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The Challenges of Improving Access to Sexual Health Services to Improve the Sexual Health of the Nation.

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Thesis for Doctorate of Philosophy
University of Durham

Helen McIlveen
2008



23 MAR 2009

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To family, friends, colleagues, employer and supervisors.

Although many could not fathom my motivation for beginning this marathon, most have been a source of encouragement and support to complete it.

I would like to particularly acknowledge the participants of this study for their input. It is through their contribution that I hope to make a difference to an NHS service area that has been marginalised since its inception and ultimately to contribute to improving the health of the nation.

The Challenges of Improving Access to Sexual Health Services to Improve the Sexual Health of the Nation.

This Thesis is submitted as a requirement for the Degree of Doctor of Philosophy, School of Applied Social Sciences, Durham University 2008

Statement of originality

I wish to clarify that this thesis is my own work. The data presented are original and were collected by me over a 48 month period between November 2003 and November 2007, with the practical fieldwork taking place between 2005 -2006.

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Abstract

The challenges of improving access to sexual health services to improve the sexual health of the nation.

This research study is set within the national context of deteriorating sexual health. It is an attempt to discover the issues and influences behind the modelling of NHS sexual health services and what is made available to the service users.

These services are having difficulty meeting the high demands of the public and achieving government targets that have been placed upon them to tackle the unprecedented rise in levels of diagnosed infection and prevent unintended conceptions.

A qualitative survey of professionals and client discourse was the design for the fieldwork, consisting of interviews and focus groups of sexual health service leads, practitioners and service users, a total of 89 voices. These were analysed within a framework of feminist and complexity theory.

This research exposed that the services themselves have historically experienced serious marginalisation. This has affected allocation of resources and maintained a closed shop culture, which, unless changed, allows little room for improvement. This issue is well known and yet allowed to remain hidden.

The findings demonstrate that the “top to toe modernisation of the NHS”, stated within the NHS plan 2000 (DH), is not greatly evident within sexual health services over 2005 to 2006, when the fieldwork was carried out. The services have not, in most cases, been redesigned around the needs of patients, access has not been improved and the roles of nurses in many services have not been extended to address these access issues, but in some cases actually blocked from doing so. The Modernisation Agency has had little effect. Service users have not felt the effect of the devolved power promised so they could have influence and service providers are not often centred on them. Attempts to improve this situation are frequently thwarted by poor strategic planning and obstruction

by senior clinical staff, who fear loss of position or power. Alongside this there was evidence of insufficient workforce fit for purpose, including commissioners, key to these developments.

Where services were shown to be aiming to modernise and develop integrated models of provision, this came from a strong ethos of having service users at the centre of care and a vision to improve access and quality of provision.

NHS Health trusts are not allowing sexual health to be centre stage. Any improvements in services will not be sustained without a change in culture within these services themselves, as well as within the wider NHS and society generally. Investigation of the actual quality of service provision and what the public want requires a national research driver.

The insider role of the researcher created opportunities to capture stories that would otherwise have been missed by an outsider. This allowed debunking or demystifying some outdated views of the functioning of sexual health service provision and the reasons for their lack of progress. The complexity theory framework gave a frame of reference for why services function the way they do, either as silo-centred or transformed. It also illustrated that forcing structural changes or service redesign, within a top down approach will not achieve a whole systems transformation.

An integrated sexual health service model was demonstrated as a complex system that allowed transformation to evolve where there was success in impacting patterns of thinking, behaviour and values of the service providers. These micro-patterns allowed a rich complexity to emerge bringing positive outcomes and maybe even supporting government targets as more new patterns emerge. This was opposite to silo-centred thinking, evident in the more traditional settings. Modernisation processes and normalisation of sexual health services, alongside integration, would be assisted using complexity principles.

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CHAPTER ONE

INTRODUCTION AND BACKGROUND TO THIS STUDY

The Aim and Context of the Research

The overall aim of this study was to investigate the modernisation processes of NHS sexual health service provision in the UK and to understand what determines the models of services that are provided. A qualitative discourse of professionals and service users will be explored to discover their understanding of modernisation and what it is that enables this process and what stands in the way of progress. The government agenda and how this is driven or translated will underpin this investigation, as will the boundaries and relationships of the staff groups involved which will also be examined. The main focus will be changes in professional practice within sexual health services that contribute to their access, the empowerment of service users and modelling of provision.

This study was set within the national context of deteriorating sexual health, evidenced by increasing levels of sexually transmitted infections (STIs), HIV and unintended pregnancies, both in adolescence and other age groups which end in abortion (DH, 1999, 2001, 2004, 2006).

Services were having difficulty meeting the high demands of the public and achieving recent government targets, which have been placed upon them to ensure performance management to tackle this rise in levels of diagnosed infection. In 2006 the North East had an average waiting time for a screening appointment of 3 weeks (HPA, 2007)

Between 1997 and 2006 genito-urinary medicine (GUM) clinics saw an increase in diagnosis of 84%. The national screening programme for chlamydia in young people has shown there is also a substantial reservoir of infection, with a prevalence of 10%, in those attending non traditional settings. Enhanced surveillance for syphilis was initiated in the North East in 2002, when an outbreak was detected in the gay community. By 2007 increased heterosexual infection was also reported. Across the nation migration has been

responsible for a sudden rise in HIV diagnosis, primarily among African people and this presents services with new challenges (HPA, 2006, 2007). These epidemiological trends call for a fresh approach to service provision. Services should be undergoing structural changes introduced by NHS policy aiming to give more power to frontline staff and more choice to patients; that is modernisation processes that will drive improved public health (Ham, 2004)

Less well documented are the difficulties of accessing services, or the feelings of regret or shame around exploitation, coercion, or just having sex too early for young people. These facets should contribute to how services are modelled to meet the diverse needs of a community and not just the statistical evidence (Macdowell & Mitchell, 2006)

1.2 The Rationale for the Research

My own practitioner experience within this field of sexual health of over 17 years and now as a manager of these services place me as an insider. I had had the opportunity to be involved in the transformation of services in my own district of North Tyneside moving from very separate services, operating around contraception and screening for infections, GUM, to them coming together as an integrated model, provided in one place. This model required very different training of staff and ways of thinking that would improve access for the public to make services more user-friendly. Modernisation processes introduced in government policy were to be interpreted and used as levers for change. Contemporary government policy has required a reorientation to consider the patient as a consumer, encouraged to exercise choice and to move from paternalist biomedical services. However, some service-users are more equipped than others to do this and most will still be putting their trust in the doctor-patient relationship. These changes are considered to be part of much more fundamental change in society driven by the economy. Transformation required for the NHS and for sexual health services must now consider a consumerist ideology within the modernisation agenda that should be seen to give the power to the user of services (DH, 1999, 2000, 2001, 2004; Ham, 2004, Nettleton, 2006; Klein, 2001; Annandale, 1998)

However, this new way of providing sexual health services was not readily accepted as a way forward in other services, where many of my professional colleagues across the nation were working. Despite the challenges services were facing, of increasing demand for them, few appeared to be considering changing their model of provision as an answer. Services had traditionally evolved around a medical or clinical model, encompassing limited? preventative approaches or more holistic health care. Power was not devolved through their models of service to achieve improved access, by equipping nurse practitioners. Clinics were not user friendly or open at convenient times. The new public health agenda (DH, 2004) was now promoting services which meet a wider range of need that would maximise health and wellbeing opportunities. This will be an important area in which to discover what the different staff groups understand by this concept of integration of services and how they would interpret it in practice.

This study was designed to enable me to investigate what modernisation processes are taking place, or indeed why they are not taking place. I suggest that if access was improved and the public found these services more acceptable and easier to use, this could make a major contribution to improving the nation's sexual health. Normalising sexual health services, so they are just like any other NHS services, may be a key to why these processes have been allowed to escape NHS scrutiny. This concept will be looked for when examining the data.

Stigma and discrimination for the subject of sexual health, both within the NHS and from the media and public view, has allowed this area to be more hidden compared to other health departments. This research was to also gain insight into how this marginalisation is experienced by the service providers and expose the culture that has developed as a result of this.

The North East region has an association with poor health and early death linked to social deprivation, yet the regional health improvements proposed in the "Better Health, Fairer Health" consultation document for a 21st century health and well-being strategy, does not

mention sexual health (DH, 2007). This gives further context to the marginalisation of this subject, even at such a late stage of modernisation of the whole NHS.

Ingham and Mayhew (2006) note that the field of sexual and reproductive health poses extra challenges for gaining adequate attention when those in positions of influence cutting across religious, cultural, social and community attitudes form resistance. They identify that most people want STIs and teenage pregnancies reduced but there is intense disagreement about how these outcomes are achieved.

1.3 The Research Process

Encompassing my own experience and reading was the foundation for this journey and will be further developed around the literature review of government policy affecting sexual health services as well as practice issues. These practice issues will be followed up using literature focused on the groups identified within the policy, those proposed as more vulnerable to poorer sexual health. I will also explore any work considering modelling sexual health services or justifying the ways they are provided.

This investigation requires more in-depth views than surveys could provide and needs to be balanced with both the perspectives of service providers as well as service users (Ali & Cleland, 2006). It has taken a qualitative approach, using interviews and focus groups, set within a framework of feminist and complexity theory and establishing that my stance will not be neutral. Ingham and Mayhew (2006) identify that the choice of issue to be researched may be determined by the value system held by the researcher and advocacy can be an underlying driver. My long association with these services and service users does indeed determine that I would like to advocate for improvements. Discovering new ways to empower both staff and clients would make this study very worthwhile.

Once the research proposal was given ethical approval, perceptions of service leads from across the UK and the North East of England were sought. Focus groups were held within

the North East. All interviews and focus groups were facilitated and transcribed by myself. Data was analysed throughout the study to build upon evolving information and to identify any gaps requiring alternative questions or a need for further respondents.

1.4 Proposing an Integrated Service Provision as a Solution

The North Tyneside model, a one stop shop, encompassing all services under the umbrella of sexual health is unusual. At the beginning of this study it was the only one in the North of England and there were few other integrated services nationally. The National Sexual Health and HIV Strategy (DH, 2001) and the Social Inclusion Unit report on teenage pregnancy (DH, 1999) proposed this model as a possible solution to improving access and developing more user-friendly services, making them more normalised and acceptable to the public. There was a recommendation that services would become more comprehensive and integrated. A more recently added impetus to this is a further White Paper, Making Healthier Choices Easier (DH, 2004), supporting modernisation of the whole range of NHS sexual health services. Having the experience of developing this model was a lever to gain interest in participating in this research. The term integrated services is readily understood by those working in sexual health services as at least contraception and screening for infection (GUM) services joining together. Other levels and designs are possible but this is accepted as the basic first step to integration. The fieldwork will explore this understanding of the concept of integration further.

However, NHS sexual health services are mostly very separate, isolated from other NHS services and placed in hospital settings or health centres. Contraception and GUM services have historically developed along separate paths but they have obvious health concerns in common. Approaching these services would give insight to future plans and reasons for those plans. This research was an attempt to discover the issues and influences behind the modelling of sexual health services that determine what is made available to the service users. The modernisation processes will be exposed alongside the attitudes and cultures that can either enhance or obstruct it.

2.1 Introduction

This is a study with a main focus on how NHS sexual health services are provided and whether they are accessible to the public to allow them to take care of their sexual health. The modernisation processes that should be in place will be explored through the literature review, which will be divided into two sections of 1) policy that is pertinent to these NHS services and 2) practice issues that are dominant themes for all stakeholders, providers, service users and the public.

To investigate why services look and operate as they do it is crucial to explore the underpinning Government policy as drivers and impetus to inform the historical context of this study. However, my own experience of working within this field has forced me to consider why, in some cases, these policy initiatives, although they could be identified as a positive influence to attract resources and improved ways of working, were not always applied, worked within, or used as levers. Because of where I am positioned, within the speciality of sexual health, I am aware that major reform and modernisation of the NHS over the last 17 years, in the early years, was slow to capture the needs of the sexual health of the nation. When the pertinent policy was developed it was then fairly slow to be implemented, or taken seriously within local contexts of hospital trusts. This literature review, as well as the fieldwork, will also consider wider reforms around the commissioning role and contracting that also brings pressure to bear on providers of services to implement action. The policy section will explore why it was necessary for lobbying, used by advisory groups, and further implementation of performance governance, before there was only the beginning of transformation and modernisation of the sexual health services and its practices.

Section two of this chapter will focus on practice issues and the voice of the service user and wider opinion on sexual health. This will encompass epidemiology of sexual ill-health to put the issues into context, alongside prevention and promotion of sexual health.

The health and inequality agenda and vulnerable groups identified through policy as more at risk to reduced sexual health will also be considered. The cultural and organisational issues within NHS service provision that affect modernisation will be uncovered, especially around the role of power and authority within the institution of the NHS, which could determine the modelling of the services. The marginalisation of sexual health services, as services not perceived as normal NHS services, affects access issues and the historical perspective of how they evolved will give further insight to this.

The questions pursued within the fieldwork will be informed by my knowledge as an insider and as an iterative, inducting process alongside this review, identifying the rhetoric of what should have been in place around service provision. The reality will be evident within the findings of what the service providers and the public were actually experiencing.

The Search Strategy for the Literature Review

The search strategy for this literature review is based on a synthesis of my work and knowledge as a service provision insider. Alongside this I am attempting to ensure pertinent contemporary issues are explored and analysed as well as the historical context, demonstrating how services have recently evolved alongside the needs of society but also often within a medical model.

Taking what I learn from this exploration will be a balance of current leading concepts, data and theory back and forward into the fieldwork. To seek further reality and clarity will require development within a framework of understanding. This will establish what can be accepted as real, demonstrating its foundation, scope or validity that is the epistemological view. This will justify the design, what I do in the methodology and where I am coming from with the findings I expose and the conclusions I draw from them. This philosophical framework, which I suggest this study best fits, will provide a new way of viewing this matter. I will place the review of this subject within the methods chapter.

The literature review of such a large topic as sexual health will initially begin with areas my experience suggests will gain/provide? most insight to the issue of improving access to services and the modelling of services. It will be an inductive, iterative process that explores the body of knowledge and helps to analyse and find relationships between ideas (Hart, 1998; Bryman 2001; Silverman 2003; Gilbert 2003; May 2002). The brevity required suggests it can not be totally comprehensive. However, I will attempt to apply sufficient breadth, depth and rigour to justify my approach to this qualitative study with the purpose of producing an illuminative evaluation and to assist me in contributing something fresh to this field of study.

To explore the main question of this investigation I draw on my experience within the speciality and my previous studies and feel the main areas to review should be around the following:

Part one will consider Government policy and NHS sexual health service provision; this will give the context of how government proposes services should be operating. There is also an exploration of the cultural and historical context of the NHS that plays a part in the modernisation agenda and contemporary issues confronting sexual health services in the 21st century. This develops further in part two alongside implementing policy in practice.

Part two considers/looks at/incorporates? practice issues and the voice of the service user, also encompassing the NHS culture and sexual health culture. This will give context to the issues and problems that services and the public are faced with when considering sexual health, with a particular focus on those harder to reach groups, or those more vulnerable to sexual ill-health, as identified within the policy for sexual health. It will include:

- Promoting sexual health and preventing sexual ill-health.
- Epidemiology, evidence of poor sexual health.
- Links between inequalities in health and sexual health.

- Gay men and what they want or need from sexual health services.
- Black and minority ethnic groups (BME) / asylum seeking and issues for sexual health and HIV services.
- Young people and sexual health issues.
- Modernisation and the complexities within the NHS sexual health services.

The combination of reviewing these policy and practice areas will demonstrate the extent and the relevance of the issues, as well as the consequences of current policy and practice, alongside some factors that underpin both areas. The fieldwork, which is carried out alongside this, will generate further areas of literature that require exploration as a grounded theory approach is used in an iterative, inductive way. This will generate ideas such as lessons learnt from the contemporary history of AIDS and the value of embedding these into modernisation processes will be explored. The issue of power and professions will most likely require consideration to understand how this programme of modernisation requires a change in culture.

Data sources explored are mainly from the last 20 years :- Proquest and Pubmed databases, nursing and allied health / medical sciences / NHS core content / health management / psychology; hand searches of health and sexual health journals and reports; Google electronic searches; NHS and other health websites; bibliographies of relevant studies and articles; pertinent conference reports. Relevant search terms were tried in an attempt to explore the field of sexual health service provision. The subject of such specialist services retrieved little and was modified around more generalist terms such as sexual health, sexually transmitted infections, HIV, NHS modernisation and other pertinent phrases.

2.2 Literature Review

Government Policy and NHS Sexual Health Service Provision

The NHS Plan 2000 (DH) and Modernisation of the NHS; Changing the NHS Culture

A major document for change following through with the modernisation of the NHS since the Griffith reforms of 1983 (DH) has been the NHS Plan, 2000 (DH). The Labour government claimed it was an attempt to address the under investment and failings of the previous century and that it would underpin all future developments. Public consultation for the NHS Plan recommended more and better paid staff using new ways of working, reduced waiting times and high quality care centred on patients, accompanying improvements in local hospitals and surgeries. It identified a lack of national standards, unnecessary hierarchy and demarcations between staff and barriers between services, a lack of clear incentives and levers to improve performance, over-centralisation and disempowered patients. Leathard (2003) notes how the seven National Service Frameworks of 2001 (DH) for specialist areas of the NHS, were to be underpinned by this modernisation agenda and it was used as a vehicle for inter-professional collaboration. Unfortunately sexual health was not chosen as a framework and therefore lost out on the scrutiny and investment that could have followed. It remained a ‘Cinderella service’ and was left behind in the modernising plans (Ham, 2004).

This NHS plan was seen to be a lever for massive modernisation with investment in staff and structure, bringing greater patient choice and suggesting decentralising power (Ham, 2004; Nettleton, 2006). This was to be accompanied by other reforms and ways of thinking and was said to be an attempt to change the NHS culture. This culture was in need of change in places such as sexual health services, where new systems of earned autonomy, devolving power and modernisation processes could transform provision.

Despite this devolving of power, the same document told us the Department of Health would set national standards, matched by regular inspection of all local health bodies by

an independent inspectorate, the Commission for Health Improvement; evidence of a top down approach rather than devolving power. The National Institute for Clinical Excellence was to ensure that cost effective drugs, such as those for cancer would not be dependent on where you live. The NHS service provision would no longer be a location lottery. By 2001 a Modernisation Agency would also be set up to spread best practice. This was designed to support the NHS and its partner organisations in the task of modernising services and improving experiences and outcomes for patients. There was a principle behind this Plan that service users would have a real opportunity to be involved and engage with these developments. Unfortunately this is not straightforward if a user of sexual health services hopes to remain anonymous. It was also doubtful that there would ever be local support for such 'Cinderella services' (Ham, 2004).

