorling, D. (1997), *Death in Britain. How local mortality rates have changed: 1950s - 1990s*. Joseph Rowntree Foundation, York.

Easterbrook G. (2003), *The progress paradox: How life gets better while people feel worse.* Random House, London.

Eckersley, R. (2004), *Well and Good: how we feel and why it matters.* Text Publishing, Melbourne, Australia.

Edinburgh Evening News (2002), A case of too much, too young*? Edinburgh Evening News*, October 21 2002. [Available at: http://findarticles.com/p/news-articles/evening-news-edinburgh-scotland/mi_7832/is_2002_Oct_21/young/ai_n33253820/]

Edwards, W. M. and Coleman, E. (2004), 'Defining Sexual Health: A Descriptive Overview'. *Archives of Sexual Behavior,* vol. 33, no. 3, June, pp. 189-195(7).

Erens, B. and Primatesta, P. (1999), *Health Survey for England: Cardiovascular Disease, Volume 1: Findings and Volume 2: Methodology and Documentation.* HMSO, London.

Expert Reference Group (2003), *Enhancing Sexual Wellbeing in Scotland A Sexual Health and Relationships Strategy Proposal to the Scottish Executive*. Scottish Executive, Edinburgh. [Available at: http://www.scotland.gov.uk/Publications/2003/11/18502/28850]

Faculty of Sexual and Reproductive Healthcare (2009), Setting standards in contraception - Improving sexual health for all. *FSRH website* http://www.ffprhc.org.uk/ [accessed on 16 August 2009].

Family Planning Directorate and Genitourinary Medicine Directorate, Greater Glasgow Health Board (1998), *Proposal to deliver family planning and reproductive health, genitourinary medicine and sexual health services from a single site alongside the Centre for Women's Health in the Eye Infirmary*. Greater Glasgow Health Board, internal document.

fpa NI (2001), *The legal position regarding contraceptive advice and provision to young people,* fpa NI Factsheet. fpa NI, Belfast.

fpa NI (2003), *Abortion.* fpa NI Factsheet. fpa NI, Belfast.

French, R., Mercer, C., Kane, R., Kingori, P., Stephenson, J. M., Wilkinson, P., Grundy, C., Lachowycz, K., Jacklin, P., Stevens, M., Brooker, S. and Wellings, K. (2007), 'What impact has England's teenage pregnancy strategy had on young people's knowledge of and access to contraceptive services?'. *Journal of Adolescent Health,* vol. 41.

General Register Office for Scotland (2008), Summary Statistics for Council Areas *GROS website* http://www.gro-scotland.gov.uk/statistics/council-areas-map/index.html [accessed on 15 September 2009].

General Register Office for Scotland (2009), News Release: Scottish Population Continues to Rise, 28th April *General Register Office for Scotland website* http://www.gro.scotland.gov.uk/press/2009/scottish-population-continues-to-rise.html [accessed on 13 October 2009].

Gillespie, R. (2002) 'Architecture and power: a family planning clinic as a case study'. *Health and Place*, vol. 8, pp. 211-220.

Gillie, O. (2008), *Scotland's Health Deficit: An Action Plan*. Health Research Forum, London. [Available at: http://www.healthresearchforum.org.uk/reports/scotland.pdf].

Glasier, A., Metin Gülmezoglu, A., Schmid, G. P., Moreno, C. G. and Van Look, P. F. A. (2006), 'Sexual and reproductive health: a matter of life and death'. *The Lancet,* vol. 368, no. 547, pp. 1595-1607.

Glasier, A., Scorer, J. and Bigrigg, A (2008), 'Attitudes of women in Scotland to contraception: a qualitative study to explore the acceptability of long-acting methods'. *Journal of Family Planning and Reproductive Health Care,* October*,* vol. 34, no. 4, pp. 213-217.

Greer, S. L., (Ed) (2009), *Devolution and Social Citizenship in the UK*. Policy Press, Bristol.
Griffiths, S., Jewell, T. and Donnelly, P. (2005), 'Public health in practice: the three domains of public health'. *Public Health,* vol. 119, pp. 907-913.
Hanlon, P. (2001), *Chasing The Scottish Effect - Why Scotland needs a step-change in health if it is to catch up with the rest of Europe*. Public Health Institute of Scotland, Glasgow.
Hanlon, P., Lawder, R. S., Buchanan, D., Redpath, A., Walsh, D., Wood, M., Bain, M., Brewster, D. H. and Chalmers, J. (2005), 'Why is mortality higher in Scotland than in England and Wales? Decreasing influence of socioeconomic deprivation between 1981 and 2001 supports the existence of a 'Scottish Effect''. *Journal of Public Health,* vol. 27, no. 2, pp. 199-204.
Hanlon, P. (2009). Personal communication with Dr Rosie Ilett.
Haslam, S. (2006), *Evaluation of the Thrive Service*. Scottish Executive, National Programme for Improving Mental Health and Well-being, Small Research Projects Initiative 2005-06, Edinburgh. [Available at: http://www.scotland.gov.uk/Resource/Doc/156882/0042195.pdf].
Hassan, G. and Warhurst, C. (Eds) (2002), *Tomorrow's Scotland.* Lawrence and Wishart, London.
Health Education Board for Scotland (2002), *Understanding the Policy Maze.* HEBS, Edinburgh.
Health Protection Scotland (2009), HIV infection and AIDS: Quarterly report to 31 December 2008. *HPS Weekly Report,* 4 February 2009 Volume 43 No. 2009/05 ISSN 1753-4224 [Available at: http://www.documents.hps.scot.nhs.uk/ewr/pdf2009/0905.pdf].
Healthy Respect (2007), *All I want-LIVE standards*. Healthy Respect, Edinburgh. [Available at: http://www.healthyrespect.co.uk/downloads-and-campaigns/resources-for-professionals-info.htm].
Healthy Respect (2009), About Healthy Respect *Healthy Respect website* www.healthyrespect.co.uk/about-healthy-respect.htm [accessed on 16 August 2009].
Hexagon Research and Consulting (2007), *Organisational Development of the Association of Scottish Local Authority Health Improvement Officers*. Hexagon Research and Consulting, Edinburgh. [Available at: http://www.cosla.gov.uk/attachments/aslahio/ASLAHIOOrgDevReport.pdf].
Huppert, F. A., Baylis, N and Keverne, B (Eds) (2005), *The Science of Well-Being.* Oxford University Press, Oxford.
Ilett, R. (1998), *The Sandyford Initiative: a possible healthy living centre?* September 29, internal document.
Ilett, R. (2000), *Discussion Paper: Advisory Group for the Sandyford Initiative*. May 2000, internal document.
Ilett, R. (2008), Learning benefits admin staff. *Managers in Partnership Report,* July 2008.
Irwin, R. (1997), 'Sexual health promotion and nursing'. *Journal of Advanced Nursing,* vol. 25, no. 1, pp. 170-177.
ISD and Health Protection Scotland (2009), Data Augmentation for Sexual Health (DASH) *ISD Scotland website* http://www.isdscotland.org/isd/4910.html [accessed on 16 August 2009].
ISD Scotland (2008a), Key Clinical Indicators for Sexual Health *ISD Scotland website* http://www.isdscotland.org/isd/5410.html [accessed on 16 August 2009].
ISD Scotland (2008b), *Mystery Shopper Study 2008 - GUM. A study of GUM service access for acute STIs in Scotland***.** ISD Scotland. [Available at: http://www.isdscotland.org/isd/5727.html] (accessed on: September 2009).
ISD Scotland (2009), Sexual Health: Teenage Pregnancy. *ISD Scotland website* http://www.isdscotland.org/isd/2071.html#excel_tables_and_charts [accessed on 02 November 2009].
Jobst, K. A. and Shostak, D. (1999), 'Diseases of Meaning, Manifestations of Health, and Metaphor'. *The Journal of Alternative and Complementary Medicine,* vol. 5, no. 6, pp. 495-502.
Kane, R. and Wellings, K. (1999), 'Integrated sexual health services: the views of medical professionals'. *Culture, Health and Sexuality,* vol. 1, no. 2, 1 June 1999, pp. 131-145(15).
Keating, M. (2005), *The Government of Scotland.* Edinburgh University Press, Edinburgh.
Keating, M. (2009), *The Independence of Scotland.* Oxford University Press, Oxford.
Kellas, J.G. (1989), *The Scottish Legal System* (4th Ed). Cambridge University Press, Cambridge.
Keogh, P., McGough, P. and Macfarlane, D. (2008), *Can alcohol screening and brief interventions work in a young people's sexual health service?* Alcohol Education and Research Council, London. [Available at: http://www.aerc.org.uk/documents/pdfs/insights/AERC_AlcoholInsight_0058.pdf].