There were contradictions when government was implying through policy that decentralisation was the way forward and yet was introducing tighter performance management throughout the NHS. Local NHS organisations that performed well for patients were told they would get more freedom to run their own affairs (to be the Foundation Trusts of 2006). There was to be a £500 million performance fund. However, the Government stated they would intervene more rapidly in those parts of the NHS that were seen to fail their patients. However, noticing this failure within sexual health services would take another few years as there were few performance measures in place.

A major aspect of this DH 2000 policy was that Social Services and the NHS would be working together with new agreements around pooling resources. New Care Trusts were suggested to commission health and social care in a single, joint organisation. This would work well for sexual health services with closer collaboration around specialist work of HIV. However, in the North East of England only one Care Trust was developed under these incentives. Other incentive schemes proposed for General Practitioners involved increases in monetary gains, alongside the new consultant contract, also with substantial salary increases, but there were none proposed for other staff groups, adding to staff divisions and tensions (Rivett, 2008; Ham, 2004).

Nurses and other health practitioners, it was indicated, would have opportunities to extend their roles. It was said by 2004 over half of them would be able to supply medicines. £280 million was being set aside over the next three years to develop the skills of staff. The number of nurse consultants would increase to 1,000 and a new role of consultant therapist will be introduced. A new Leadership Centre was to be set up to develop a new generation of managerial and clinical leaders, including modern matrons with authority to ensure all patient needs were met. Increased autonomy of nurses was proposed through these new opportunities to improve service provision. This was an obvious way to save costs for the NHS but would bring challenges from medical staff, who felt excluded from this strategy (Nettleton, 2006).

It was said that patients would have a real say in the NHS. They would have new powers and more influence over the way the NHS worked. Patients were entitled to copies of any letter written about them, their views on local health services were to be integral to allocation of finance, patient advocates were being set up for every service. Everything was proposed to be patient centred in the future. Nettleton (2006) and Klein (2001) propose that this exercising of choice is a new consumerism in the NHS, which will need to be balanced with finite resources. This was being experienced in the sexual health services, under demand but which had been not invested in until much later after the NHS Plan (DH, 2000). Nettleton suggests there is no counter argument to improving patient choice as it has tremendous political and public appeal.

Access issues were supposed to be addressed by 2004. Patients should have been able to have a GP appointment within 48 hours and there would be up to 1,000 specialist GPs taking referrals from fellow GPs, alongside other major reforms regarding referrals for cancer, cardiac, mental health, accident and emergency and older peoples care. New screening programmes were also introduced to promote improved health. This NHS Plan (DH, 2000) was proposed to bring health improvements across the board for patients, but there were also to be national inequalities targets to increase and improve primary care in economically and socially deprived areas.

The government claimed these were the most fundamental and far reaching reforms the NHS had seen since 1948. Incremental changes were suggested but it was said that over the next few years the NHS was going to be modernised from top to bottom (DH, 2000). However, sexual health services would have to wait a number of years before the effects were realised, or the process even started, evidence of their poor profile within the government agenda. Within their policy the government was proposing continually to devolve power to PCTs and service providers but was using a top down approach to ensure it would happen through increased targets, monitoring and frameworks and not through the decentralisation they suggested.

Further Levers were Needed for Sexual Health Service Providers

By 2004 this plan should have been well on its way to being foundational to any change within the NHS, but sexual health service providers were only just becoming aware of it. Previous legislation around improving the nation's health had not identified sexual health as a priority and these services were seriously lagging behind. Lobbying and awareness of increasing levels of STIs and HIV/AIDS brought the first National Strategy for Sexual Health and HIV (DH, 2001). This document identified a relationship between sexual health, social exclusion and poverty. This was alongside the unequal impact of HIV on gay men and some minority ethnic groups. This document appeared to represent a determined intention by a government, for the first time, to raise standards for sexual health.

From my stance as an insider it became obvious with this policy in place workers felt they now had a lever for substantial change, one that would draw resources and really make a difference to improving sexual health for the nation. There was still some dissatisfaction, as this strategy was seen to be very clinically focused and not giving enough credence to the prevention and health promotion work that was needed to underpin any change. However, it was divided into three sections around better prevention, better service provision and better commissioning. There was a suggested aim for commissioning to become stronger. It also introduced the individual versus

structure debate regarding health promotion and the inequalities debate, focusing not just on lifestyle as previous sexual health promotion campaigns had moralised. However, it could be suggested life was coming under closer scrutiny and people being held to account for it, despite wider determinants of health (Ham, 2004; Nettleton, 2006).

Areas of dissatisfaction were a constant underlying factor which identified the highly political nature of this subject area, as each agency attempted to gain power or retain power. The voluntary sector through the HIV/AIDS impact had a strong voice and would no longer be told by the expert. The health promotion units, within health authorities, had specialist workers employed through AIDS Control Act funding (1987) who had a strong allegiance to this voice (Berridge, 1993; Rosenbrock, 2000; Ferlie, 2003).

The National Strategy for Sexual Health and HIV (DH, 2001) stated:

“This strategy applies the values and principles of the NHS Plan to sexual health. It sets out to redesign services around the people who use them and aims to improve services, information and support for all who need them. Reduce inequalities in sexual health; and improve health, sexual health and well-being.” (p12)

Principles built into this plan were stated as shaping services around the service user; supposed to reduce health inequalities, increase partnerships between agencies, working with the vulnerable or marginalised with continual improvement and investment. The proposed outcomes were supposed to be fewer undiagnosed infections, lower rates of unintended pregnancies, better support for teenage parents, better health and social care for those with HIV/AIDS and reduced stigma; unfortunately by 2004 there was little change, only increase in diagnosed? infections (HPA, 2006). There were specific targets for the NHS to achieve and performance management was to be introduced (DH, 2001), demonstrating a heavily prescriptive approach not in line with the devolving power ethos underpinning the NHS Plan. This was said by some to be still employing public health authority to redirect individual behaviour, as seen in the AIDS campaigns and not as

suggested by government as a way of getting resources to services perceived as the 'Cinderella' of the NHS and an opportunity to open up some closed departments (Ham, 2004; Nettleton, 2006).

Within this document the Government also was considering research priorities and recognizing the need for a more robust evidence base for service provision. Professional education and training were identified as needing improvement to ensure the skills were within the workforce and voluntary sector. It noted the need for education across the NHS and not just within the specialist services, as stigma was an issue for professionals not just the public (Goffman, 1963; Berridge, 1993).

Another major policy that was to drive the direction of sexual health services and demanded a heavy performance management agenda for local authority and health providers was the Social Exclusion Unit's report on Teenage Pregnancy (DH, 1999). The aim of this report was to develop an integrated, multi-agency strategy to reduce rates of teenage conception and parenthood, aiming towards the European average; as well as proposing better solutions to combat social exclusion of vulnerable teenage parents and their children. This policy was continuing the theme of authoritative public health controls and one that pursued social regulation of reproduction (Klein, 2001; Nettleton, 2006; Ham 2004).

These two major sexual health reports were the impetus for dramatic change to drive sexual health to the top of Primary Care Trust and local authority's priorities within their Local Delivery Plans by the year 2006, as the inbuilt performance targets were seriously lagging behind. This research study will demonstrate how a change in culture was needed for these documents to be taken seriously by the chief executives and boards of directors, as well as many working within services, to really achieve outcomes that matched the optimistic intentions of these strategies.

Policies for Modernisation

There were prolific government policies addressing access, consultation and social disadvantage; all with implications for NHS modernisation and sexual health services. Many other government documents had been produced from the end of the 1990s to address these same themes also suggesting choice, or introducing a more consumer culture, and consulting with the community. Changes could be seen within them to move from cure to prevention. Infinite demand was making the overburdened NHS untenable (Klein, 2001; Ham, 2004; Nettleton, 2006). Those particular to sexual health services:

- Neighbourhood Renewal (DH, 2001)
- Reducing Health Inequalities. An Action Report. Our Healthier Nation (DH, 1999)
- The Expert Patient. A New Approach To Chronic Disease Management For The 21st Century (DH, 2001)
- Raising Standards For Patients: New Partnership In Out Of Hours Care - Three Year Planning Guide (DH, 2001)
- Tackling Health Inequalities, Cross-Cutting Review (DH, 2002)
- Shifting The Balance (DH, 2002)
- Effective Commissioning Of Sexual Health And HIV Services, A Toolkit For Primary Care Trusts And Local Authorities (DH, 2003)
- Getting The Right Start: The National Service Framework For Children, Young People And Maternity Services – Emerging Findings (DH, 2003)
- Liberating the Public Health Talents Of Community Practitioners and Health Visitors (DH, 2003). And Tackling Health Inequalities: A Programme For Action (DH, 2003)
- Standard General Medical Services Contract (DH, 2004)
- Health And Neighbourhood Renewal: Guidance From The DOH And Neighbourhood Renewal Unit (DH, 2002)
- Every Child Matters (DH, 2003)
- The Children's Act (DH, 2004)
- Choosing Health, Making Healthier Choices (DH, 2004)

This was an endless production by the Labour government and many had serious implications for sexual health services. It would take time to digest and interpret them into practice. It would also require commitment and drive to achieve this.

The Green Paper, *Every Child Matters*, (DH, 2003) was to prompt an unprecedented debate about services for children, young people and families and allowed wide consultation. A response to this consultation was the *Children's Act* (DH, 2004). This also brought legislation around safeguarding children and young people within our communities that needed to link with sexual health work, and multi-agency groups realised this was a priority area. Links to/between? risk-taking behaviour and young people, with alcohol and drugs and the effects on sexual health were beginning to be formalised and addressed through these documents, forming baselines and demanding action plans and targets to be met by each organization. Senior management, through this *Children's Act* and a lever of performance management, were now to really take notice of sexual health issues that needed to be addressed locally. Nettleton (2006) notes government were increasingly keen to emphasise that a range of organisations were to play a key role in enabling, rather than telling people how make healthier choices, as in previous policy.

Liberating the Public Health Talents of Community Practitioners and Health Visitors (DH, 2003) proposed to begin a transformation of the role of NHS nurses and impact the culture of how care was to be provided in the future; not stated in the policy was the fact that nurses taking on doctor roles would most likely increase productivity and give more value for money. The following year the new *General Medical Services Contract* (DH, 2004) was looking for enhanced service from GPs in specialties such as sexual health, taking services into the community and attempting to improve access and choice for the public, providing financial incentives as the hook. A *Primary Care prevention* focus also allowed GPs to create a more professional identity, where they had previously struggled in the face of hospital medicine, shifting the focus from hospital to people; all adding to the changing nature of healthcare and blurring the role of the expert and working practices of professionals (Klein, 2001; Ham, 2004; Nettleton, 2006).

Choosing Health, Making Healthier Choices, 2004 (DH), claimed to drive a prevention message for everyone in England. It stated key principles for supporting the public to make healthier and more informed choices with regards to their health. The government suggested they would provide information and practical support to get people motivated and improve emotional wellbeing and access to services so that healthy choices would become easier to make. Nettleton (2006) suggests this is a new paradigm for health with transformational and revolutionary qualities which will see the demise of the practitioner-patient relationship, the patient with electronic access taking on a role of expert. The emphasis on choice is seen as individualistic with the government drive on prevention as a new public health shifting the focus to people and everyday life and away from hospitals and professionals. There is also a suggestion that these themes are emerging as a new form of social regulation. However, people's lifestyles are socially embedded and socially structured and ill-health is/remains? strongly linked to inequalities or disadvantage.

The government stresses widening health inequalities, a sharp rise in obesity, a slowing in the decline of smoking rates, growing problems with alcohol, teenage pregnancy and sexually transmitted diseases. They claimed old ways of responding to public health problems were increasingly shown to be inadequate. Sexual health with this policy was becoming centre stage in the NHS but only because the problems were seen statistically as out of control, with social consequences. Increased surveillance and professional accountability became inbuilt characteristics of achieving these policy aims around providing more flexible, responsive services that are less paternalistic, hence giving patient choice that ? would drive this agenda (Ham, 2004; Nettleton, 2006). Finance was promised through PCT allocations, sexual health a priority area to be brought out of the 'Cinderella' service arena. There was to be a mix of hope and disbelief amongst the service providers that long over-due resources would arrive. There was however, a dichotomy in the messages that were given through this policy, on one hand suggesting agency and personal responsibility for health, but on the other driving a very top down external agenda with central control; with some being more able to exercise choice than others. This will be considered throughout the fieldwork.

Sexual Health Services Underpinned by Multiple National Policies

By 2004 sexual health was underpinned by multiple national policies and strategies which should have been interpreted locally into action planning. These documents were supposed to be levers available to the providers of services to drive modernisation. There was a fundamental shift in healthcare policy that required a reorientation for sexual health staff; it could be suggested these changes for contemporary healthcare match those in advanced capitalist society and are economically and ideologically driven (DH, 1999, 2000, 2001; Ham, 2004; Nettleton, 2006; Klein, 2001; Leathard, 2003).

The previous year had also seen some major reform in the Sexual Offences Act (CPS, 2003), changing the 1956 Act. This gave more protection to children and young people around sexual abuse and exploitation, with more emphasis on defining abuse, rape and consent and defining sexual grooming of children as an offence. Boundaries about age of consent were restated and now under 13 year olds were perceived as unable to give consent. This was to cause problems across the nation for workers managing young people and their sexual health, previously being able to assure them that interventions would remain confidential. Local protocols now had to be written that would support assessing exploitation and definitely taking forward to Social Services any disclosure of sexual activity under 13 years. It demanded more training of staff and service leads defining the rules for staff. This work with children and young people was now a joint responsibility of local authorities and PCTs and required partnership work, not always easy between two very different cultures within the field of sexual health, youth work and clinical staff.

The government was concerned that the Sexual Offences Act was open to mis-interpretation and in 2004 produced guidelines for workers within sexual health (DH, 2004) and now to include other professionals, such as teachers, to ensure young people received confidential services and that they were informed they were entitled to this. The Act stated that a person does not commit an offence of aiding or abetting a child sex offence if they give advice to children in order to protect them from sexually transmitted

infection, or are protecting their physical safety, or preventing them from becoming pregnant, or promoting their emotional well-being. This implied that parents, doctors, other health professionals, in fact anyone, can provide sexual health advice to children whose only motivation in doing so is the protection of the child. However, it reiterated that persons who cause or encourage the child to engage in the activity or if they do it to obtain sexual gratification would be liable to prosecution. These policies show a government responding with caution in trying to achieve less unplanned pregnancy but also aware of the accusation of encouraging young people to have sex.

A duty of confidentiality was to be constantly stated, but also misinterpreted. On one hand, services were expected to tell young people to take care of their sexual health, to access services and provide them with confidentiality. On the other hand, to warn the young person that if they disclose cause for concern it would need to be reported. This required a high level of skill and professionalism by sexual health workers. It would become further complicated with mixed messages as the government's drive to improve access to services and reduce teenage pregnancies and STIs would take emergency hormonal contraception and screening for the STI chlamydia into non clinical settings and pharmacies from 2004. Young people could avoid complex holistic sexual health interventions and support, which required lots of form filling and questions, put in place to provide quality care as well as to protect and educate them.

Government Targets were Introduced as Levers for Change

Quality issues for providers became more of a concern as services were becoming target driven. The Medical Foundation for AIDS & Sexual Health (MedFASH, 2003, 2004) is a charity which works with policy-makers and health professionals, to promote excellence in the prevention and management of HIV and other sexually transmitted infections. They are supported by the British Medical Association, but despite its medical allegiance this group claim to promote a multi-disciplinary and multi-specialist approach to HIV and STI prevention, treatment and care, recognising equal value in the roles of all disciplines and specialties involved. In 2003 they published recommended standards for HIV

services and the following year for sexual health services. These standards encompassed health promotion and prevention, empowerment and access, public consultation and service provision. There was an expectation that they would be driven locally into action plans and be integral to all services. There was also an addition to the quality agenda to ensure young people were seen as a special scenario within sexual health with the introduction of a toolkit for making health services young people friendly and welcoming (DH, 2005). The pressure was increasing for sexual health services to give more choice and improved access with external controls becoming stronger.

Capital investment was needed in genito-urinary medicine clinics (GUM) to implement all of these plans and assessments of departments began in 2004 to allocate £15 million nationally through strategic health authorities to assist with the modernisation. There was a cost to these departments in the form of yet another target to be achieved, 48 hour access to a G.U.M appointment by the year 2008 (DH, 2006). Performance management was seen as, or decided to be, imperative to ensure this was taken forward and that monitoring with national publication of progress was in place. This target was to be made one of only six main PCT priorities and was reiterated within the new plans for 2007-08 as an operating framework for the NHS. These priorities referred to as a Selby 6 (after Duncan Selby who devised them) brought a top down interest within the organisations, as the chief executive would be held accountable if they were not achieved. Sexual ill-health was identified again as an underlying determinant of health inequalities and all the previous targets of reducing teenage pregnancy and STIs were to be maintained. Sexual health services were now under the spotlight and being scrutinised for performance and outcomes; possibly a short lived focus, but one that should bring resources to the PCTs. However, this did not match the suggested ethos of the NHS Plan of devolving central power.

This operating framework was emphasising the work of policy since the 2000 NHS Plan. It was to state more about promoting health, reducing health inequalities and delivering the best care. It had key issues of a stronger voice and more choice for patients, alongside greater diversity of providers of service and a guarantee of quality and safety

through a framework of system management, regulation and decision-making. There would be a greater focus on joint commissioning between health and social care and better integration that proposed to bring benefits for service users. Commissioning could be perceived as yet another outside control for service providers, an aspect of the NHS internal market, determining what should be provided and how, and implementing performance management tools (Klein, 2001).

This framework had been pre-empted by the Independent Advisory group for sexual health (2006) who had become a strong lobbying force and had probably helped maintain the sexual health focus by producing their report for government. They included similar themes but noted that strong leadership and funding of training for specialist sexual health staff should also be invested in. Sexual health service providers felt they had a voice and were now being listened too, although the consultants continued to be a strong force within this.

The complexities of the NHS were tied down in these documents with a process of investment and reform, alongside scrutiny. Things were getting tighter with core principles of devolving power to services providers and service users constantly restated. This was not just around quality and safety but also effectiveness and sustainability, dignity and respect for patients, shaping services around need, equality and non-discrimination, supporting and valuing staff, partnership working and seamless services, confidentiality and access to information. The government generates such policy, they say, from lessons learnt and by listening to the public voice. This study will draw on what the government is trying to achieve and consider whether it is the correct focus and whether in fact there is the fitness for purpose within sexual health service provision to achieve it. How much policy is rhetoric rather than reality will be determined. It will also argue that the reason for inadequate services has been that they were not always “fit to practice” under the new spotlight of recent targets and that the culture of the NHS had allowed this to go unnoticed as it had been long overdue for major reform.

2.3 Literature Review Practice Issues

Policy within practice issues and the voice of the service user, the NHS culture and the sexual health culture, will all demonstrate within this section how these government drivers should be underpinning and bringing change; also where sexual health services were seriously lagging behind or ignoring the modernisation processes and not contributing to empowerment of service users, giving choice or improving access.