Keverne, E. B., (2005), 'Understanding well-being in the evolutionary context of brain development', In: F. A. Huppert, N. Bayliss, and B. Keverne, (Eds) *The Science of Well-Being.* Oxford University Press, Oxford.

Kinn, S. (2002), *A before and after study of the clinical impact, user and staff satisfaction of the integration of sexual, reproductive and women's health services*. Glasgow Caledonian University.

Kinn, S., Macdonald, C., Hinks, S., Nandwani, R., Ilett, R., Carr, S. and Bigrigg, A. (2003), 'Client and staff views on facilities and services, before and after the convergence of sexual, reproductive and women's services'. *European Journal of Contraception and Reproductive Health Care,* vol. 8, pp. 65-74.

Knussen, C., Bingham, D. and Flowers, P. (2008), 'The acceptability of health service and community-based venues for syphilis testing amongst men who have sex with men: The views of potential service users in Scotland'. *Public Health,* vol. 122, no. 9, September, pp. 959-961.

Kodner, D. L. and Spreeuweberg, C. (2002), 'Integrated care: meaning, logics, applications and implications - a discussion paper'. *International Journal of Integrated Care,* vol. 2, 14th November, no. 12.

Lakha, F. and Glasier, A. (2006), 'Unintended pregnancy and use of emergency contraception among a large cohort of women attending for antenatal care or abortion in Scotland'. *Lancet,* vol. 368, pp. 1782-1787.

Laughlin, S. (1998a), *The Sandyford Initiative: creating added value to health and health care*. Greater Glasgow NHS, internal document.

Laughlin, S. (1998b), 'From theory to practice - the Glasgow experience', In: L. Doyal, (Ed) *Women and Health Services.* Open University Press, Buckingham, pp. 221-237.

Laughlin, S., Nandwani, R., Ilett, R. and Bigrigg, A. (2001), 'The Sandyford Initiative: creating added value to health and health care'. *Health Bulletin,* vol. 59, no. 4, July, pp. 238-243.

Lawson, L., Mackenzie, L. and Mackinnon, J. (2002), *Evaluation of the Sandyford Initiative: Having Your Voice Heard: final report*. University of Glasgow, Glasgow.

Layard, R. (2006), *Happiness: Lessons from a New Science.* Penguin Books, London.

Lefebvre, R. C. and Flora, J. A. (1988), 'Social marketing and public health intervention'. *Health Education Quarterly,* vol. 15, no. 3, pp. 299-315.

Leon, D. A., Morton, S., Cannegieter, S. and McKee, M. (2003), *Understanding the health of Scotland's population in an international context; a review of current approaches, knowledge and recommendations for new research directions*. Public Health Institute of Scotland, Glasgow.

Leyland, A. H., Dundas, R., McLoone, P. and Boddy, F. A. (2007), *Inequalities in mortality in Scotland 1981-2001*. MRC Social and Public Health Sciences Unit. MRC Occasional Papers, Glasgow.

London School of Hygiene and Tropical Medicine, University College London, and BMRB (2005), *TPSE: Teenage Pregnancy Evaluation: Final Report 2005*. [Available at: http://www.dcsf.gov.uk/research/data/uploadfiles/RW38B.pdf].

Lovett, J., Regan, L. and Kelly, L. (2004), *Home Office Research Study No.285. Sexual Assault Referral Centres: developing good practice and maximising potential.* Home Office, London. [Available at: http://www.homeoffice.gov.uk/rds/pdfs04/hors285.pdf].

Low, N., McCarthy, A., Macleod, J., Salisbury, C., Campbell, R., Roberts, T. E., Horner, P., Skidmore, S., Sterne, J. A. C., Sanford, E., Brahim, F., Holloway, A., Patel, R., Barton, P. M., Robinson, S. M., Mills, N., Graham, A., Herring, A., Caul, E., Davey Smith, G., Hobbs, F. D. R., Ross, J. D. C. and Egger, M. for the Chlamydia Screening Studies Project Group (2007), 'Epidemiological, social, diagnostic and economic evaluation of population screening for genital chlamydial infection'. *Health Technology Assessment 2007,* vol. 11, no. 8. [Available at: http://www.hta.ac.uk/fullmono/mon1108.pdf].

MacDowall W., G. M., Nanchahal K. and Wellings K. (2002), *Analysis of Natsal 2000 data for Scotland.* Health Education Board Scotland, Edinburgh

Mahood, L. (1993), *The Magdalenes.* Routledge, London.

McKeganey, N. P., Barnard, M. A. and Bloor, M. J. (1990), 'A Comparison of HIV-Related Risk Behaviour and Risk Reduction between Female Street Working Prostitutes and Male Rent Boys in Glasgow'. *Sociology of Health and Illness,* vol. 12, no. 275, p. 292.

McLoone, P. and Boddy, F. (1994), 'Deprivation and mortality in Scotland, 1981 and 1991'. *British Medical Journal,* vol. 309, pp. 1465-1470.

Medical Foundation for AIDS and Sexual Health (2005), *Recommended standards for sexual health services*. Medical Foundation for AIDS and Sexual Health, London. [Available at: http://www.medfash.org.uk/publications/current.html].

Melville, C., Bigrigg, A. and Nandwani, R (2003), 'Impact of the Sexually Transmitted Infections Foundation course on the knowledge of family planning nurses and doctors.' [letter] *Sexually Transmitted Infections,* vol. 79 p. 346.

Ministry of Health (1968), *Health Services and Public Health Act*, HMSO, London.

Mitchell, R., Fowkes, G., Blane, D. and Bartley, M. (2005), 'High rates of ischaemic heart disease in Scotland are not explained by conventional risk factors'. *Journal of Epidemiology and Community Health,* vol. 59, pp. 565-567.

Mitleton-Kelly, R. (2004), 'Co-evolutionary integration: a complexity perspective on mergers and acquisitions', paper presented at the 20th EGOS Colloquium 2004, Ljubljana University, Slovenia. [Available at: http://www.psych.lse.ac.uk/complexity/papers/co_evolutionaryintegration.pdf].

Nandwani, R. (2005), 'Sexual health and HIV in Scotland'. *Sexually Transmitted Infections,* vol. 81, editorial, pp. 3-4.

National Assembly for Wales (2000), *A Strategic Framework for Promoting Sexual Health in Wales*. Health Promotion Division, Cardiff. [Available at: http://www.wales.nhs.uk/sites3/Documents/568/WAGStrategicFramework.pdf].

National Institute for Health and Clinical Excellence (NICE) and the National Collaborating Centre for Women's and Children's Health (2005), *Long-acting reversible contraception: the effective and appropriate use of long-acting reversible contraception. Clinical Guideline 30*. RCOG Press, London. [Available at: http://www.nice.org.uk/nicemedia/pdf/CG030fullguideline.pdf].

National Institute for Health and Clinical Excellence (NICE) (2009) *NICE website* http://www.nice.org.uk/ [accessed on 16 August 2009].

National Sexual Health Advisory Committee (2005), *Notes of Second Meeting held on Monday 24 October 2005*. [Available at: www.scotland.gov.uk/Topics/Health/health/sexualhealth/advisory-committee/minutes/second-meeting].

Nettle, D. (2005), *The Science Behind Your Smile.* Oxford University Press, Oxford.

NHS Education for Scotland (2007), *A Route to Enhanced Competence in Sexual and Reproductive Health Nursing*. NHS Education for Scotland, Edinburgh.

NHS Education for Scotland (2009), *A Career Framework for Nursing in Sexual and Reproductive Health*. NHS Health Education for Scotland, Edinburgh.

NHS Grampian (2007), Effective Implementation of the NHS Grampian Sexual Health Strategy across Community Health Partnerships and local authorities : a discussion document, NHS Grampian. [Available at http://www.hi-netgrampian.org/hinet/secure_files/2007JanuaryCHPdoc.pdf].

NHS Health Scotland (2007), *Learning about relationships and sexual health in school and at home: information for parents*. NHS Health Scotland, Glasgow/Edinburgh. [Available at: http://www.healthscotland.com/uploads/documents/4637-SRE_Resource.pdf].

NHS Health Scotland and the Healthy Respect Phase Two Programme Implementation Team and External Evaluation Team (2008), *Evaluation of Healthy Respect Phase Two: Interim Report*. NHS Health Scotland, Glasgow/Edinburgh. [Available at: http://www.healthscotland.com/documents/2440.aspx].

NHS Health Scotland (2009a), Wellbeing in Sexual Health (WISH) *Health Scotland website* http://www.healthscotland.com/topics/health/wish/index.aspx [accessed on 19 October 2009].

NHS Health Scotland (2009b), *Awareness and knowledge of long acting reversible contraception: what women and professionals in Scotland need: feedback from Qualitative Research*. NHS Health Scotland, Glasgow/Edinburgh. [Available at: http://www.healthscotland.com/uploads/documents/9415-LARC%20Research%20full%20report.pdf].