2.3.1 Promoting Sexual Health and Preventing Sexual Ill-Health

The conceptualisation of health has been found to vary among social groups and over time, with views adjusting according to the concerns of individuals. This postmodernist perspective accepts that multiple views and realities coexist. Nettleton (2006) introduces the idea that people do not construct realities but some do create order out of their chaos, all ideas about health being shaped by culture and ideology. The inequalities debate has introduced ideas of individual responsibility versus structural explanations, with there now being evidenced a clear relationship between patterns of mortality, morbidity and social class (Annandale 1998).

The World Health Organisation (WHO) defines sexual health as:

“a state of physical, emotional, mental and social well-being related to sexuality; it is 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. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.” (2002)

This work and its statement had grown from the 1986 WHO Ottawa Charter which was to be the basis of many international developments for public health. It had proposed a clear design for best practice delivery for promoting health, supporting sexual health and preventing HIV. It specified five areas of activity:

- Building healthy public policy
- Creating environments that are supportive of public health
- Developing personal and social skills related to sexual health and HIV
- Building on the evidence base and developing staff skills, knowledge and attitudes.
- Strengthening community action

These five areas were reflected within the National Strategy for Sexual Health and HIV in 2001 (DH), each aspect should be built upon for future work.

Service providers for sexual health, whether NHS or otherwise, are expected to contribute to this well-being of service users, empowering and encouraging with knowledge, skills and attitudes, to not only avoid infections and unintended pregnancies, but to endorse safe and fulfilling lives. The recommended sexual health standard (MedFASH, 2005) No.2 states providers should also promote sexual health so as to enhance emotional well-being, and that there would be sufficient information and support, saying it would:

“Enhance personal and social skills, to enable people to exercise control and improve their sexual health” (p.6).

These standards suggested that a comprehensive programme of sexual health promotion was needed. This was to address local need and target marginalised groups, to ultimately reduce inequalities in sexual health. These standards also emphasised the involvement of users and the public in service planning and that social exclusion, discrimination, power imbalances and stigma must be taken into account (MedFASH, 2005). This appears to be an attempt to address some imbalance between blaming the individual and structures

taking responsibility to support people to take care of their health. However, a community approach would go further to suggest there could be less paternalism and deem the service user as the expert (Klein, 2001). However, MedFASH do not go as far to suggest this, as it would not be accepted by many GUM services, or medical consultants retaining power, who remain hospital based (Ham, 2004; Nettleton, 2006; Annandale, 1998; Witz, 1992).

2.3.2. Epidemiology Suggesting Evidence of Poor Sexual Health.

The establishment of smoking as a cause of lung cancer in the 1950s is said to be the best known finding of epidemiological research. Epidemiologists and sociologists are rooted in different paradigms but the study of health inequalities requires that they work together. This development allows reformist epidemiologists to continue to challenge the appropriateness and the validity of the biomedical model (Nettleton, 2006). The year 2006 was noted, because of statistical collation, as the 25th anniversary of the first reported case of acquired immunodeficiency syndrome (AIDS) in the UK. HIV and all sexually transmitted infection surveillance in the UK plays a key role in informing clinical practice and service delivery, as well as the monitoring and targeting of intervention strategies. The Health Protection Agency collects statistical information from NHS services and promotes the UK as having one of the world's most comprehensive and informative systems. Any screening service is required through legislation to report its findings every quarter to this central body (VD regulations, 1974). Contained within the national strategy of 2001 was a target to reduce HIV and gonorrhoea infections by 25% by 2007. Despite a slight decrease in gonorrhoea, unfortunately numbers of all other infections had increased annually, and are unlikely to abate by 2007. It could be argued that raising awareness of sexual health issues had brought more people forward for screening who would otherwise have remained undiagnosed. HIV and STIs are of major public health concern in the UK, with substantial morbidity and mortality associated with them (HPA, 2006).

The previous 25 years had seen key initiatives to public health control with screening of the blood supply for HIV antibodies; the early introduction of voluntary counselling and testing for HIV; the commencement of the needle exchange scheme; targeted health promotion campaigns and the introduction of ante-natal screening for HIV. Although this all brought increasing demand on sexual health service provision and in local services such as North Tyneside, there was no investment until recent years to help take the strain.

The Health Protection Agency reported on a “complex picture” (HPA, 2006), with a steady rise in all STIs and HIV. Alongside this was a significant increase in syphilis over the previous two years, an infection thought to have been abating and services previously considering whether routine testing of ante-natal and GUM patients was actually a cost-effective exercise. The HPA commented on the epidemiological shifts and developments within the sexual health field which had led to changes in how services were being provided, or needed to be provided, through different approaches in clinical management. This report showed there were an estimated 63, 5000 adults between 15 and 59 living with HIV in the UK, of whom 20% were unaware of their infection. The HPA summarised that these sustained levels were due to newly acquired infections in men who have sex with men (MSM), the black minority ethnic (BME) community, often the African asylum seeking population, as well as just a question of more people actually coming forward to seek an HIV test. They also stated that as the number of BME heterosexuals living with HIV, both diagnosed and undiagnosed, in the UK increases, the likelihood would be an increase of expanding heterosexual HIV transmission. MSM were also unduly affected by gonorrhoea and syphilis, as co-infections with HIV was becoming more common within the gay community.

However, chlamydia was identified as mainly affecting young people with 75% of diagnosis in females being under 25 years and 57% in men under 25 years. Similar levels were also seen for the genital wart virus in young people.

The key points from the HPA in 2006 were:

- New diagnosis seen at GUM clinics rose by 60% between 1996 and 2005

- Total GUM workload increased by 268%.
- Chlamydia was the most commonly diagnosed STI.
- Diagnosis of gonorrhoea declined by 13%, although resistant strains had increased by 22%
- Syphilis was continuing to rise, with a 23% increase between 2004 and 2005 (but in the North–East, in males, between 1998 and 2004, it had increased by 1,520%, many with untraceable contacts)
- HIV treatment strategies had helped in reducing the proportion of children becoming infected from maternal transmission and in enabling people to live with much improved prognosis when diagnosed with HIV and preventing the opportunistic illness of AIDS.

The following graphs demonstrate these trends for HIV and syphilis in England and North Tyneside service attendances increase:

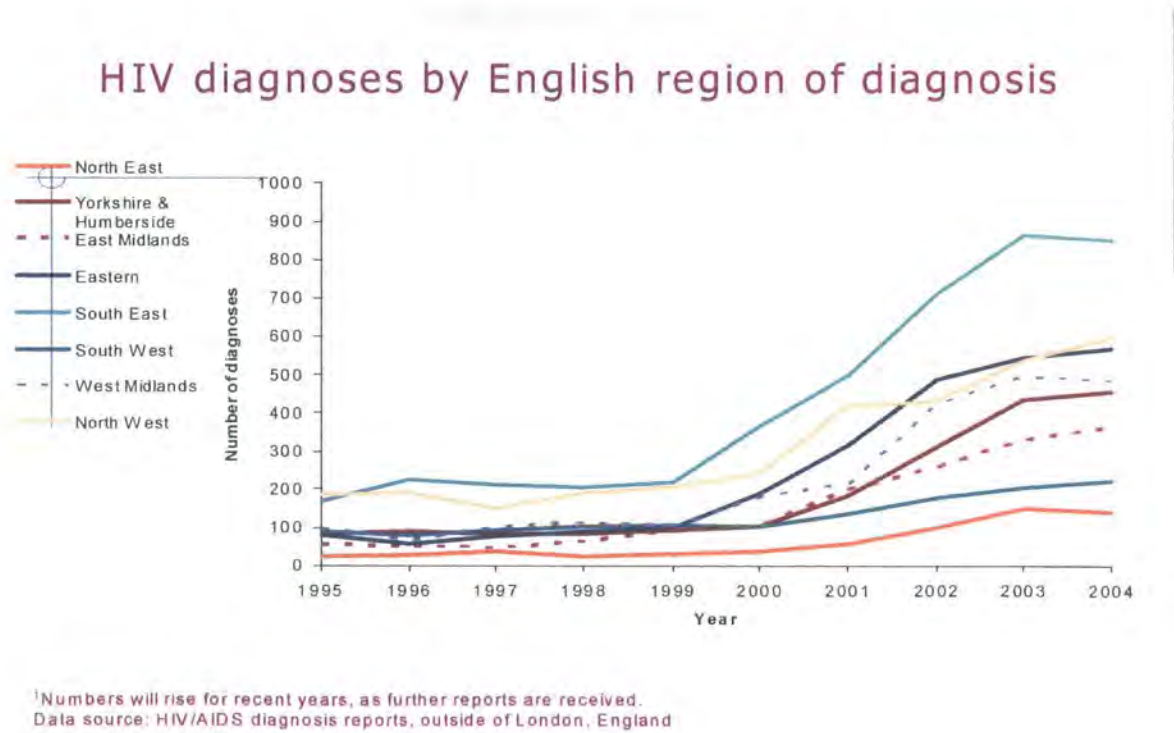
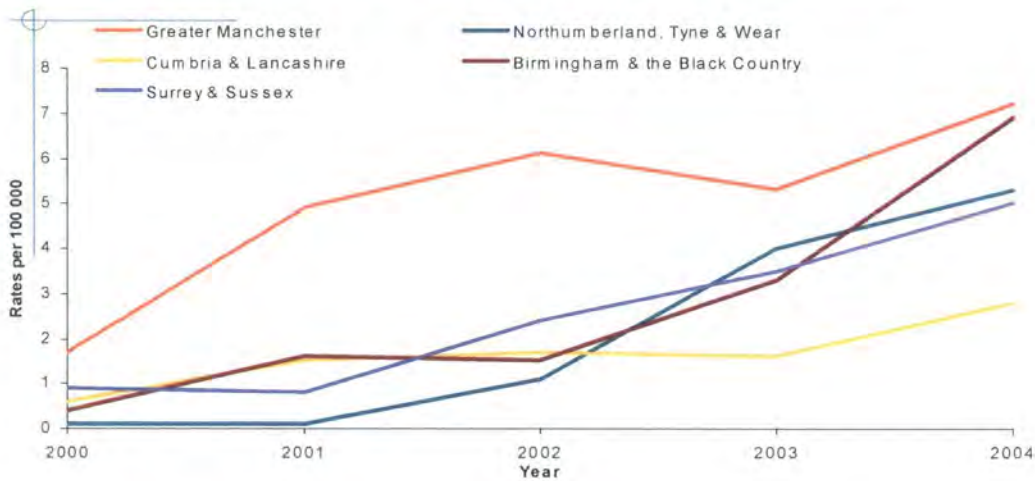


Figure 1. HIV 1996-2004 in selected regions, source HPA, 2006.

Rates of syphilis (primary and secondary) diagnoses among selected English SHA



Data source: KC60 returns from GUM clinics, outside of London, England.

Figure 2. Syphilis 2000-2003 in selected regions, source HPA, 2006

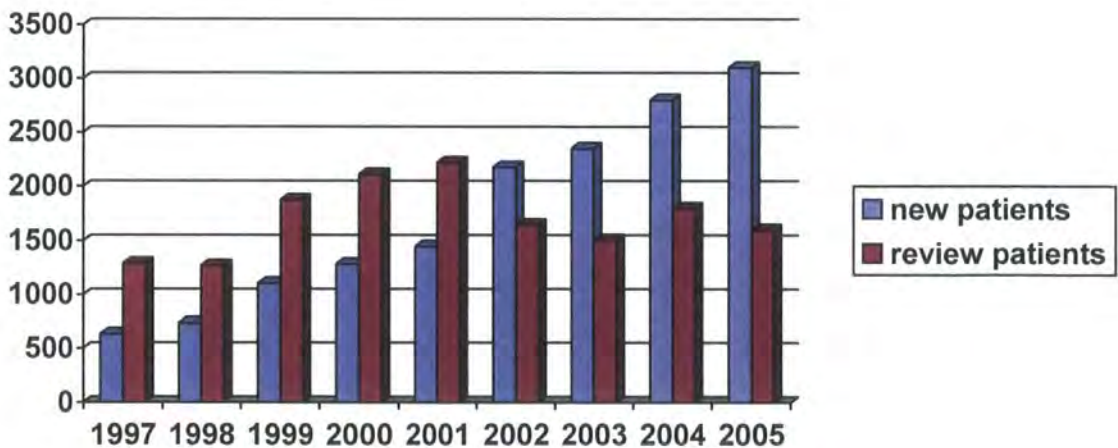


Figure 3. North Tyneside GUM Attendances 1997 –2005

Source North Tyneside PCT annual report of sexual health services 2005

The HPA report in 2006 focused on the need for continued improvement of access to sexual health services; along with the focus of this study rapid access was seen as key to infection control and health promotion. It also identified a need for more focused screening for sexually transmitted infections and had tripled its attendances to GUM within a few years as demand increased, matching the national trend.

The work of many HIV/AIDS health promotion teams of the mid to late 1990s had begun to develop strategies that would clearly identify these vulnerable groups as at risk and requiring this targeted approach. These groups were also named in the National Strategy for Sexual Health in year 2001 (DH) as gay and bisexual men, young people, black and minority ethnic groups and injecting drug users. By 2006 the HPA report showed they were still the groups disproportionately affected by the increasing levels of STIs and HIV. Hence, these groups will be a focus for the fieldwork.

Unintended adolescent pregnancy was also still hitting the headlines in 2006. In the 1970s the UK had similar teenage birth rates to other European countries. In the 1980s and 1990s throughout most of Western Europe rates fell, but UK rates remained at the level of early 1980s. There was a national target within the 1999 strategy to reduce this by 50% by the year 2010. North Tyneside has local targets to achieve a 15% reduction by 2004 and a 55% reduction by 2010. There had been huge investment and the setting up of the teenage pregnancy unit within the Department of Health, linked to regional and local co-ordinators, all responsible for strategies and action plans that would achieve this aim. By 2004 things were looking a little disappointing with some reduction but doubt that the trajectory would ever reach 50% (HPA, 2006; North Tyneside PCT, 2005). Access to good service provision was again identified as key to improvement. The following graphs demonstrate the trends nationally, regionally and locally for North Tyneside:

Teenage Pregnancy Rates 1998 - 2004

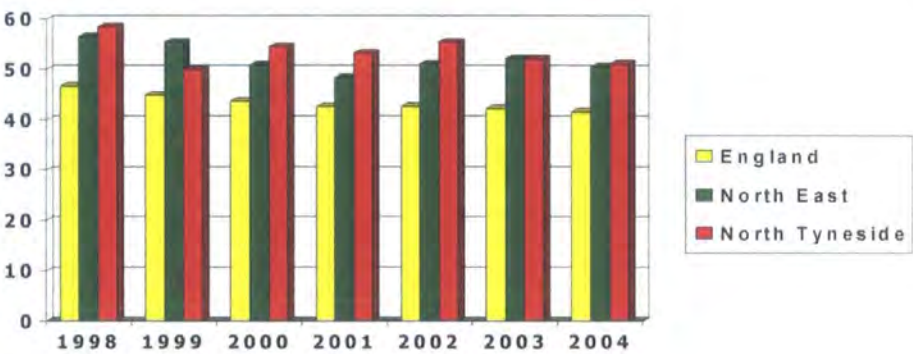


Figure. 4. National, regional and local comparison of teenage pregnancy.

North Tyneside Teenage Pregnancy Rate

	1998	2004	% Change
England	46.6	41.5	- 11.1 %
North East	56.5	50.5	- 10.6 %
North Tyneside	58.4	51.1	- 12.4 %

Figure 5. National, regional and local teenage pregnancy rate and reduction in rate
Source Annual report for sexual health North Tyneside PCT 2005

2.3.3 Inequalities in Health and Sexual Health

The NHS Plan, 2000 (DH) had stated that no injustice is greater than inequalities in health. The Social Exclusion Unit Report for Teenage Pregnancy (1999) and the National Strategy for Sexual Health (2001) made clear reference to the links between poor sexual health and social exclusion. An attempt to address the inequalities agenda was made

through the Choosing Health Government White Paper (DH, 2004). The five priority areas identified included sexual health.

This paper was acknowledging that in the 21st century Britain's profound health inequalities still exist in relation to life expectancy, perinatal mortality and lifelong health between north and south, between urban and rural, between the relatively affluent and the relatively impoverished, and those who were socially excluded often because of disability, ethnicity and sexual orientation. PCTs were called to address these challenges through a fundamental shift in thinking to achieve social justice. However, this was not just a matter for health management and medical interventions. This document was calling for people to challenge and take control of their own health needs and lives. It wanted less of a dependency culture; with the NHS seen as part of that problem by the way it had engaged with the public in frontline services. It was the move from paternalism to one of choice and consumerism for the patient suggested in the 1990s (Klein, 2001). The PCTs were being challenged to become the catalysts for changes that would lead to a more just and accessible NHS. They were supposed to strengthen their public health function and invest more in prevention and promotion. John Reid, the Minister for Health at the time, was calling for the NHS to move away from being a national sickness service to now proactively promote healthy lifestyles. Nettleton (2006) identifies these ongoing debates around individual explanations versus structural ones as historic within the inequalities and health debate. An emphasis on behaviour is often used when ignoring socio-economic factors and the distribution of income and wealth. An example being that empowerment is severely limited for most of those who live with HIV/AIDS, as across the world these people are disproportionately socially disadvantaged and economically and politically marginalised.

However, a system that followed in the UK was one primarily driven by targets and measures concerned with activity, not one necessarily improving health. There was much more work to be done on strengthening the "psychological contract" with the public and factors/issues? with service deliverers preventing mutual engagement. A more open, informing and welcoming relationship centred system was what was being called for. The

health service journals (Sang, 2004) were carrying commentary that voiced concern about an NHS that was logistically and financially driven at the cost of ignoring the psychological contract and a moving away from the fully engaged scenario identified by Derek Wanless and his team researching inequalities and health issues (DH, 2004). The imbalance of power within the institutionalised NHS was spoken about by Sang as a barrier to health, which started at reception areas through to the clinicians. For the socially excluded the NHS was perceived as a hard to reach place. People did not always feel listened to, valued and respected as individuals. As an insider I could see the NHS had talked for years of having patient centred systems, but it needed to be relationship centred. The process model emerging was one of inclusion to involvement, to engagement and joint action. There was work to be done to enable and bring down barriers and make services more accessible and user friendly, especially within sexual health.

It had been long established in the UK that healthcare is only one determinant of public health (Townsend, 1982). Housing, transport, environment, access to shops and education and a myriad of other factors will all have profound health impacts. North Tyneside's Meadowell estate was infamous for its riots and its disadvantage in the late 1980s and investment and research into cause had followed (Barke & Turnbull, 1992; Campbell, 1993). Barke and Turnbull claim that despite three decades of policies aimed at combating social deprivation they remained as prevalent as ever on this estate. They saw this lack of solutions as due to a top down approach, the outsiders looking in and they noted that to be able to really understand them one must be on the inside, and certainly to include the voices of those who know what it is all about.

Since 1992 the Joseph Rowntree Foundation has been trying to discover what is effective in the regeneration of deprived neighbourhoods (JRF, 1998). They identified uniqueness in both problems and opportunities. They suggest for any long-term sustainability of regeneration to succeed it will require a comprehensive approach with residents at the centre. Identifying assets and energies was seen as key. They researched North Tyneside within this study, using local residents to carry out a skills survey of more than 1,000

households revealing a wealth of unexpected talent that led to resident-run community activity. They claimed neglect in the past had caused problems in disadvantaged neighbourhoods to grow and fester. Some cultures were resistant to change and professionals and agencies will need to reshape and retrain to become culturally relevant. North Tyneside's sexual health services were placed a mile up the road from where the riots had taken place and yet it took national drivers to relate poor sexual health to the need for resources in this speciality. 2005 saw North Tyneside in the nation's bottom quintile of social deprivation, hence required to make faster progress on a larger scale to reduce inequalities. It was identified as a Spearhead Local Authority Area and was to ensure it worked in partnership with other agencies through local delivery planning, neighbourhood renewal and public service agreements (North Tyneside PCT, 2006). The Spearhead Group of areas consists of 70 Local Authorities and 88 PCTs. There will be a focus for improvements on life expectancy and faster reductions in premature deaths from cancer and heart disease. While all areas have health inequalities, the scale of inequalities is greater in the Spearhead Group areas. Their challenges are greater and faster progress on improving health outcomes will be needed to reduce the inequalities gaps.

Tackling health inequalities in the Spearhead Group is about major social change. The Group accounts for over a quarter of the population of England with the most deprived and vulnerable people. Spearhead areas also tend to have higher than average levels of unemployment and economic activity, more lone parents and a higher proportion of Black and minority ethnic groups (DOH, 2006).

The following chart demonstrates where local data has been used and compares North Tyneside to the rest of England; it is obvious they are low on health capital, both physically and psychologically. Effective primary and social care resources do not seem to be in place, regional prospects around jobs, education and wealth also are presented as the worse scenario.

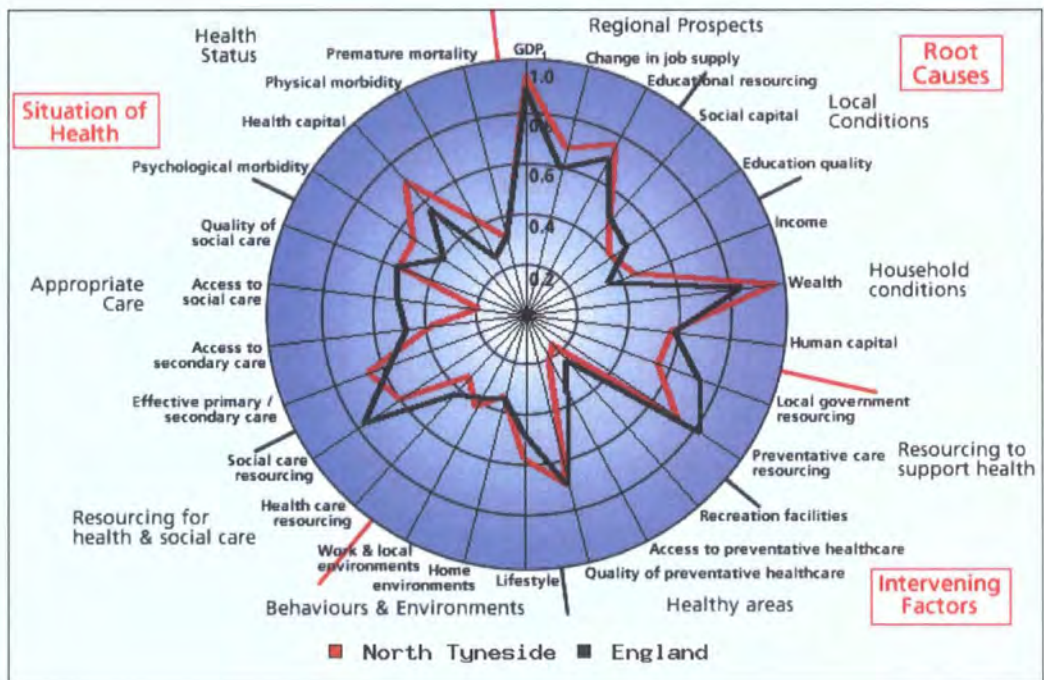


Figure 6. Health Poverty Index, 2004, comparing North Tyneside with England (Score of 0, towards centre, is the best situation and on outside of spidergram score of 1 is worst)

The health poverty index visualisation tool (Dibbens & Simms et al, 2004), a collaborative work between the Social Disadvantage Research Centre (SDRC), University of Oxford, and the South East Public Health Observatory (SEPHO) and the Department of Geography and Geosciences, University of St Andrews, which is sponsored by the Department of Health.

A pertinent quote from a health minister at this time commenting in conference on the reforms expected from the Choosing Health white paper (2004) was:

“We need to know what works so we can do more of it and what doesn’t so we can stop doing it.” (Dr Fiona Whitehead, Deputy Chief Medical Officer, DOH, 2005).

Community involvement and consultation have become order of the day for PCTs and local authorities, it is in every level of documentation that it is really getting to the roots and bringing transformation to the area. However, it is not easy or quick work, talking and listening takes time and perseverance to address unfulfilled promises of generations. The affront on health inequalities will require work to be relentless, but then actively involving citizens in their own health is surely what Bevan intended. Alongside socio-economic structural changes health improvement should now be an integral part of the NHS and at the core of day to day business. 211 million pounds of non-ring-fenced finance was to be allocated to this public health agenda in 2006-07. Unfortunately most of it was used to bail out the PCTs in deficit to balance the books (Lloyd, 2006).

2.3.4 Gay Men and what They Want or Need From Sexual Health Services

The prevalence of HIV in MSM under 25 years attending GUM clinics, who were previously undiagnosed, was 1.55% for London and 1.35% outside London (HPA, 2006). This indicator in young men shows it is a relatively new infection and transmission and a gauge that health promotion messages are not always received. For the actual year of study for this report (2005), gonorrhoea accounted for 4,388 cases in MSM. From those diagnosed with HIV, 49% also had gonorrhoea diagnosed and 34% also with syphilis (DOH, 2003).

The following graph demonstrates that from 1996 to 2005 the number of gay men diagnosed with HIV went from 8,450 to 19,863. The age group with the most increase each year was the 33 – 44 age bracket. The prevention messages were obviously not having the desired effect, with increases in HIV and all sexually transmitted infections.

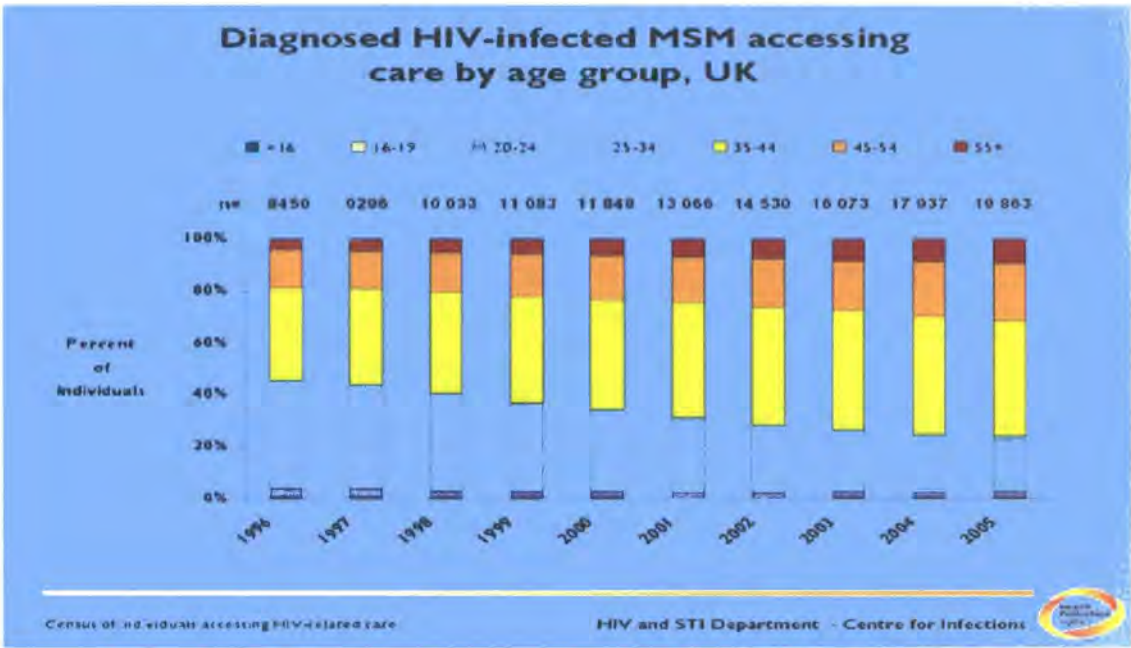


Figure 7. MSM with HIV using services, UK. Data source SOPHID 2006

The Health Protection Agency and the Health and Clinical Excellence Advisory Committee (NICE) stated that particular priority should be given to MSM who engage in unprotected sex for focused prevention work. They also noted that the effectiveness of other behavioural modification and intervention strategies needed to be evaluated in the UK settings (HPA, 2006); again emphasising individual behaviour (Nettleton, 2006).

The Health Development Agency (H.D.A., 2002) review of reviews since 1994, assessing the effectiveness of interventions to reduce the risk of sexual transmission, found that none of the core papers contained any information about health inequalities which were relevant to the UK priority populations. It seemed that MSM who might be at risk because of their socio-economic status or educational qualifications, and whether interventions had been effective, had not been considered up to this date. Although they did find that evidence of interventions was more for this group than any other group, much of the research was often not undertaken in this country. There was a call for more research in specific areas where gaps had been highlighted. Pertinent to my study was that they noted the need for more work around the acceptability and availability of

services for STIs and HIV and levels of client satisfaction with the different services on offer. They also identified a need for researchers to “engage more closely with the concerns of practitioners and service providers in scoping and conducting intervention evaluations” (p76).

The voluntary counselling and testing for HIV (VCT) has provided opportunities for health promotion for many years both in preparation for the result and when results are known, negative or positive. This testing most frequently takes place within GUM services. The H.D.A. suggested more research was needed around whether VCT influenced behaviour change and sexual risk-taking and indeed why there was test seeking behaviour. This does not appear to have been taken up in the UK, although since the syphilis epidemic evolved over the last 3-4 years these same services are now doing in-depth surveys with those diagnosed to collate national and local information databases about behaviour and venues identified where sexual partners are met, to be used to target health promotion outreach.

Further gaps were identified around impact and outcome of the strategies that MSM use for reducing risk and how they negotiate safety. Alongside this was the question at what level were interventions by peers, individuals or groups effective? There were additional questions around internet based work, telephone help-lines and cognitive behavioural therapy and other counselling work as methods of minimising risk. Therefore, despite 25 years of HIV knowledge and we still, as a nation, are not greatly informed as to how to help the most affected group. However, recommendations for practice were around placing interventions around the broader context of men’s lives and addressing what influences risk.

These findings and others from the “Making data count; findings from the national gay men’s sex survey 1997” (Hickson et al, 1998), seemed to be the foundation for an abundance of in-depth research studies of the gay community over the next few years. These are mostly driven by Sigma research, in collaboration with the Terence Higgins Trust and CHAPS (Community HIV and AIDS Prevention Strategy). Sigma Research is

a social research group specialising in the behavioural and policy aspects of HIV and sexual health which has made a major contribution to this specialist research area.

In 2005, the eighth annual report of a survey of sex among gay men was published (Weatherburn & Reid et al). Evidence was becoming more reliable and usable for prevention work and could be built into service provision. This research evidence, however, was not heavily weighted towards findings from services, from a user or provider perspective. The key areas in these yearly reports seemed to be standardised each year, possibly as comparative studies to more easily recognise change in behaviour. The depth and quality of the information gained was of a high level. Questions that were pertinent to services tended only to be around whether they had been accessed for screening for STIs or HIV testing and what factors lay behind attending. What they actually experienced when they got there, or if their needs were met, was not evident. This is reasonable, as the crisis of increasing STIs and HIV should be around understanding what the drivers to risk-taking behaviour are and then developing appropriate prevention strategy. However, I would argue that services play a huge role in prevention and reducing transmission of infection, not just by the tests they provide but also by offering support, advice and information. Alongside confidentiality and one to one interventions, these should be used as quality opportunities to develop trust and rapport that would contribute to improved self-esteem and assertiveness skills of the service user.

Sexual history taking within a GUM service is core to the intervention with the service user and rarely is such sensitive information disclosed in any other situation. Faced with the facts and an anxiety about infection the client is usually in reflexive mode to avoid such worry in the future. I would suggest services need to be user friendly and accessible to gay men in every way to encourage their use and providers need more good evidence to understand how that is interpreted in reality.

Extrapolating from this research field it is possible to gain huge insight into what the issues that put MSM at risk are. Service providers will need to be aware of these findings

to gain increased confidence and respect of the gay community. Many of the studies investigate the social and cultural factors around gay identity, at the same time attempting to remove monolithic categories, generalisations that eliminate the uniqueness and social differences of individuals. There is a moving away from simplistic concepts of restricted groups, such as “gay community”. Even the government language of inclusion and exclusion is seen as implying the white middle classes are without need (Keogh, 2004) and sees other groups as always disadvantaged and weaker. All of these findings will assist much needed transformation in how service providers think of their gay clients and how to meet their needs, as well as challenging many assumptions.

Other Sigma research projects were around migrant men (Keogh et al, 2004); stigma and discrimination (Dodds et al, 2004); ethnic minority (Keogh et al, 2004); HIV prevention interventions work (Bonell et al, 2000); HIV disclosure between male partners (Dodds et al, 2004); exploring the contribution of general practice (Keogh et al, 2004); Use of the Offences Against the Person Act 1861 for sexual transmission of HIV (Dodds et al, 2005); morality, responsibility and risk (Keogh et al, 2006). They all explored areas that had come from the gay men sex survey each year and show a tremendous attempt at getting to the roots of risk and real life issues for gay men.

From this mountain of research findings I did identify useful recommendations for NHS staff within the report on sexual transmission of HIV and prosecution risks (Dodds et al, 2005). This was suggesting clear guidance on protocol development to address informing gay men, and others, about this legal issue. This practical tool was an example of what could help to give improved services and to support the providers.

The Government’s move to have more services provided by GPs through practice based commissioning will be assisted by Keogh et al’s report in 2004 examining why some men disclose their sexuality to GPs while others do not, and goes on to suggest interventions to promote better services. They ask the question ‘do men miss out on best services by not disclosing their sexuality to health professionals?’ If the doctor is not aware of their patient’s sexual behaviour they can’t then do anything about the sexual risks taken or

meet prevention needs. Issues related to sexual identity, such as relationships, alcohol and drug use, with important health outcomes are then not linked and the opportunity for support and an intervention is lost.

Through the National Strategy for Sexual Health and HIV (DH, 2001), GP surgeries should be providing at least level 1 service with others choosing to specialise more to level 2, still recognising that GPs cannot be expected to be GUM clinics and know everything pertinent to the health of gay men. However, Keogh et al's research study showed over half of all men registered with a GP stated they had not disclosed their status and 39% would not be happy for the staff at their surgery to know they had sex with men. Fear of stigma and how it would be documented were common reasons for not doing so. It was noted that it would be unusual for GP surgeries to ask routine questions about sexual history as they would about smoking, diet or alcohol. There appears to be an education gap for GPs and their teams. This study did suggest, however, that gay men were actually more interested in registering with a good GP rather than a gay friendly GP. There were keys identified to be learnt from this work around equitable provision, developing specialist interest for GPs through education from the 3rd level providers and also signposting of GPs for services to cope with the increasing workload of the GUM service, but at the same time offering more choice to gay men.

All of this work and many more studies, demonstrate that being disempowered or marginalised, as a group or as an individual, profoundly influences susceptibility to risky practices and HIV. Information giving alone is not effective and Reid et al (2004) recommend a diverse portfolio of interventions that are encountered by men with a wide variety of relationships to HIV.

This is reinforced in 2006 with Keogh et al stating that such interventions would require significant community infrastructure development and should seek to influence social norms in order to influence sexual practices.

The Terence Higgins Trust (THT, 2004) appeared to be taking a practical stance to support NHS services and to develop more non-NHS services to improve access, and it was not just commenting on services for gay men. It recognised the major challenge to the UK and the increasing sexual ill health and burden on the health economy, with yet more people going undiagnosed and untreated than ever before. However, it also recognised best efforts of frontline services.

This report acknowledges it does not cover abortion or contraception services but supports investment in them as vital aspects of provision. They cite poor access to sexual health services as playing a part in the ongoing transmission of infections. Improving patient choice and patient experience is seen as key alongside all the other themes of tackling inequalities and improved interagency working.

In 2006, THT in another report that had moved away from a singly gay-centric focus, considered how PCTs managed sexual health and HIV in 2005 and how this was viewed by specialist clinicians. They demonstrated how things were beginning to change and that with proper use of funding streams and modernisation of services easily preventable conditions could be managed well.

This was a useful and insightful report to assist the government to drive the changes they had already thought were in place. THT had carried out yearly surveys of services since 2002 and had gathered a clear picture of services under strain, managing need without funding, coping in inadequate buildings with low levels of staff. As THT was also a service provider and not just working in the world of prevention they now seemed to bring more understanding of the pressures on NHS services. They had been leaders in the field of HIV in this country in the late 1980s and early 1990s, when statutory agency responses were slow and lacked empathy for the most affected community, at that time they were not showing such allegiance with the clinicians. Certainly in the most recent research they do not identify political contentions around the role of the clinicians. The power of the consultant role, in particular, from an insider perspective, is one that could be identified as a blocker or obstructer of improved access for GUM services nationally;

however, it is not written about explicitly. This is an interesting area of exploration for my own field work. Had THT found it easier to identify as an ally rather than as foe?

2.3.5 Black and Minority Ethnic Groups (BME) / Asylum Seeking and Issues for Sexual Health and HIV Services

The complex picture presented by the HPA (2006) identified that 34% of adults aged 15–59 years, living with HIV, were African born men and women. They represented 64% of heterosexual infection. Undiagnosed infection in the UK is estimated in this report as being 20,100 with 27% of these being from an African community. Nearly two-thirds of new diagnoses in 2005 were for this group, the majority of infections acquired in sub-Saharan Africa.

Between 1996 and 2005 there has been a seven fold increase in BME individuals accessing HIV care. The HIV prevalence in black Africans living in the UK is estimated as 3% and 0.3% among black Caribbeans. This is 46 times the estimated prevalence in the white heterosexual community. Another indicator of poor sexual health in this group is syphilis, black populations accounting for a third of all diagnoses. Black Caribbean also accounted for a fifth of gonorrhoea diagnoses for heterosexual men and women in GUM clinics.