NHS Health Scotland (2009c), *'Giving you more choice' Longer-lasting Contraception Social Marketing Campaign Briefing*. NHS Health Scotland, Unpublished. [Available at:

http://www.healthscotland.com/uploads/documents/10092 LLC%20Campaign%20Briefing%20from%20NHS%20Health%20Scotland%20-%20July%202009%20(2).doc].

NHS Lothian (2009), *Sexual Health Action Plan*. NHS Lothian, Edinburgh.

NHS National Services Scotland (2007), *Sexually Transmitted Infections and Other Sexual Health Information for Scotland*. ISD Scotland Publications, Edinburgh. [Available at: http://www.documents.hps.scot.nhs.uk/bbvsti/sti/publications/sexual-health-2007.pdf]

NHS National Services Scotland (2008), *Scotland's Sexual Health Information*. ISD Scotland Publications, Edinburgh. [Available at: www.isdscotland.org/isd/5717.html].

NHS National Services Scotland (2009), *Scotland's Sexual Health Information*. ISD Scotland Publications, Edinburgh.

NHS Quality Improvement Scotland (2006), *NHS Quality Improvement Scotland Sexual Health Services Project - Preliminary Report*. NHS Quality Improvement Scotland, Edinburgh/Glasgow. [Available at: http://www.nhshealthquality.org/nhsqis/controller?p_service=Content.showandp_applic=CCCandpMenuId=0andpElementID=0andpContentID=3132].

NHS Quality Improvement Scotland (2007), *Sexual Health Services Draft Standards - 2007*. NHS Quality Improvement Scotland, Glasgow/Edinburgh. [Available at: http://www.nhshealthquality.org/nhsqis/files/sexualhealth_july2007.pdf].

NHS Quality Improvement Scotland (2008a), *Sexual Health Services Standards - March 2008.* NHS Quality Improvement Scotland, Glasgow/ Edinburgh. [Available at: http://www.nhshealthquality.org/nhsqis/files/SEXHEALTHSERV_STANF_MAR08.pdf]

NHS Quality Improvement Scotland (2008b), *Sexual health standards. A report on the budget impact for Scotland and by NHS board. May 2008*. NHS Quality Improvement Scotland, Edinburgh. [Available at: http://www.nhshealthquality.org/nhsqis/files/SexualHealth_BudgetImplications_May08.pdf].

NHS Quality Improvement Scotland (2009a), *NHS Quality Improvement Scotland website* http://www.nhshealthquality.org/nhsqis/144.html [accessed on 16 August 2009].

NHS Quality Improvement Scotland (2009b), *Management of Genital Chlamydia Trachomatis Infection: A resource and budget report*. NHS QIS. [Available at: http://www.sign.ac.uk/pdf/sign109_%20Budget_Impact_Report.pdf].

Nicoll, A., Hughes, G., Donnelly, M., Livingstone, S., De Angelis, D., Fenton, K. Evans, B., O Noël, G. and Catchpole, M. (2001), 'Assessing the impact of national anti-HIV sexual health campaigns: trends in the transmission of HIV and other sexually transmitted infections in England'. *Sexually Transmitted Infections, vol. 77, pp. 242-247.*

Norton, C. (2000), National drive unveiled to cut teenage pregnancies, *The Independent website* http://www.independent.co.uk/news/uk/this-britain/national-drive-unveiled-to-cut-teenage-pregnancies-724281.html [accessed on 13 October 2009].

Nunns, D. and Mandal, D. (1995), 'Most genitourinary physicians are trained in family planning.' 6 May. *BMJ,* vol. 310, p. 1194.

Nursing and Midwifery Council (2007), *Circular 35/2007 Programme Requirements for Registration as a Specialist Community Public Health Nurse - Sexual Health Advisers*. NMC, London. [Available at: http://www.nmc-uk.org/aDisplayDocument.aspx?documentID=3427] .

Open Road Project (2007), *Open Road Project website* http://www.openroadproject.com/ [accessed on 1 September 2009].

Park, A., (2001), 'Scotland's Morals', In: J. Curtice *et al*., (Eds) *New Scotland, New Society?* Polygon, Edinburgh, pp. 92-122.

Parliament, (1973), *National Health Services Reorganisation Act*, HMSO, London.

Paterson, L. (1994), *The Autonomy of Modern Scotland.* Edinburgh University Press, Edinburgh.

Royal College of Nursing (2004), *Sexual health competencies: an integrated career and competency framework for sexual and reproductive health nursing*. RCN, London.