The global HIV epidemic impacts the UK as our black and minority populations, originating from the countries with the highest prevalence, are among the most adversely affected.

Late diagnosis is also a common factor. BME adults were ten times more likely to die within a year of their HIV diagnosis. The HPA (2006) report states only a minority were recent arrivals to the UK; they accounted for only 34% of the total diagnosed late in the course of the disease who had arrived within the year in the UK. In the UK HIV is a treatable condition, but preventable deaths occur in this group as treatment is less

effective in late disease. The HPA say other reports identify missed opportunities for testing in both primary and secondary health care settings. A BHIVA report in 2005 showed 70% of the newly diagnosed HIV from BME groups had been in contact with medical care in the previous six months. Although many individuals delay testing until they are symptomatic or admitted to hospital, opportunistic screening or targeted testing is suggested as reducing this mortality. There is also a need for more awareness and education of non GUM clinicians.

However, the HPA also noted 3% of BME HIV diagnosis were individuals born in the UK and 50% of this group acquired their infection in the UK, it is estimated this number will increase as the number of BME heterosexuals living with HIV increases. The following graph demonstrates the increase in HIV in BME community within England, Wales and Northern Ireland, between 1996 and 2005:

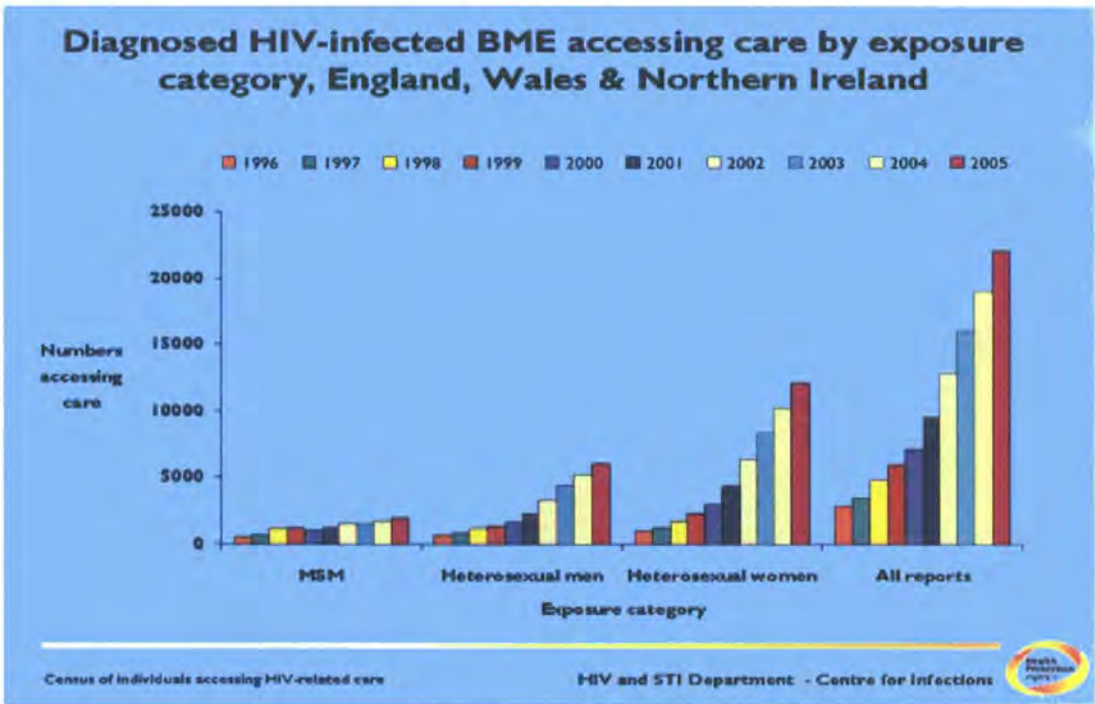


Figure 8. HIV positive BME accessing services by exposure category. Data source SOPHID (HPA, 2006)

The HPA also reports on high levels of all STIs for BME populations. Work with young people within this population suggests that poor sexual health knowledge is a factor in the rising rates, particularly for young men.

Clearly targeted interventions are needed, but stigma and prejudice for both HIV and BME are real issues and strategies need to be developed wisely.

Asylum seekers in the UK with diverse health needs, who have often undertaken arduous journeys from war-torn lands are usually living with only the most basic physical needs met and those made destitute because of refusal of asylum are living off the good will of others until their appeals are heard by the Home Office (Prior, 2006). Most PCTs have asylum seekers with HIV who require support from sexual health and infectious diseases departments. They bring new cultures and differing priorities than those of the local communities. Integrating into communities is challenging without others finding out about an HIV diagnosis. There are many emotional and social needs to be met alongside their health needs. Access to health care, or the NHS, has become restricted to only primary care services, and the government is now consulting on whether to even restrict these to failed asylum seekers (Save the Children, 2005).

There are health concerns to respond to but also methods of prevention that are culturally appropriate. There will be disparity of understanding between the provider and the asylum seekers or BME groups who are by no means homogenous (Palinkas et al, 2003). This work identifies the importance of non-assumption making and providers of services ensuring they are promoting health and not just screening and treating disease. Migration has been a challenge globally to programme development for health related knowledge, skills and attitudes.

By 2002 it was recognised in the UK that there was a need for a specific HIV prevention framework, a co-ordinated approach to HIV prevention, which involved statutory sector and voluntary sector and African community organisations. A framework for action was produced and updated in 2005 with a prevention and care strategy published by the

department of health (DH, 2005). This latest document promises to tackle inequalities and promote the spread of good practice and draws on all the national evidence. It acknowledges that the African community with HIV/AIDS have poorer health outcomes than most, despite having access to treatment, as often diagnosis is late in the stage of the illness and they are compromised by their higher levels of disadvantage. This document acknowledges also that promoting better health demands different approaches where women are often un-empowered and an HIV positive diagnosis may not be accepted by a male partner and women may be blamed for it. There is, however, a major contradiction within this document in that it states the rules around entitlement to healthcare being only the HIV test and counselling and not to treatment.

Sigma's reports in 2003 and 2004, on ethnic minorities and HIV and stigma and discrimination (Weatherburn et al; Keogh et al; Dodds et al), noted that studies had shown within African communities that half had not revealed their diagnosis to anyone they lived with, two thirds had not told their employer and a quarter had not told their GP. This study went on to explore how stigma and discrimination contributed to reduced health and well-being for the two largest groups living with HIV in the UK, gay and bisexual men and African migrants. They investigated the social function of stigma and how it isolates by being subjected to the judgement of others. They drew on the work of Goffman (1963) which analyses the way in which behaviour is affected by blame and guilt by those who do not match social expectations of normality. Goffman talks of a spoilt identity and behaviour that is seeking to avoid any negative reactions by hiding the stigmatising condition. Stigma will continue in these circumstances to either preserve or undermine social structure. It becomes a functional practice to maintain boundaries between the powerful and those without power. It will only be with this understanding that it can be challenged and recognised. Other well established work around shame and disapproval, if people don't behave how they are expected to in specific circumstances, shows how this justifies public attention (Foucault 1978; Becker 1973).

We may describe discriminatory attitudes as ignorant or uneducated, but these theories and the Sigma research findings were able to demonstrate this is more connected with a

complex means of producing power structures within society. They went on to apply this model to HIV, to having a social and political function to maintain social inequalities, not just between those who are infected or not infected, but also between different ethnicities and sexual orientations and attempts to maintain the status quo. Thus understanding the purpose of stigma will help to effectively counteract it within successful prevention strategies. Individual and group empowerment is only seen as successful if it is alongside improving the broader social environment with advocacy. Listening to those living with the infection and what their needs are is thought to be a gap in how the HIV services operate around African people, both statutory and voluntary. Individuals cannot safely speak out in the absence of social structures that defend disenfranchised people.

2.3.6 Young People and Sexual Health Issues

The HPA reports (2004 and 2006) comment about STIs in young people and identify them as a major public health problem. They note that young men and women are at increased risk of STIs and other markers of sexual ill health (such as unintended pregnancy) because of a complex interaction of factors related to behaviour, socio-economics, healthcare provision, and biological factors. They say young people are behaviourally more vulnerable to STI acquisition as they generally have higher numbers of sexual partners, conduct greater numbers of concurrent partnerships, and change partners more often than older age groups. Many young people may not have developed the skills and confidence to implement consistent and proper use of condoms to reduce the risk of STI transmission and unintended pregnancy.

The reports demonstrate that young people aged 16-24 accessing HIV-related care almost tripled between 1996 and 2005, although remaining stable as a proportion of the total (4.9% in 2005). The majority of diagnosed HIV-infected young adults were infected

heterosexually, 61%, over a quarter were infected through sex between men (HPA, 2006).

The STI diagnoses for young people in the UK in 2004 are demonstrated in the following graph, from the HPA, showing them as a percentage against all age groups:

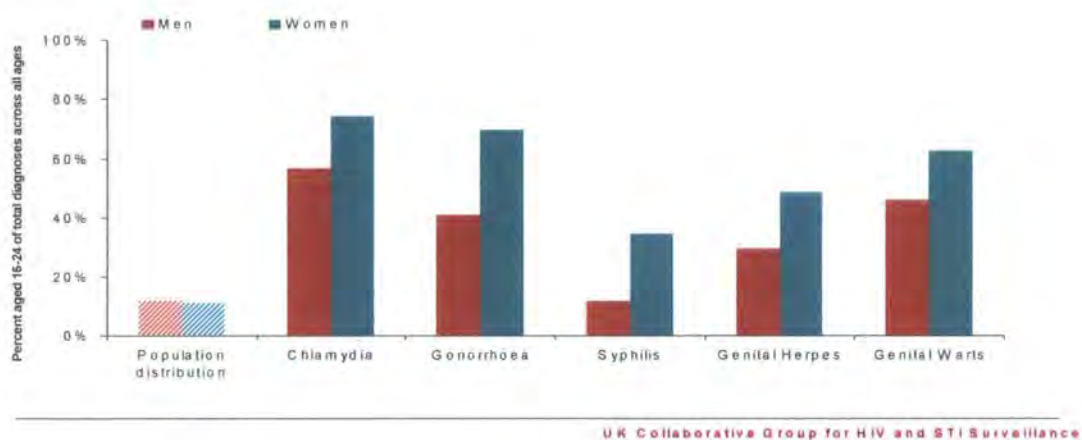


Figure 9. STI diagnoses in young people (16-24yrs) as a percentage of total diagnoses across all ages: 2004. Data source HPA 2004

These are huge issues facing the providers of sexual health services and prevention agencies as they attempt to have the right approach for another vulnerable section of society, who account for large numbers going through services. The government policy was supposed to be a lever to assist them in providing accessible services.

Teenage pregnancy alone is a major focus for sexual health services. Since the launch of the strategy in 1999 (DH) there has been a small reduction, but UK rates still remain higher than comparable EU countries. It was acknowledged in 2006 that progress would need to be accelerated to achieve the national target of halving the under 18 years conception rate by 2010 (DfES, 2006). A report on the consequences of teenage parenthood (Berrington et al, 2005) used data from two large longitudinal cohort surveys.

This research took into account that the predisposing factors to young parenthood, such as social disadvantage, would also be associated with the outcomes. Their results supported many previous findings around increased risk and social deprivation and the age at which the cohort's own mothers had their first child, as well as the importance of aspirations.

Brook, a national voluntary sector agency that supports young people with sexual health, reported that many parents do not feel equipped to teach their children about sex and relationships. They are calling for comprehensive sex and relationships education (SRE) to become a compulsory part of the national curriculum. Provision is still seen as patchy and often delivered by untrained teachers. They suggest that the school nurses, during drop-in sessions, are a good source of information and support for sexual health issues for young people. However, they stress the whole package of SRE, access to confidential, young people friendly sexual health advice and services, alongside action to increase self-esteem, are all key to reducing teenage pregnancy and improving sexual health outcomes (Barlow, 2005). Sexual health services working alongside school health services in North Tyneside are aiming to use this approach to address these issues in a more holistic way.

By 1996 the nation already had awareness raised around what young people needed to improve their sexual health. There had been an evaluation of teenage pregnancy prevention programmes (Peckham et al, 1996). This extensive study considered unpublished literature and policy approaches as well as surveying 177 providers of sexual health services. They reported that there was little evidence of systematic needs assessment performed by health authorities or other purchasers of services and little reference had been made to any published materials to develop sexual health services for young people. From a service point of view it was now clear that they would need to be young people friendly and informal and accessible by being open at convenient times, such as evenings and weekends. Other elements of service design that were identified, such as a guarantee of confidentiality and specifically trained staff for young people, were going to begin to underpin the national teenage pregnancy prevention strategy in 1999.

UK researchers reviewed international evidence on preventing and reducing teenage conceptions, considering the United States, Canada, Australia and New Zealand (Cheeseborough et al, 2002). They identified that the median age of first intercourse was around 17 years in all the countries studied. Teenagers by now were more likely to use contraception and protection than they were in the 1980s. However, women reporting sex at a younger age, particularly with an older partner, were more likely to have regret and to have not used contraception. Low income and low aspirations were still positively linked to teenage mothers. The most successful intervention appeared to be increasing the aspirations of girls and the disadvantaged; starting these in pre-school years was definitely linked to reduced teenage conception.

The literature has shown that an external locus of control and an inability to self actualise seem to be key to determinants of poorer sexual health, for most vulnerable groups and especially as young people. The Joseph Rowntree foundation funded research to consider low self-esteem and links with teenage motherhood (Emler, 2001). A review of the current literature at that time showed a raised risk, even possibly up to 50%. Although why low self esteem has this effect was not clarified, the link was made with unprotected sexual intercourse. Wellings et al (2001) reporting on the national attitudes and sexual lifestyle survey of 11, 000 people between 16-44 years in Britain, seemed to confirm this by showing earlier intercourse was less likely to be autonomous and consensual, and most likely to be regretted, unprotected and lead to pregnancy.

However, communication with parents is also a key element as a predictor of teenage parenthood. In a survey of young people to evaluate the national teenage pregnancy strategy in 2003 (BMRB), nearly half surveyed said they had received no or very little information on sex and relationships from parents. Main sources of information were identified as from school and over 70% were actually aware of the local clinic. Models, such as those in North Tyneside, where numerous agencies and staff groups collaborate for joint action to achieve the aims of the Social Exclusion Unit Report on Teenage

pregnancy (1999), have been employed across the nation. This brings a multi-dimensional approach attempting to support everyone, including parents.

It appears the national strategy has had some effect in getting information out to young people but there are still gaps in their understanding of levels of risk, and their level of skill to apply the information. Social advantage, or disadvantage, or culture, are shown to interweave (Lee et al, 2006; DH, 1999). It almost appears from the evidence that we could predict those who will become teenage parents or begin their sex lives early. To change that course and prevent it is another issue. Roy Boyne (2003) and Nettleton (2006) in their discussion of risk would firstly ask why this focus was highlighted as a problem? There are specific motives and values driving that focus. The Social Exclusion Unit Report is quite clear it is about the economy and creating a less dependence on the state culture. However, it is also acknowledged that teenage mothers, teenage fathers and their children are all predisposed to longer term consequences such as poorer psychosocial health alongside multiple disadvantage, restricted access to housing, education and employment, all adding to the social exclusion (DH, 1999, 2001; Hirst et al, 2006; Berrington et al, 2005).

Hirst et al (2006) consider whether adverse consequences of teenage parenthood have been overstated, as research outcomes were mostly shaped by poverty and not by the timing of motherhood. Again a weak sense of agency is inferred as most pregnancy in these circumstances is perceived as unplanned, but they observe in this study, not necessarily unwanted. Their work noted young parents voiced it was just one route to adulthood and age alone does not define identity or experience. A stronger sense of agency is seen when there is a decision to continue with the pregnancy and reject the idea of abortion, despite frequent pressure from others, taking responsibility for their actions and defying expectations by being a good parent, engaging with education or work after the birth. The benefits of being a young parent were seen as having more vitality to enjoy life and closer relationships with their own parents and grandparents. This study, of three generations of young parents within families, made explicit the stigma experienced from others such as employers and health professionals and having to work harder generally to

be accepted in society. It was identified that judgmental attitudes around maternity support was a particular aspect. Negative effects such as depression were related to this stigmatisation. A study that explored national variation in teenage abortion and motherhood (Lee et al, 2006) reported that most young women who continue with pregnancies have mainly positive experiences. However, they also had evidence of a minority feeling stigmatised by the health care professionals.

A youth advocacy agency in the USA note that youth serving professionals tend to focus on the negative health outcomes of sexual health (Rogers et al, 2005). This agency promote the benefits of approaching sexual health holistically, integrating prevention messages and programmes, and shifting delivery of services to a networked, integrated provision. Offering such services under one roof and encouraging youth friendly environments, they suggest, will reduce barriers for young people and expand the reach and impact they have. There is said to be improved economies of scale for organisations with more effective information giving and service development. They claim this also increases opportunities for interagency collaboration and synergy across the sphere of public health. They acknowledge this will be a challenging process as staff may require professional development to have the necessary skills and that a shift in culture may be needed, as well as financial sources.

Policy tends to focus on a direct approach with targeted interventions in schools that presents early parenthood as a disadvantage, and resulting in only slight improvements in rates of sexual ill health. Dicenso (2002) showed from his review of reviews , that the abstinence message, more often seen in the USA, has not been successful in reducing teenage pregnancy or STIs in young people. A controlled UK study looking at a teacher delivered sex education programme (SHARE), conclude that comprehensive approaches are needed to incorporate parental influences and more emphasis on the delay of early sex message (Henderson et al, 2007).

Boyne (2003) and Nettleton (2006) remind us that culture, knowledge, language and attitudes are bonded together, to examine them only reveals complexity and uncertainty.

We avoid many daily risks by simply taking care. But even as adults we don't always have perfect information to assess risk and we operate within multiple perspectives and within wider social determinants of health. The changing culture of British society is giving mixed and changed messages to young people. The government message in 2006 of "leave it to later" or a delaying early sex campaign seems to be a vital component missed out in earlier messages of promoting condom use. Young people searching for meaning and identity will have wider socio-cultural aspects influencing, and not just talk of sex. In fact it was suggested in the BMJ (Stammers, 2007) that the government's announcement to increase the school leaving age to 18 years should do more to reduce teenage pregnancy than anything they have introduced previously.

2.3.7 Modernisation and The complexities within the NHS sexual health services

The government requires commitment from its NHS leaders to see their vision of public health delivered. Within all the protocol and policy is the vision that the experts will give up their power and the service users become empowered, the expert, through new approaches. Everyone will take responsibility for their health and prevent ill health before it becomes a problem for the NHS. However, there is a dichotomy in the messages that pervade society, mixed messages that cause confusion. Taking risks no longer seems to be encouraged, the institutions or social controls tell us we are running into problems because we are ignoring the messages or themes in society that are there for our own benefit, to keep us safe and healthy. This is particularly so as an emerging, strongly political, public health movement reinforces that the onus is on the consumer of the health services to stay well. The White Paper, Choosing Health, (DH, 2004) demonstrated inequalities in the health of the nation are widening. Pouring money into ill-health and medical models of care has brought few solutions and suggesting prevention is the only way forward. However, individual responses must also be matched by structural socio-economic change to have any impact.