Royal College of Nursing (2009), *Sexual health competencies: an integrated career and competency framework for sexual and reproductive health nursing*. Royal College of Nursing, London. [Available at: http://www.rcn.org.uk/__data/assets/pdf_file/0007/78631/002469.pdf].

Sandyford Initiative (1999a), *Healthy Living Centre: summary of community consultations*. February 1999, internal document.

Sandyford Initiative (1999b), *Peripheral sites, Sandyford Joint Planning Group*. (Newsletter, 2nd September) Greater Glasgow NHS.

Sandyford Initiative (2000), *Sandyford Profile*, Sandyford, Glasgow, internal document.

Sandyford Planning Group (1998), *October meeting minutes*. Greater Glasgow NHS, internal document.

Schonbucher, V. and Kelly, L. (2009), *Archway: Evaluation of the Pilot Scottish Rape and Sexual Assault Referral Centre*. Child and Woman Abuse Studies Unit, London Metropolitan University, London

Scott, G., Brown, U. and Frondigoun, E. (2000), *Sandyford Initiative : Process Evaluation: Report prepared for Greater Glasgow Health Board*. Glasgow Caledonian University, Glasgow.

Scottish Council Foundation (1998), *The Scottish Effect?* Scottish Council Foundation, Healthy Public Policy Network, Edinburgh.

Scottish Executive (2000), *Our National Health: a plan for action, a plan for change*. Scottish Executive, Edinburgh.

Scottish Executive (2003a), *Enhancing Sexual Wellbeing In Scotland: A Sexual Health and Relationship Strategy - Summary Shortened version of the full draft strategy, prepared under the guidance of an expert Reference Group*. Scottish Executive Health Department, Edinburgh. [Available at: http://www.scotland.gov.uk/Publications/2003/11/18504/28893].

Scottish Executive (2003b), *Improving Health in Scotland: The Challenge*. Scottish Executive, Edinburgh.

Scottish Executive (2003c) *Enhancing Sexual Wellbeing in Scotland: A Sexual Health and Relationship Strategy, Supporting Papers 1-6*. Scottish Executive, Edinburgh [Available at http://www.scotland.gov.uk/Resource/Doc/47063/0013759.pdf]

Scottish Executive (2003d), *Partnership for Care*. Scottish Executive, Edinburgh.

Scottish Executive (2003e), *Local Government in Scotland Act*. Scottish Executive, Edinburgh. [Available at: http://www.opsi.gov.uk/legislation/scotland/acts2003/asp_20030001_en_1]

Scottish Executive (2004), *The Local Government in Scotland Act 2003, Community Planning: Statutory Guidance*. Scottish Executive, Edinburgh. [Available at: http://www.scotland.gov.uk/Publications/2004/04/19168/35272].

Scottish Executive (2005a), *Respect and Responsibility: A Strategy and Action Plan for improving Sexual Health in Scotland*. Scottish Executive, Edinburgh. [Available at: http://www.scotland.gov.uk/Publications/2005/01/20603/51182].

Scottish Executive (2005b), *Delivering for Health*. Scottish Executive, Edinburgh.

Scottish Executive (2006a), *National Statistics. Scottish Index of Multiple Deprivation 2006 General Report*. Scottish Executive, Edinburgh. [Available at: http://www.scotland.gov.uk/Publications/2006/10/13142739/18].

Scottish Executive (2006b), *Respect and Responsibility Sexual Health Strategy First Annual Report*. Scottish Executive, Edinburgh. [Available at: http://www.scotland.gov.uk/Resource/Doc/155025/0041655.pdf].

Scottish Executive (2006c), *Non Medical Prescribing in Scotland*. Scottish Executive, Edinburgh.

Scottish Executive Health Department (2001), *Report of the HIV Health Promotion Strategy Review Group*. Scottish Executive, Edinburgh.

Scottish Government (2007a), *Respect and Responsibility Sexual Health Strategy Second Annual Report*. Scottish Government, Edinburgh. [Available at: http://www.scotland.gov.uk/Resource/Doc/206136/0054787.pdf].

Scottish Government (2007b), *Concordat between the Scottish Government and Local Authorities*. Scottish Government, Edinburgh. [Available at: http://www.scotland.gov.uk/Resource/Doc/923/0054147.pdf].