NHS staff are being strongly encouraged to develop health promoting models for their specialities and in areas they have thought little about previously. The title of public health nurse has been given to school nurses and health visitors, with it comes increasing responsibilities for healthy initiatives for their localities, on top of already heavy commitments. Local health plans are implemented with targets to be achieved for PCTs, all of which must include patient and public involvement. Performance management and payment by results will each have a part to play for the managers of these Primary Care Organisations. New language and roles, social constructions of reality, impact us, NHS staff and the public, continually, helping to maintain social order (DH, 1999, 2000, 2001, 2004).

Fears about the future are developed from the anxieties that are put upon us today, according to Furedi (1997). The supposed rising crime rates means we invest more in securing our houses, concern over our water supply causes us to invest in bottled water. Hence, continually telling us how unhealthy we are will drive us to invest in better diets, exercise, smoking cessation and safer sex. The media revel in worst case scenarios; it is accepted that good causes are promoted by using fear. We rely on flimsy evidence to convince us that we should take fewer risks. There is an acceptance that we live in an increasingly dangerous world with more risks than ever, even though people live longer and are healthier than ever before. Risk management has become a growing industry, every human experience becoming a safety situation. Risk consciousness and a growing demand for safety are symptoms of today's society. As we become more risk sensitive every innovation will merely increase potential danger. Nettleton (2006) agrees that notions of risk are being heightened but that the responses to them are circumscribed. She sees contemporary discourses with ideas of rights and responsibilities, which in relation to health translate into avoidance of risk. Furedi refutes this notion that risk should always be avoided. He sees risk-taking as one of the most important expressions of humanity and once seen as an admirable quality. He notes how the understanding of natural and social processes through history actually demonstrates life has become safer for humans and if we accept these modern ideas of risk then human potential can only dissipate.

As the HIV/AIDS epidemic emerged in the 1980s and we began to classify groups into higher risk, there was a call to consider that sexual risk-taking was not a question of who you are, but of what you do, how and with whom. The targeting of high risk groups was used as the key to the social problem to both explain it and contain it, high risk behaviour outside of those groups will not benefit from any particular focus. As we have developed treatments for HIV the risk and uncertainties continue as society now has an increased prevalence when people live longer. Those who struggle to get access to this treatment in the developing world live with increased uncertainties, maybe even to risk asylum to seek out treatment (Holland et al, 1998; Ferlie, 1993; Berridge, 1993; Rosenbrock et al, 2000; Weeks, 1993; Nettleton, 2006).

The Cultural and Historical Context affecting Contemporary Sexual Health Services

Ferlie (1993) presents the notion that the history of organisational change in the NHS highlights the obstacles and failures of policies that are agreed in principle but often not put into practice. He talks of institutional paralysis where there is insufficient power to reconfigure services and resources away from dominant groups. He identifies the leadership of change in these situations to be crucial to move the inertia. Whether that is a clinician or a manager is unimportant, but a champion, a risk-taker with a power position is what is needed. Ham (2004) also notes the attenuated impact of policy during the 1990s because of the hierarchical processes and structural interests. He sees the impact of patient choice and plurality of providers having great influence in the 21st century.

The history of the NHS and the evolving staff roles within it give crucial insight to staff working relationships and how the public are given a service within departments of sexual health. The NHS Plan (DH, 2000) required a complete rethink and a change in attitude and culture, an evolutionary process that was slow if there was evidence of resistance or belligerence. Lack of change can be more easily understood if put in context of the organisation of health since the inception of the NHS in 1945. This context is

described by Rivett (2008) in the cradle to grave history of the NHS; in the very language used to describe this history he identifies that over the last 60 years it infers power and gender issues, doctors mostly being referred to in the masculine and terms such as “mental defective” expressed with little regard to the offence it may cause. The history of nursing shows that characteristics of obedience, subordination of will and making others happy were the expectations of society. It was not until the inception of the NHS that the training of nurses was considered to emphasise social and preventative medicine. Their training was attached to hospitals, unlike medical students who were university trained. However, 1992 saw the UK Central Council for Nursing (UKCC) issue guidance on the scope of professional practice and conduct, maintaining that nurses were not dependent on doctors but responsible for developing their own competence.

Rivett (2008) and Ham (2004) describe a major change in the NHS from being a monolithic bureaucracy to moving to the GP Contract (DH, 1990). The Conservative government at the time introduced this as one of the most significant cultural shifts since 1945 by taking it forward to an internal market mechanism, designed to be a response to meet the needs of the consumer and change the monopoly of hospitals over the community. This was the purchaser-provider split with the introduction of new health organisations in the form of Trusts, with internal competition. New systems of financial flow and payment by results brought increasing complexity. Wanless (2004) has reported on the financial crisis within the NHS that followed and mistakes made in contracts of GPs and hospital consultants since then. However, the result is separate worlds of primary and secondary health care with commissioners and providers now working separately.

It took wider societal change before sexual health was first addressed in public health strategy, in 1992 with the launch of The Health of the Nation (DH). Conceptions among girls aged under 16 years and HIV/AIDS were then identified as health targets and sexual health then had a profile in the NHS. Evidence was also increasing that health was correlated with income and that healthcare systems should emphasise primary care. Rivett notes that STIs were now second only to respiratory disease as a cause of

communicable disease in Europe. By the end of 1994 20,400 people in England were diagnosed HIV positive (HPA, 2006). Debates around individual rights and testing for HIV abounded, with little hope offered around therapy if results were positive. The only two drugs AZT and DDI had been proven to not prolong life and it would take the introduction of other drugs in the mid to late 1990s, protease inhibitors, before clinicians and those affected could adjust to the idea of a possible longer life (Rosenbrock et al 2000; Berridge, 1993).

Berridge strongly recommends that the history of AIDS and how society has dealt with this epidemic, as well as previous ones, associating disease with moral panic, or disease and stigmatising minorities, helps determine lessons to be learnt for healthcare. It adds to the evolving historical record of managing STIs in the UK with a focus around public health policy. Debates around the rights of the individual versus the good of society proliferate; with AIDS not becoming a compulsory notifiable disease until 1987 when history was used to construct a defense for a more liberal approach, as lessons had been learnt from having voluntary and confidential STI services provided. Berridge notes AIDS has brought a revival of interest in public health and a focus on epidemiology alongside promotion of HIV testing and surveillance.

Towers (1993) put the history of AIDS in context with screening for Venereal Diseases as a preventative policy. In 1951 ante-natal screening for syphilis was introduced, he notes this was within a culture of legitimising scientific claims of medical procedures through expansion of medical roles into a broader range of social policy and deemed as health work. This was alongside compulsory treatment of children and breaching the previous confidential guarantee of the 1918 Venereal Diseases (VD) regulations. Confidentiality of an HIV test was crucial in the 1990s as most insurance companies were now asking for the results and refusing indemnity if positive. Towers notes the role of the sexual health clinic perceived as a safe and confidential place, being clear about the boundaries of sharing identifiable information. Lowy (1993) also explores this role of the VD clinic and its national network for the pragmatic management of syphilis, even before the discovery of penicillin, and how it contributed to the control of the disease. Weindling

(1993) investigates the politics of STIs and identifies that the origins of sexual health services were used as a prevention and control measure in post war years to protect civilian population from the soldiers, seen as reservoirs of infection. This was early 20th century socialisation of medicine with the provision of free diagnosis and treatment. However, this was also alongside military models of containment of infection which created an authoritarian and coercive ethos. Weindling compares this attitude with the history of AIDS management and elaborate schemes for medical controls. The most affected members of society needing to shout loud for respect of cultural diversity and individual needs and feelings. This history within a context of health policy and ‘Cinderella’ services such as sexual health, will demonstrate in the fieldwork that there was a huge gap in what was the intention of policy-makers and the reality in practice.

The introduction of safer sex education and the work of voluntary organisations, mostly groups focussing on gay men, was a response to the moral reactions from government and society around AIDS issues (Weeks, 1993). The Thatcher government of the 1980s banned the promotion of homosexuality by local authorities through what became known as section 28 of the Local Government Act, 1988. Weeks stresses how this highlights the difficulties of policy formation concerning sexuality in such a complex society, when the government were trying to manage the crisis through traditional measures of a biomedical model, not taking it too seriously unless a real threat to heterosexuals. Although constrained by this moral agenda at this time, the gay community achieved a voice and a public presence through extensive gay lobbying and activism when most deaths from AIDS were in the gay community.

Lewis (1993) suggests that the history of AIDS highlights the weaknesses of both public health and the NHS in not addressing initially the social and environmental determinants of health and illness.

The NHS before 2000 was perceived as an under developed organisation which was rule-bound with no fluid forms of decision-making (Ham, 2004; Ferlie, 1993). *Shifting The Balance of Power* (DH, 2001) brought new decentralised structures, giving power to

frontline staff and a commissioning role to the new PCTs. This was as The NHS Plan (DH, 2000) was emphasising patient choice and greater plurality of provision (Ham, 2004). History from the previous decade had demonstrated that HIV/AIDS had been a naturally occurring opportunity that embraced new designs and responses using collaboration between multi agencies and professionals and earmarked resources which could accelerate service development. However, lessons learnt alongside this were dominant coalitions which excluded other emerging constituents (Berridge, 1993). The modernisation of the NHS is considered by Street (1993) to undermine specialist care for AIDS and wider policy in local government encouraging equality and anti-oppressive practice. In 1993 he saw the devolution of care to GPs as difficult because of drug costs and complex contractual arrangements. Competition for scarce resources against the statutory sector made the voluntary sector vulnerable to closure. The plurality of provision had also brought its problems. The fieldwork will expose if this is still the case and if the NHS really did improve performance and work for patients (Ham, 2004).

An exploration of the normalisation of AIDS in Western European countries (Rosenbrock et al, 2000) demonstrates how a health calamity was able to impact a dramatic change in culture in the way professional groups could work together across nations and contribute to the modernisation processes of health policy. This alliance was identified because of what is termed exceptionalism in Europe, with policy that emerged in response to this catastrophe. As the NHS Plan (DH, 2000) was being implemented there were many lessons that could have been drawn from the evidence within this response. Equally the Choosing Health (DH, 2004) agenda would benefit from reflecting on the processes and outcomes of what is described in the work of Rosenbrock et al in a journey investigating the forces responsible for normalisation and changed management of HIV/AIDS. They investigate the resulting innovations and modernisation of healthcare policy through consideration of both the primary prevention and healthcare strategies, recognising that the degrees of modernisation of health policy varied depending on how exceptionalism of HIV had been institutionalised. HIV became the exception within the rules of healthcare policy as innovation and large funding was dispersed to address this problem. Rosenbrock et al identify how initially policy has to be conceptualised, and implemented

with uncertainty, often within political tensions and short timeframes. They claim AIDS retained an unchallenged special status until the early 1990s, regarding the amount of profile and finance given to it. However, by 1996, now as a chronic illness with available therapy, this special status became eroded. Debate that followed was calmer and some of the innovations were then integrated into prevention and healthcare and civil liberty strategy. This is seen as the move forward to normalise, as AIDS becomes perceived as endemic. Normalisation was said to be also a consequence of successful prevention work.

Normalisation of UK sexual health services is not evident in their history, always being separate from other services, very medically focused and lagging behind with modernisation, requiring centrally driven targets and levers to drive them forward, as devolved power to services and patients was not a concept yet taken onboard (Rivett, 2008; Towes, 1993; Berridge, 1993; Ham, 2004; Klein, 2001). Rosenbrock et al (2000) noted there were changes in the management of HIV/AIDS made because of this normalisation, that it no longer was extraordinary but was becoming familiar. They say this process follows from a period of intense public debate with high social attention; until it becomes treated as less of an issue and until there is a move to some mute agreement. They suggest this is because the topic is often overtaken by other pressing issues, especially within the health arena.

There will be other consequences of this normalisation, particularly around reduced motivation and withdrawal of social attention. The high commitment and willingness to act in times of exceptionalism, especially when gratification potential declines, will no longer be driven by the pioneers it initially attracted. The changing dynamics in the transition to normalisation will require adjustments and redefinitions. Rosenbrock et al's conceptualisation of this process is still a phase to be faced as sexual health services now remain high on the government agenda, attempting to address the deteriorating health of the nation.

The NHS as an Institution with Power

Berger and Luckman (1991) see society as an objective reality, that social order exists as a product of human activity and that man is a social product. They see the emergence and maintenance of social order through the theory of institutionalisation. We need to free up our energy for decision-making and therefore our activity is subject to habitualisation. This allows institutions to control human conduct by setting up predefined patterns of conduct which channel us in one direction, feeding the roots of an expanding institutional order. The establishment of sanctions is required. If conduct is institutionalised then it becomes more predictable, not changed so readily and more controlled. New generations can posit problems of compliance, conduct can be too spontaneous and taken for granted. Therefore reinforcing is needed to maintain control such as language, symbolic actions, role typification and traditions. If we are told often enough “this is how things are done” we will start to believe it. Berger and Luckman note the objective reality of institutions is not diminished if we don’t understand their purpose, or if it is incomprehensible, even oppressive. But any deviance from the institutional order will appear as a departure from reality and will be boxed up, or assumed as, ignorance, mental illness or morally depraved. We need transmitters and formula that can be memorized and reinforced upon our consciousness so we can retain institutional meanings, and so they are legitimized. Government campaigns and education around sexual health messages help this process and sexual health services are there to both reinforce the messages and also viewed as the penalty of deviance from it. Roles make it possible for institutions to exist, not just as an outward performance of a role but as learnt cognitive and affective layers of the body of knowledge appropriate to the role. The role becomes representative of how organized society is, having a stock of specialist knowledge, specific for that role. The clinical view is that doctors and nurses have become integral to the role of the expert. Individual social consciousness then becomes socially determined, particularly as we rely on these experts to tell us how to stay healthy.

The public health agenda is an ambitious ideal, but are the government creating conditions that are conducive to health i.e. political and economic empowerment that

allows people to make informed choices related to their health? We need to ask, do the health providers invest in this empowerment and let go of their own power (Nettleton, 2006; Witz, 1992; Lukes, 1974; Foucault, 1976, 1980, 1988; Faubion, 1994; Hindess, 2001; Freidson, 1970, 1994)?

The UK approach to sexual health is often presented as problematic and not seen in positive ways, the term of sexual health itself often viewed as something to be kept secret. Finland seem to have had a quite different approach to sexual health and sexuality for a number of decades than we experience in the UK. Lottes and Kontula (2000) note a report by the Finnish National Board of Health with a clear message that research had shown sexual expression can improve the health and general quality of life of individuals and their families. This report demonstrated that positively experienced sexual activity was an efficient antidote against the ill-effects of stress and the business of life. It recommended that health-care providers give guidance on these sexual matters to all margins of society including the ill, disabled and elderly. A survey of the Finnish population agreed with this connection between sexuality and health. But it was also acknowledged that people must have enough resources in terms of knowledge and economic and political power in order to exercise their sexual rights.

Rights will automatically bring with them responsibilities, both for the individual and for the government. Responsibilities lie around use of contraception, without unnecessary risk of infection and equally with providing accessible services. Lottes explores the macro level determinants of sexual health and asks in what ways do societal institutions affect sexual health? She notes the complexity of the notion of sexual health, a multi-dimensional concept not easily measured. But extrapolating data for STIs, conceptions, abortions and rape alongside a nation's laws, values and discriminations for different sectors of society will assist in evaluating the state of sexual health. These are indicators that will give some measure of some of the dimensions of sexual health. Lottes explored international literature that showed an emphasis on the empowerment of women as a means for improving their sexual health and sexual rights. Empowerment was interpreted as gaining control and access to material assets as well as to intellectual resources.

Empowerment mechanisms cited were formal and informal education and group formation to build solidarity among women so they can work more effectively to improve self-esteem; she illustrated a strong association between the empowerment of women and their sexual health.

Lottes' evidence does have some aspects in common with the public health agenda as well as with other evidence within the National Strategy for Sexual Health (2001). Nettleton (2006) also identifies that the balance between centrally driven, institutional directives and empowerment of marginalised groups in the UK still has some way to go. This government is very aware of the inequalities in health and does attempt to address them through these strategies but this shifting of power needs to happen faster if they really want to address this massive increase in identified infections.

Power will enhance the capacity of those possessing it and hinder the freedom of those coming under it (Hindess, 2001; Witz, 1992; Lukes, 1974); it prevents victims of it from doing what they would have done and from obtaining what they would have obtained. Power is seen as legitimate if it is based on real consent. Other forms of power are perceived as illegitimate when exercised over those without autonomy. Hindess identifies this from a critical theory view as one of the most important obstacles to the achievement of individual autonomy.

Hindess has drawn from the work of Foucault (1980, 1988) who conceives of power in terms of "structure of actions" (p97) and in his view power relations will often be unstable and reversible. However, his conception of domination and government designates power relationships as more stable and hierarchical, as they have been in the history of the roles of the professionals in the NHS, or when government are aiming to regulate the actions or conduct of individuals, as in the public health agenda. Power is everywhere and available to everyone. Foucault suggests the exercise of power requires a degree of freedom, as there is no power without some resistance. The outcomes will be far from certain and will always involve cost. This provokes refinement of techniques of power, which themselves produce new forms of resistance and evasion. It is suggested by

Foucault that hierarchical relationships of power are inescapable; they are fixed by history, in rituals and procedures, imposing rights and obligations. The NHS as an institution is riddled with such things within its internal structures. However, he stresses domination should be distinguished from power, as power is not always negative. Indeed power should be negotiated in relationships to minimise domination. This will apply in most situations whether political, economic, sexual or institutional.

Foucault suggests successful government of others depends on the capacity to govern oneself through personal conduct and regulation of behaviour. Although discipline of others is seen as important training for practical purposes within education, the military and other institutions such as hospitals and prisons. This idea that the conduct of others can be subjected to control, views the world essentially as a force that can be harnessed. However, he does place this idea of discipline within humanist ideals of consciousness, guilt, remorse and other characteristics that could be worked on by another. This is an external locus of control, as opposed to an internal locus of control suggested by Rogers (1980) in person centred care when empowerment is the aim. However, Foucault does argue that discipline will often be unsuccessful in its aim.

Pastoral power is a term used by Foucault (1988) as a shepherd exercises power over his flock. Being concerned with welfare but alien to the concept of liberty, it is not based on consent and it was fundamental to the conception and role of the welfare state, playing a part in public health strategy. Government, or institution, working from a shepherd-flock model will assign appropriate identities such as healthy or unhealthy and provides a norm against which the deviant other can be measured.

Hindess (2001) states power can be a cumulative phenomenon and in the event of conflict, those with the most power will invariably prevail over those with less. Power in the Western world is thought to have two aspects, with the idea of power as a capacity and power as a right. Institutions with knowledge have power. In places such as NHS services that deal with a discourse of sex and sexuality (Foucault, 1976) the medical examination has the power to question and bring to light any symptoms or dysfunction,

medicalising what should be normal with the possibility of reinforcing the power of the practitioner.

The history of the professions within the NHS, principally of doctors and nurses, also placed the nurse within the flock of the shepherd. The new nurse practitioner of the 21st century no longer fits this mould but takes on the guise of the medic when managing the public. The institution needs to reform to allow this. However, consent was not necessarily given by the medical profession for this new role of the nurse, she/he is not always seen to have legitimate power; she/he may have capacity for power but could be perceived to not have the right to take power (Witz, 1992; Foucault, 1980).

The English system of medicine historically had organised itself with multiple features and forms of authority, with well defined boundaries (Foubion, 1994). These are now moved and evolving as never before or since its inception, producing a new institutional order. The fieldwork will discover if nurses continue to accept “this is how it is done” or if they choose, or are able to take hold of, their own capacity for power and whether the doctors are willing to give up some of theirs to allow this. As Foucault predicted power relations are unstable and reversible, that is unless domination continues as an aspect of the governance of the institution. He demonstrates in his exploration of power that levels of power require negotiation to avoid entrenchment of resistance, allowing an appropriate identity to be assigned and providing a norm from which measures can be made. However, sexual health services with their history of military models of containment of infection with an authoritarian, coercive ethos and schemes of control may find this negotiation a difficult concept (Weindling, 1993).

The Medical Model and the Caring Professions Explored.

Latham (2002) in an exploration of medical professionalism summarises how a profession is identified against a checklist created from sociological literature of the 1990s. An occupation is classed as a profession if:-

- Formal education is required.

- Members control training standards and are self-regulating.
- An academic journal is devoted to applying those standards.
- Practitioners have high social status.
- Practitioners are protected from market forces and state regulation.

This checklist allows ongoing discussion as to whether an occupation is a profession. It also describes professionals in positive terms. Latham comments that this checklist approach was of the structuralist/functionalist school of sociology, the founder being Talcott Parsons, the originator of the concept of professional. He goes on to explore Parsons' use of legitimate authority in a new way, which Weber had done previously, by introducing the notion of expert authority. This is interpreted as people obeying a command because they believe you know something they do not. Latham notes Parsons would view this explicitly as associated with professionals. Their authority as a professional was to be used to mediate between individuals and their clients, and society as a whole. Interests and actions of clients were to be aligned by the professional to social norms. Professionals would be motivated by the desire for status and reputation, both among peers and society, rather than by a desire for money and power. Parsons claims the public will be inspired to respect and trust the profession by production of transparent standards of competence and ethics. The authority of the professional is grounded in their knowledge and expertise; they have superior wisdom and privileged access to a body of knowledge. For the medical profession they know things that neither their patients nor the public can know. This allows vulnerability of patients and the public to misuse of their authority. It is only their professional status that allows them to exercise this authority, expected to be in the best interest of the patient. This now outdated Parsonian view ignores any possibility of the exploitative actions of professionals, who may actually be hungry for money and power, as he determines they are separate from this and self interest is only in reputation and status.

Nettleton (2006) suggests, however, this role is often still played out and expected to facilitate the smooth functioning of society. The doctor needs the patient and the patient needs the doctor. Latham and Nettleton introduce to this foundational view criticism of

the medical profession noting that much medical practice is not based on scientific evidence and is heavily influenced by economic and marketing forces. However, one word from a medic can trigger powerful social forces that could accommodate illness or decide there is nothing wrong. This authority then is not just over the patient but over his community as well. They have a heavy investment in status-capital, to maintain it they can only act as professionals. Lukes' (1974) theory of power agrees that institutionalisation of authority, such as that of doctors, makes it difficult to challenge; it is legitimised by the patients, and the community. He sees power as belonging to a group, not an individual; he is empowered by people to act. Power indicates capacity or ability, not a relationship. Revolution can only occur when power is dissipated from being a superior organisation. He agrees with Foucault (1980) that consensual authority, with no conflict of interests, is not a form of power. Challenging such vested interest as the doctors would not be an easy journey. The government require nurses to take over some of their role, but their power is embedded in the authority the public imbues in them. This requires identifying individual variables that could be handed over easily, things that would make improvements for the service as a whole.

Barker and Roberts (1993) explore the emphasis Parsons puts on "how much power" a party holds and hence what sanctions it is able to bring which reinforces their position. He also identifies this brings legitimised rights to use the power granted to them by structures within the organisation. This is a historical construction within the NHS. At its inception medical doctors were "in charge" and a possible perception of the public is that this is how it remains. Barker and Roberts also considered the concept of power by Foucault and suggest his application of arguments over time has provided examples of how social identity is constructed, rather than naturally determined and so could be used as material for the theory of dominance. They see his perspective being of less use for those who see power as something to be exercised by responsible agents. Knowledge and information are a contemporary source of power, particularly in large governmental organisations. Throwing a veil of secrecy around knowledge and skills will assist the powerful to govern or in some way to retain advantage. Barker and Roberts (1993) note the formalisation of this exclusion by notions of differences in understanding or

intelligence, possibly seen between the medical and nursing group, is a key to retaining power. However, it appears someone must hold the authority to take the lead and to make the changes, for the NHS it is moving away from doctors and within sexual health departments the realisation is only beginning.

Rosenbrock et al (2000) note in their work around the normalisation of AIDS, that there was a temporary retreat of medicine from their usual dominant role which allowed other approaches and roles to become more visible, this was prior to AIDS being managed as a chronic illness with the availability of therapy. They suggest this was possible because of greater need for care and competence from non health professions. The result was innovations in the social handling of health, which influenced many other policy arenas. The claim is that medicine was de-legitimised because of a lack of treatment for AIDS, but also there was a reliance on other professional policy to bring innovation in practice.

2002 saw the introduction of an alliance of health and social care education with a Statement of Strategic Alliance for Health and Social Care (DH, 2002), proposing to invest in future partnership working between two large organisations. This was an effort for greater collaboration and shared care that would meet the needs of responsive care management. The learning of professionals together so they would be equipped to assess through a common assessment framework was perceived as foundational. This would allow a widening of the participation of the workforce and bring changes in individualised thinking, to be a NHS/social care workforce that was representative of the diverse local communities that it served. Inter-professional education would improve perspectives, sharing knowledge and resources, but would require smart organisational change to achieve it.

The role and power of doctors and the medical model was also seen to change with the intention to develop a primary care led service with greater emphasis on care in the community in 1993 (DH). Local authority social service departments became the lead agents in the provision of social care. Like the NHS this policy is still evolving and

moving away from the mass institutionally based care towards packages of care and devolving power intimately to the service user, now being seen as a consumer.

Care in the community and responding to what the public want, rather than in medicalised or clinically focused ways continued to move forward with this concept of the consumer and listening to local people. Professionals, whether doctor, nurse or social worker would be required to work in a context of health needs assessment with the client at the centre of decision making and no longer within a culture of having things done to them by experts (Annandale, 1998; Ham, 2004; Nettleton, 2006, Leathard, 2003).

The concept of professional dominance was seen by Freidson (1970) as protecting against outside scrutiny. He particularly referred to medicine in this context, although he also encompassed nursing, as it also has much to gain by moving from a traditional pattern of subordination to a claim for responsible autonomy. Witz (1992) suggested the gaining of autonomy of nurses was not so much a counter attack on the monopoly of doctors and re-negotiation of occupational boundaries, but more about the cost-cutting potential of the workforce.

Freidson (1970) proposed that professions with autonomy and dominance provided protection for themselves and with self-regulation a further opportunity for misuse and abuse of clients. He saw this as a critical flaw, encouraging a self-deceiving view of objectivity and reliability of knowledge. His solutions included changes in the way training is provided and more inter-professional, joined up thinking to really impact a culture of care giving; this was 38 years ago and yet little has changed in bringing professionals together for their education.

The new health policy has created an ethos of individualism, holding patients accountable for their own health and care workers accountable for what they provide through standard setting and audit proof. The individual is encouraged to seek information and make choices and cultivate a sense of agency. The ability to actually achieve this could be circumscribed by the politicised nature of health and social care, as well as by their own

economic and social situations. Enhancing quality is the aim; the result could be defensive practice, putting providers against purchasers, but also providers against service users and service user against provider, within this consumer culture. Who is taking responsibility as we are now in a health-care culture, with supposed collaborative relationships (Annandale, 1998; Ham 2004; Klein 2001; Nettleton, 2006)? Some have proposed increased accountability ensures resources are used in service users' best interests but political and social alliances emerge over time, with many being temporary coalitions as different camps are formed and dissolved, depending on the issue at stake and whether it is the place for competition or co-operation. Confusion prevails for staff and the public trying to establish what the culture is, a trusting relationship or a contracting relationship? NHS and local authority monopoly providers now realise commissioners are looking at economies of scale, and achieving targets. Their understanding of the detail of quality will not be their forte. This type of provision may actually be in the private rather than public sector (Ham, 2004; Nettleton 2006).

Freidson's theory of dominance of medicine (1970) and other debates around professional status and power in health care (Latham, 2002; Lukes, 1974; Annandale 1998; Nettleton, 2006; Klein, 2001; Witz, 1992) has sensitised us to the changes that are necessary to bring more equality and less dominance. However, we must be careful not to over generalise as power is never neutral and many sociologists identify gender lens when examining uses of power (Morgan & Stanley, 1993; Smith, 1987; Holland and Atkins, 1996; Larrabee, 1993; Holland et al 1998, Butler, 1993; Hawkes 1996, Witz, 1992). Brush (2003), argues that state power and most policy is gendered and that many people in places such as large organisations consider male dominance, and not just that of the doctor, to be normal, neutral and universal and the lens of feminism distorting and political. This aspect will be explored more as the study develops and considers the role of gender in their situations; Annandale (1998) suggests medicine may still have the upper hand but that the war is still being waged.

Investment in Infrastructure to Improve Access to Services

We know in the work of sexual health that the “more we look the more we will find”. Much of the increase in diagnosis of sexually transmitted infections is because more people are being screened and we are using more sensitive tests that identify at least 40% more infections than previously. However, screening for infections and preventing unwanted pregnancy and a host of other issues associated with sexual health could be housed in a one stop shop, or within an integrated sexual health service, mentioned as a possible solution, as it was in the national strategy for sexual health in 2001. Generally, more accessible sexual health services are recommended repeatedly as a vital aspect to improve the nation’s health (Doherty 2000; Dawson et al 2000; Kinn et al, 2003; Miles et al 2003; Adler et al 2002; Lush 2002; Hock-Long 2003; Stone et al 2003; Dixon-Woods et al 2001; Dehne et al 2000; Coombes 2005; HDA 2003; HDA 2004,; Davey 2005; Poulcallec-Gordon 2004; Nguyen et al 2004; Dodd et al 2002).

Yet real investment in infrastructure of services has been lacking since the inception of the health service as sexual health was never a priority. Having adequate buildings and skilled staff takes years of investment and forward planning. “Choosing Health” (DH, 2004) is supposed to be empowering to communities as it stresses matching solutions to local circumstances and need, with those with the worst inequalities to be tackled first. Every intervention by NHS staff with the public is to be used as an opportunity to promote public health messages. Therefore a sexual history taking intervention within a sexual health clinic also involves exploring diet, exercise, as well smoking and alcohol use. Often taking the service user by surprise, but intending to convey the message of holistic health, that sexual health is not a separate issue. This is an obvious example of transmitters and formula and roles of experts being used to reinforce as we socially construct this reality of poor health due to risk-taking or lack of personal responsibility (Berger & Luckman, 1991).

Choosing Health identifies its role as marketing an important and fundamental cultural change in the way the NHS relates to patients. They will use the NHS massive workforce

to assist this shift of emphasis; not only in the NHS but within local authorities who are to work in partnership with these objectives. A complex network of organisations will have a major role to play in ensuring the detail is delivered.

Sexual Health Services are They Different to Other NHS Services?

Recent years have seen a proliferation of national guidelines and protocols advising of best practice based on robust evidence. Nothing is being left to chance or individuals, but a centrally driven model of health protection tells us how it should be done. This is despite the policies also suggesting agency and personal responsibility; there is political contradiction in place with the rhetoric of devolving power to individuals or to organisations such as healthcare Trusts, alongside the reality of central controls through performance management for target attainment and advertising and other controls for individuals that marginalise those who choose not to conform.

The issues that need to be managed around sexual health services are often quite different to those around cardiac or cancer services and this is not always obvious to the policy makers. As they roll out a national computerised system for a single set of patient information records to be shared with all services there is a realisation that GUM departments are governed by different rules of confidentiality and other staff should not have access to these records. Confidentiality within General Practice remains a concern for some patients, particularly when dealing with HIV. There is promotion of devolution of services through the document of *Shifting the Balance of Power* (DH, 2002), to Primary care, principally to improve access. However, GPs maintain they have not the capacity to develop these specialist skills. The Select Committee on Health, third report 2004, noted some PCTs have not even acknowledged sexual health and HIV in their service and financial frameworks, they had claimed no priority. The new Public Health agenda is driving sexual health as a priority but the NHS service providers still have some way to go.

Improving access to health care and modernising sexual health services will involve not just investment in the infrastructure but creating models that require a different way of working, different ways of conceptualising, alongside models that challenge the health service culture and the power and control that has always been part of maintaining a medically focused provision (Dehne et al. 2000; Dawson et al, 2000; Dixon-Woods et al, 2001; Hock-Long et al, 2003; Lush, 2002; Adler et al, 2002; Doherty, 2000; Spence & Taylor, 2003; Jaccard, 1996, Ham, 2004; Annandale, 1998; Nettleton, 2006; Klein, 2001; Lukes 1974; Witz, 1992; Freidson, 1970).

The stigma and marginalisation of those most vulnerable to sexual ill health has also been the experience of the NHS sexual health service providers within the NHS system (Kinn et al, 2003; Kane & Wellings, 2003; Tayal & Opaneye, 2003). Decades of post war years, left to their own devices, to just get on and do their own thing that other more “worthy” services did not want to be part of. The result was that the new NHS management of the 1970s really did not manage this area too closely and the medical leads in the form of consultants for genito-urinary medicine and the associate specialist leads for family planning created a response that fitted a very clinical, bio-medical, way of working, as that is how they were trained.

Leadership, power and control were key issues that needed to be addressed if the modernisation of these services was to be a reality as they moved into the 21st century. Interestingly from all of the review of reviews and other evidence bases around sexual health I found little evidence of this factor. This would have to be explored more closely through my own study as an insider and a researcher.

A Deep Dive Study into Teenage Pregnancy (DOH, 2006), using key agencies working together, identified that the seniority of key individuals involved in steering the local strategy would influence the impact of the action plan and hence influence local rates of teenage conceptions. This should include service leads but in many health partnerships they were not represented. A national evaluation of one stop shops for sexual health provision (Bristol, 2006) showed a common mindset to integration of sexual health

services as well as an identified leader, responsible for management, was a key factor to the effectiveness of the model of service.

Leadership of a one stop shop, or integrated sexual health service, by a medical doctor proves difficult as their training in two quite separate specialities of contraception and genito-urinary medicine has historically defined that services would be provided in the community usually by a female medic, not quite of consultant grade, and a male in a hospital setting with the higher status of consultant physician. Culturally they were not natural partners, despite an overlapping agenda. Service users nationally trail from service to service to have needs met (DH/I.A.G., 2006). Despite the overwhelming evidence to improve accessibility and create more user-friendly services there was a blockage to opening up services under one roof and joining forces to provide this integrated model of provision. The whole government agenda around modernising the NHS was implicating nurses to take over much of the work the doctors were saying they could no longer keep up with. However, this transition would not be easy as power and control was reluctantly relinquished to allow an integrated sexual health service evolve, such as that developing within North Tyneside where contraception and GUM services had come together, or integrated.

Effective Leadership

Effective leadership that will mould services and encompasses all that the evidence tells us what the public need to improve their sexual health may require a paradigm shift. It is not just about good clinical care, although this is a vital component. Services need to be provided when the public want them, in the evenings and at weekends, in a way that does not disempower them. We are required to respond not with paternalism but to view the service user as a consumer. There need to be systems and processes in place that respond not just to symptoms, screening and medication, but to the needs of the whole person within the context of their lives within society, maintaining dignity throughout. The service user now empowered and part of an alliance, at the centre of all collaboration. A partnership between patient and practitioner is what is required. A fundamental shift in

thinking may not be instantaneous, unless faced with a life crisis. The paradigm will create the lens through which we see the world, they are powerful but limited by our perceptions and experience (Covey, 1989; Nettleton, 2006; Witz, 1992; Leathard, 2003).

Birkett (2005) explored what “treating patients well” implied and asked the question what is it that we want from doctors, if we don’t want paternalism, insensitivity and authority? Current key targets determining star-rating do not take into account the doctor-patient relationship, but maybe they should. The Independent Advisory Group for sexual Health (2006) suggested extra funding and priority of sexual health services should be an opportunity to consider the medical-led structure and explore ways of enhancing the roles of nurses and other staff comparable to other modernised services. Prioritising training would be required to achieve this, but enhancement of staff roles was seen as vital to the success of the investment. Bevan (2006) noted, within a discussion of an American health success of saving lives of people in hospital that would otherwise have died, that quality standards or specifications are not enough on their own to engender wholesale change, they will only create an externally driven dynamic that tell providers what to do. It was hoped the MedFASH standards for sexual health services (2005) would bring dramatic change, but she referred to this as the push approach. The power of the pull approach is to frame the proposed change as an irresistible, logical and as an emotional argument. What is suggested is an emergent self-fuelling approach, from the bottom-up; success will depend on good planning and strategy. This is further evidence of centralised top down directives, despite contemporary policy presenting an ethos of devolving power.

This is a campaign that would challenge our NHS ways of organising and leading. It would involve moving away from top down performance improvements, concentrate on the evidence based action and the frontline staff intervening with it. Designing future improvement systems will require whole staff teams onboard, united around specific aims that even exceed outside goals. It will entail competent leadership with a vision that will keep everyone involved.

The world of the modern organisation is complex, filled with challenges and opportunities. To survive and prosper it needs the full engagement of its members to think creatively. A training group that provide strategic effective leadership training for the NHS are tasked with creating champions, able to influence and translate corporate vision into action (Management Research Group, 1999). They introduce developmental processes designed to improve effectiveness of NHS leaders. They theorise that personal competence and leadership effectiveness is a function of how you manage your power relationships with individuals at three different levels, your manager, your peers and those you manage. The idea is to gain the loyalty and dedication of independent thinking and talented people as an empowerment process takes place. Achieving such aims within sexual health provider units will carry the vision for the nation of improved sexual health for everyone.