Scottish Government (2007c), *The Government Economic Strategy*. Scottish Government, Edinburgh. [Available at: http://www.scotland.gov.uk/Publications/2007/11/12115041/0]

Scottish Government (2008a), *Respect and Responsibility: Delivering Improvements in sexual health outcomes 2008-11*. Scottish Government, Edinburgh. [Available at: http://www.scotland.gov.uk/Resource/Doc/924/0079236.pdf]

Scottish Government (2008b), *Equally Well: Report of the Ministerial Task Force on Health Inequalities*. Scottish Government, Edinburgh. [Available at: http://www.scotland.gov.uk/Publications/2008/06/25104032/0].

Scottish Government (2009a), *HIV: Proposed Action Plan in Scotland Phase One: May 2009 to March 2011*. Scottish Government, Edinburgh. [Available at: http://www.scotland.gov.uk/Topics/Health/health/sexualhealth/hivplan/hivplan].

Scottish Government (2009b), Latest news *Respect and Responsibility website* http://www.scotland.gov.uk/Topics/Health/health/sexualhealth/respect [accessed on 12 August 2009].

Scottish Government (2009c), Key reference documents. *Scottish Government website* http://www.scotland.gov.uk/Topics/Health/health/sexualhealth/keydocs [accessed on 12 August 2009].

Scottish Government (2009d), Sexual Health Scotland *Sexual Health Scotland website* http://www.sexualhealthscotland.co.uk [accessed on 1 September 2009].

Scottish Government (2009e), Sexual Health *Scottish Government website* http://www.scotland.gov.uk/Topics/Health/health/sexualhealth [accessed on 16 August 2009].

Scottish Intercollegiate Guidelines Network (2009), *Guideline 109: Management of genital Chlamydia trachomatis infection*. Scottish Intercollegiate Guidelines Network, Edinburgh. [Available at: http://www.sign.ac.uk/guidelines/fulltext/109/index.html].

Scottish Office (1997), *Designed to Care*. Stationery Office, Edinburgh/London.

Scottish Office (1999), *Towards a Healthier Scotland*. Stationery Office, Edinburgh/London.

Scottish Parliament (2009), Sexual Offences (Scotland) Bill (SP Bill 11). *Scottish parliament website* http://www.scottish.parliament.uk/S3/bills/11-sexualOffences/index.htm [accessed on 23 October 2009].

Seedhouse, D. (2002), *Total Health Promotion: Mental Health, Rational Fields and the Quest for Autonomy.* Wiley, Chichester.

Seligman, M. E. P., Steen, A., Park, N. and Peterson, C. (2005), 'Positive Psychology Progress: empirical validation of interventions'. *American Psychologist,* vol. 60, pp. 410-421.

Shaw, A., McMunn, A. and Field, J. (Eds) (2000), *The Scottish Health Survey 1998, Volume 1: Findings and Volume 2: Technical Report*. Scottish Executive Department of Health, Edinburgh.

Social Exclusion Unit (2009), *Teenage Pregnancy*. Stationery Office, London.

Society of Sexual Health Advisers (2004), *The Manual for Sexual Health Advising.* SSHA, London. [Available at: http://www.ssha.info/public/manual/ha_manual_2004_complete.pdf].

Society of Sexual Health Advisers (2007), *SSHA Questionnaire to Establish Qualification and Registration Status of Current membership.* SSHA, unpublished.

Sonnex, C, Carne, C.A. and Edwards, S (1995), 'Patients prefer clinics to have non-descriptive titles' [letter] *BMJ,* May 1995; vol. 310, p. 1195.

Sridharan, S., Tunstall, H., Lawder, R. S. and Mitchell, R. (2007), 'An exploratory spatial data analysis approach to understanding the relationship between deprivation and mortality in Scotland'. *Social Science and Medicine,* vol. 65, pp. 1943-1952.

Stedman, Y. and Elstein, M. (1995), 'Rethinking sexual health clinics' [editorial]. *BMJ,* vol. 310, pp. 342-343.

Stewart, A., Petch, A., and Curtice, L. (2003), 'Moving towards integrated working in health and social care in Scotland : from maze to matrix'. *Journal of Interprofessional Care,* vol. 17, no. 4, November, pp. 335-350.

Stewart, J. (2004), *Taking Stock: Scottish Social Welfare After Devolution.* Policy Press, Bristol.

Swanson, I. (2009), 'Sex outside marriage fine if it is 'intimate'' says Kirk. *The Scotsman,* 21 May [Available at: http://news.scotsman.com/scotland/Sex-outside-marriage-fine-.5289499.jp].

Swinton, J. (2001), *Spirituality in Mental Health Care: Rediscovering a Forgotten Dimension*. Jessica Kingsley Publishers, London.

Tannahill, A., (2003), 'Promoting health in Scotland', In: K. Woods and D. Carter, (Eds) *Scotland's Health and Health Services.* The Nuffield Trust/The Stationery Office, London.

Tannahill, C., (2005), 'Health and Welfare Policy', In: G. Mooney and G. Scott, (Eds) *Exploring Social Policy in the 'New' Scotland.* Bristol University Press, Bristol.

The Scotsman (2009a), Scotland's population rises to highest level in three decades: http://heritage.scotsman.com/scotland/Scotland39s-population-rises-to-highest.5213016.jp *heritage.scotsman.com website* [accessed on 23 October 2009].

The Scotsman (2009b), Readership and circulation April 2008 - March 2009 *media.scotsman.com website* http://media.scotsman.com/readership.cfm?section=21 [accessed on 23 October 2009].

Tyler, C. and Hicks, C. (2001), 'The occupational profile and associated training needs of the nurse prescriber: an empirical study of family planning nurses : Issues and innovations in nursing education'. *Journal of Advanced Nursing,* vol. 35, no. 5, pp. 644-653.

University of Aberdeen and SPCERH, University of Edinburgh (2005), *External Evaluation of Healthy Respect. A National Health Demonstration Project Final Summary Report*. Scottish Executive, Edinburgh. [Available at: http://www.scotland.gov.uk/Resource/Doc/37428/0009547.pdf].

Walsh, D., Taulbut, M. and Hanlon, P. (2008), *The Aftershock of Deindustrialisation*. Glasgow Centre for Population Health, Glasgow.

Walters, H. (2008), Gillick competency or Fraser guidelines: An overview. *NSPCC website* http://www.nspcc.org.uk/inform/research/questions/gillick_wda61289.html [accessed on 22 October 2009].

Watt, G. C. M. (1993), 'Differences in Expectation of Life between Glasgow and Edinburgh. Implications for health policy in Scotland'. *Health Bulletin,* vol. 51, pp. 407-417.

Watt, G. C. M. and Ecob, R. (1992), 'Mortality in Glasgow and Edinburgh: a paradigm of inequality in health'. *Journal of Epidemiology and Community Health,* vol. 46, no. 5, pp. 498-505.

Whyte, C (ed) (1995), *Gendering the Nation: Studies in Modern Scottish Literature.* Edinburgh University Press, Edinburgh.

Wilkinson, C., Hampton, N. and Bradbeer, C. (2000), 'The integration of family planning and genitourinary medicine services'. *Journal of Family Planning and Reproductive Health Care*, vol. 26, no. 4, 1 October 2000, pp. 187-189(3)

Wilkinson, R. and Marmot, M. (Eds) (2003), *Social determinants of Health: the solid facts. Second Edition.* World Health Organisation, Copenhagen.

Williamson, L. M. and Hart, G. J. (2007), 'HIV prevalence and undiagnosed infection among a community sample of gay men in Scotland, UK'. *Journal of Acquired Immune Deficiency Syndromes,* vol. 45, pp. 224-230.

Wilson, L. (2004), *Sex on the Rates: memoirs of a family planning doctor.* Argyll Publishing, Argyll, Scotland.

Wilson, L. H. (1914), 'The nursing of venereal disease in the Glasgow Lock Hospital'. *British Journal of Nursing,* Feb 21st 1914, pp. 154-156.

World Health Organisation (1986), *Ottawa Charter for Health Promotion*. WHO, Geneva.

World Health Organisation (2000), *The World Health Report 2000, Health Systems: Improving Performance*. WHO, Geneva. [Available at: http://www.who.int/whr/2000/en/whr00_en.pdf].

World Health Organisation (2002), *Defining sexual health: Report of a technical consultation on sexual health, 28-31 January 2002, Geneva*. WHO, Geneva. [Available at: http://www.who.int/reproductivehealth/topics/gender_rights/defining_sexual_health.pdf]

World Health Organisation (2005), *The World Health Report 2005 - make every mother and child count*. WHO, Geneva. [Available at: http://www.who.int/whr/2005/en/index.html].

Zuilhof, W. (1999), 'Sex for money between men and boys in the Netherlands: Implications for HIV prevention', In: P. Aggleton, (Ed) *Men who sell sex: international perspectives on male prostitution and AIDS.* Taylor and Francis, London.

SUBJECT INDEX

Note: Common terms like NHS, family planning and genitourinary medicine have not been indexed.

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