NHS reforms in the 1980s around introducing a new management style inspired by Sir Roy Griffith brought non-clinical managers into the field and greater accountability for resources. By the 1990s a definite business culture came with the separation of purchaser and provider (DH, 1983). Patients were increasingly being seen as consumers, individual rights and expectations were to be taken into account. Consumer satisfaction was to be measured and quality standards introduced. New tools for assessing need and provision were developed. This model was seen as congruent with an internal market and an enterprise culture. However, resistance and resilience to these changes was very evident within the NHS as we begin to see this shift from paternalism to consumerism, suggesting more significant social change in contemporary capitalist society (Davies et al 2000; Klein 2001; Ham, 2004; Annandale, 1998; Nettleton, 2006). By 1997 quality became the suggested driver for reform for the Labour government and standards and monitoring were put in place for all but sexual health services until 2005; previously, monitoring had been an aspect of collating national statistics but not used as a measure of quality of activity. Davies et al, suggest culture is an emergent property of that organisation's constituents. It emerges from things that are shared among colleagues, including shared beliefs, attitudes, values and norms of behaviour. A sense of the organisation is made by having these attributes in common and allowing people to see

situations in similar ways, “ it is the way things are done around here” being immediately understood.

Davies et al (2000) suggest that visible elements can be manipulated, but deep-seated beliefs and values will be more resistant to external influences. Attempts at transformation may only be successful at a superficial level. They believe the power bases of entrenched views are within clinical practice, hence clinical autonomy remains unchanged. Revolutionary internal market reforms have initially had little impact on the medical profession. Cultural diversity does emerge, particularly within professional or occupational groups. Subcultures are associated with differing levels of power and influence within the organisation and may seek to differentiate themselves. The rise of the management culture is one example, but nursing is another. Health care is seen as notoriously tribal, rivalry and competition between groups (Witz, 1992; Harrison et al, 1992; Lukes, 1974). Subcultures can be either malleable or resistant to change. Organisations will learn to function with discordant sub-cultures though there will be overlap and disagreement on aspects of the culture.

Davies et al (2000) also suggest it may not even be desirable that an organisation seeks joined up attributes. They describe their approach to understanding organisational culture as a modernist approach regarding phenomena as concrete entities, which can be described and explained. Therefore better understanding of this empirical reality will bring improved organisational control and performance. They suggest a postmodern approach would deconstruct the social processes and practices to reveal hidden contradictions and tensions inherent in them, where what is seen as legitimate knowledge is actually constrained by vested interest. A post-modern perspective would encourage a diversity of voices, open dialogue on the course and nature of change and it would particularly give a voice to the disenfranchised and marginalised. It would challenge balances of power rather than refining control. It seems clear that managing culture is one route to managing healthcare.

Attitudes to innovation and risk-taking within the organisation also need to be taken account of. This could determine how people interpret work roles and the autonomy within them. However, the introduction of a risk adverse culture through clinical governance may not give confidence to be more innovative. Failures in healthcare does put those within the organisation on their guard, no-one wants to be the subject of a complaint or enquiry. The Department of Health in its discussion paper on “an organisation with a memory” identified the culture of the NHS as central to reporting incidents and using them as learning opportunities to bring change. This was to be a move away from the culture of blaming of individuals and looking more towards systems and processes, thought to bring more transparency and less covering up for fear of retribution (DH, 2001; Klein, 2001; Ham, 2004).

An integrated culture will occur when there is consensus on the basic beliefs and appropriateness of behaviours within the organisation. If views are widely incompatible the culture will be differentiated. Although culture will be a shifting and dynamic force, traits can also endure for long periods. Outside influences of media reporting and public opinion and regulatory frameworks also exert influence. We have seen these influences following the Shipman enquiry, with the multiple murders by a GP, and the Bristol enquiry, with the use of body tissue by doctors without consent. Such high profile cases will alter the level of trust the public place in the medical profession. However, valuable traits are foundational such as free healthcare at the point of provision and more recent values emerge such as patient centred care, evidence based care and the application of quality standards to measure the provision. Davies et al (2000) suggest attempts to change culture must be selective, identifying those that need reworking.

Schein (1992, 2006) noted that “organisational culture is the key to organisational excellence” and understanding and interpreting it is important to be able to influence the strategic developments. The group’s collective belief systems are shaping behaviour and separating groups from each other. This could be demonstrated for the roles of the professions but also for the different departments within the NHS. He notes that cultures do not need to be logical or consistent, but in fact can appear haphazard and chaotic to the

outsider. A strong culture will be internally consistent, being clear what it expects of individuals and how they should behave. Schein sees this as the outcome of shared experience, but also not static but an evolving process.

Schein's work confirms that leadership is fundamental in forming and changing culture. He sees leadership and culture as being two sides of the same coin neither can be understood alone. He argues that not enough attention has been given to analysis of culture, particularly around groups that affect the functioning in forms that are difficult for an outsider to detect. He suggests strategies for analysing organisational culture and getting to the root of issues, through the use of interview methods that involve interested outsiders and motivated insiders. He suggests this will illuminate aspects of organisational life around many of the irrational and mysterious things that go on in human systems. It is shared assumptions that operate unconsciously, usually in an effort to survive the external forces and taken for granted, that need to become exposed. These assumptions are often just learnt responses to the environment. Schein believes that group dynamics when understood can lead to strategies for change and growth. The insider researcher, or assistant, can help decipher the culture, not normally possible through observation. This view of Schein gives me confidence in the insider view which I will have within this study.

2.3.8 Conclusions of Literature Review

This review of literature demonstrates from the epidemiological perspective there is a major role for sexual health services in managing the consequences of the increasing sexual ill-health. It also shows that there are many barriers to health promotion aims being met. It illustrates that stigma and discrimination, as well as social disadvantage reduces the control people have over their lives and compromises how effective services could be for those who may then not access them. It suggests service provider responsibilities include not only delivering services directly, but they have a role of advocacy that should impact policy and training for professional development, ensuring

the best practice and access is available. The literature identified the many players or agencies that contribute to good health, all with a role that impacts the social processes and epidemiology.

There is evidence that the sexual health services themselves have struggled with issues of marginalisation even when a modernisation agenda is being driven throughout the NHS. Organisational constraints of power and control, much related to being entrenched within a strong medical culture will need to be considered as the fieldwork progresses. It will be interesting to explore with different professionals and staff groups what influence these power issues around professional roles brings to the modelling of services and the effects on access for the service users.

Service users have also been identified within the literature review as frequently disadvantaged and marginalised; the role of the providers of services should be to address this imbalance and to support empowerment using the modernisation processes given to them through policy. The government requires individual responsibility to be taken for health and less reliance on the NHS and yet much wider economic and social structures create barriers to this. The possibility of NHS staff contributing to empowerment will be discovered within the findings.

Government policy has been produced as a lever for change with the expectation that it will not only transform healthcare provision but also move British society to seek prevention of ill health and to find good health for itself. Much of the policy was around addressing the imbalance of power between medical and nursing staff as well as with service users. There are expectations on nursing staff to take on more medical responsibilities and also to ensure the service user is listened to and that services meet their needs. The government on one hand talks of reducing central control by developing an internal market for the NHS, however, on the other hand introduces multiple targets and performance management and redefines central control.

The lessons learnt from the history of AIDS show the importance of attention to policy and the willingness to allocate funding to bring reform that could impact epidemiology. Such “exceptionalism” (Rosenbrock et al 2000) as AIDS clearly demonstrates, that innovation leading to modernisation will eventually result in normalisation, but also embedding much improved prevention and management strategies. Discovering how policy is applied or utilised within sexual health services to bring change will be revealed from the interviews.

The field work and the findings will create an opportunity to explore these concepts and data further. Exploring the literature has not raised any new questions but drives me to develop the original ones of are we seeking new approaches to drive modernisation to improve access, which will in turn impact on sexual health improvements? The integrated model of provision, or one stop shop, appears to be a possible solution and seems would require the vision of those in authority to drive such modelling of more comprehensive services.

The insider view, which I will take, considers the questions around modernisation and access to sexual health services and how they are perceived by service users and service providers. I am expecting this will contribute some fresh understanding to the literature and field of sexual health.

I feel this review of the subject now justifies the design I propose for the research and identifies that I need to seek further clarity and reality within the field. I will consider within the methodology how an insider applying qualitative methods is an appropriate way forward for new discoveries of this subject, when placed within fitting frameworks that determine the epistemological view that I take.

3.1 Research Design

Taking the current concepts and data from the review of literature, which was also carried out alongside the fieldwork, this study continues to inductively explore, but not to deductively test, the suggestion that how we model sexual health services will determine how accessible they are to the public. Good access could promote improved sexual health for the community and empower them to take care of their sexual health. An integrated model of service provision, with all services in one place, provided by multi-skilled practitioners, could meet the needs of the public by providing much improved access. Good access would be defined as user- friendly, non-threatening and empowering for the service user, or for all groups in society. It is the modernisation processes that require uncovering and the understanding of the concept of modernisation from the research participants established. Policy shows these processes should be in place to provide good quality services with good access. Why these are, or are not, in place will require sensitive research of all the staff groups involved and of service users, or possible service users.

The design and question areas used to develop this exploration were generated from my insider knowledge and the initial literature review, using concepts that required further investigation within the field and generating further concepts and need for literature searches. This was a qualitative study aiming to bring fresh understanding to those concepts within this specialist field of sexual health. Concepts such as modernisation, devolving power, decentralisation, professional, medicalisation, normalisation, patient choice, empowerment, dominance, institutionalisation, integration of sexual health services, new public health, risk-taking and lifestyle, individualism, autonomy, culture and influence, authority, professional alliance and collaboration, joined up working, leadership, levers, patient-professional relationships, disadvantage and inequalities in health, marginalisation, sexual ill-health, consumerism and health, commissioning and disease prevention (DH,1999, 2000, 2002, 2001, 2004; Ham, 2004; Nettleton, 2006;

Klein, 2001; Annandale, 1998; Leathard, 2003; Lukes, 1974; Rosenbrock et al, 2000; Ferlie, 1993; Foubion, 1994; Berridge & Strong, 1993; Foucault, 1976, 1980, 1988; Freidson, 1970; Harrison et al, 1992; Hindess, 2001; Street, 1993; Witz, 1992). These concepts will be used and looked for throughout the fieldwork and in the question areas such as:

- Why have many sexual health services remained static since post war years and required major Government drives to bring change?
- Why have some of these services remained within medical models and not become user friendly or accessible?
- What is the understanding of modernisation of the NHS within a context of sexual health services?
- What drives some services to modernise?
- What is it that blocks attempts to modernise?
- Despite poor access why is there now a huge demand for these services that is so difficult to manage?
- What does modernisation of sexual health services involve, what are the experiences?
- Is integration of sexual health services identified as the way forward for services and what is the understanding of the concept of integration?
- If someone is disadvantaged in society or vulnerable to poorer sexual health what should they expect or want from services? How do services engage with these service users?
- What deters the public from using sexual health services?
- How are these services viewed by the public, outside professionals and by those working within them?

Drawing out four strands from the literature review that could be directed to the professionals and to the public or possible service users, these questions are attempting to scope:

- Improving access to sexual health services and modelling of those services.

- Policy and practice.
- Sexual ill-health and the nation.
- Acceptable service to service users.

This study is a qualitative survey of professionals and service-user discourses involved within the field of sexual health. Semi-structured interviews of professionals were carried out across the nation and focus groups facilitated from across the North East region.

The Processes

This will be a qualitative study, appropriate to gathering more in-depth understanding and meaning of the social processes and culture involved in both providing and accessing a sexual health service.

Following approval of the research proposal by the university and by the NHS Local Research and Ethics Committee the methods used were: a literature review, focus groups and individual semi structured interviews, followed up with electronic interviews. The literature review evolved side by side with the field work, generating increasing concepts to explore both in the literature and back in the field, in grounded theory style that could not go in naïve, without knowledge or presumption, uncontaminated, when I am an insider. The theoretical frameworks I was working within and investigating were drawn from to mould the research design, the methods used and carry out an inductive analysis of the findings.

All participants either received a letter and an information sheet or a poster was displayed within projects, to gather focus group interest and an information sheet was explored with project workers (**Appendix 1**). When there was agreement to take part there was signed consent (**Appendix 2**). This consent guaranteed confidentiality and gave permission for audio recording and allowed opt out at any time during the proceedings.

When approaching any NHS site further approval was gained through each individual research and development manager to comply with research governance standards. I travelled across England, Wales and Scotland for some individual interviews and all focus group work was carried out within the North East of England.

When the fieldwork was completed I was audited by my own research and development unit. This was to ensure I was complying with NHS/DOH research governance requirements around safe storage of identifying information and tapes and that each consent form had been genuinely signed by participants. It also gave an opportunity to discuss and report on some of the hurdles I had come across within NHS research procedures to access individual NHS trusts.

Achieving the Sample

The initial sampling was purposeful:

Phase one of the design was to use smart-mail on a national website for sexual health service leads to explore interest in taking part in this study and providing semi- structured interviews. The subject posted was around modernising sexual health services, considering access issues and integrating contraception and GUM services.

Phase two of the design was to follow through on contacts that phase one interviewees had suggested as well as local contacts. At the same time to approach voluntary and statutory projects to display a poster. This was to attract people who would be interested in being part of a focus group to give views about sexual health services. Interviews and focus group work was now running parallel.

Phase three involved identifying gaps in representation. I noted this was around wider professional groups. I approached two groups of workers who had sexual health as a main aspect of their roles and responsibilities. This phase also required using five

electronic interviews to encompass other respondents who had been too busy to have face to face interviews but were deemed as important voices to the process.

The inductive process of grounded theory analysis, the literature review and the knowledge and insight I had as a practitioner, assisted in identifying gaps and directed me to field study areas which were identified as key to this exploration.

The following fieldwork schedule illustrates the phased approaches and the individual interviews and focus groups which are given codes. These can be matched to **Appendix 3**, analysis of the interviews and the concepts and categories drawn from each one, used to develop the grounded theory. This chart also shows the question prompts used to gain the focus around the four strands of improving access and modelling sexual health services; issues around policy and practice; perceptions of sexual ill health in the UK; and what would be perceived as acceptable service provision to service users. Encompassing these strands and prompts for the sub questions would allow exploration to gain evidence, providing insight and answers.

The chart demonstrates there are 89 voices or respondents in total:

7 focus groups, 20 semi-structured interviews and 5 electronic interviews.

The focus groups were made up of a gay men project 12, young offenders and their workers 6, teenage mothers 6, integrated specialist nurses 6, workers for young people 22 (mostly youth workers and school nurses), African women with HIV and seeking asylum 10 and youth workers from disadvantaged community 2.

Individual interviews consisted of 4 NHS GUM consultants, 4 senior nurse managers for NHS sexual health services, 1 national lead for sexual health policy (Department of Health), 1 national lead for Family Planning Association, 2 NHS commissioners of sexual health services, 4 senior managers/heads of NHS sexual health services, 4 lead medics for NHS contraception services.

The electronic interviews were 1 General practitioner, 2 lead nurse managers for GUM, 1 health adviser for GUM, 1 senior university lecturer, provider of sexual health education.

Demonstrated in the following Fieldwork schedule:

FIELDWORK	SCHEDULE Question areas / prompts	Method and samples used	total voices 89
Strands	Present service provision	Individual semi-structured interviews 20, focus groups 7, E- surveys 5	
1.	Views on integrating services	Induction of sample :-Smart email response phase 1 *	
Improving	Plans to modernise to meet demand	phase 2 approaches ** phase 3 approaches ***	
access to sexual	Evidence base or evaluation done before change		
health services	Implementation difficulties /change management issues	Interview Consultant physician GUM South England	1 *
and modelling of	Nurse led service issues	Interview Consultant physician GUM North West England	1 *
those services	Education and training issues	Interview Consultant physician GU M North East	1 **
	Format of service user consultation	Interview Consultant physician GUM North East	1 **
	Perceptions of good access	Interview Director of Nursing with G U M South England	1 *
	Sexual health targets and local delivery plans	Interview Senior Sister GUM South of England	1 *
2.	Politics of sexual health as a speciality NHS	interview Nurse Lead GUM Wales	1 **
Policy and	Should we invest differently	Interview Nurse Lead integrated service Scotland	1 **
Practice	Ease of access to services	Interview National Lead sexual health policy	1 **
	Attitudes of staff and user-friendliness	Interview National Lead Contraception	1 *
	Environment of a service	Interview Head of service sexual health Midlands	1 *
3.	Primary care service or acute	Interview Head of service sexual health North West	1 *
Sexual ill-health	Advice and support access	Interview Commissioner sexual health North East	1 **
and the nation	Expectations of a service	Interview Commissioner Strategic Health Authority North	1 **
	Experience of using a service	Interview Head of service sexual health North East (south)	1 **
	How should services be modelled	Interview Head of service sexual health North East (north)	1 **
4.	Views on integration	Interview Associate specialist Contraception North West	1 **
Acceptable		Interview Community consultant Contraception North East City	1 **
Service to		Interview Associate specialist Contraception North East rural	1 **
service user		Interview Associate Specialist Contraception North East urban	1 **
		Focus group Gay men group Gateshead	12 **
		Focus group African women	10 **
		Focus group Youth offending team	6 **
		Focus group Integrated Nurses / one stop shop	6 **
		Focus group Mixed professional workers of young people	22 ***
		Focus group Youth workers of disadvantaged community	2 ***

		Focus group Teenage mothers6 **
		Electronic survey G.U.M Health Adviser1 ***
		Electronic survey GUM nurse1 ***
		Electronic survey University education provider1 ***
		Electronic Survey General Practitioner1 ***
		interviews 20, focus groups 7 , E- surveys 5. Total voices 89

3.2 Framing The Research To Achieve The Aims And Answer The Questions.

Introduction

The methodology is the theory and analysis of the how the research will proceed and a description of what governs the choice of methods and the procedures and techniques used to gather and analyse data (Crotty, 1998).

3.2.1 Placing the Study in a Theoretical Context

Crotty (1998) identifies that the theoretical perspective lying behind the methodology provides the context for the process and grounds it in logic and criteria. The epistemology (or the theory of knowledge) is then observed as embedded within it. May (2002) advises that research findings from the social world are devoid of meaning until they are situated within a theoretical framework. Williams and May (1997) note the importance of stating your philosophical position as it has methodological, moral and political consequences.

Thus the philosophical stand taken will potentially construct the frame of reference for the researcher. It will even decide the subject chosen for investigation, but at all levels the researcher should bear in mind her standpoint that bears influence on the whole process. The credibility of any outcomes will rest heavily upon how the investigation has taken place, with the transparency of all aspects and the explicit theoretical context will make it more easily open to judgement. Of course, this implies judging from differing standpoints will not necessarily mean being in agreement or accepting findings but allows more understanding and credibility to be gained regarding the approach. Williams and May see the linking of social research and philosophy as an important relationship, with both aiming to improve our knowledge of the world. They see every research decision, made within the process, as having a philosophical assumption and directing us to ask questions of what we take for granted. May (2002) also points out that our personal interests will guide our decisions, even before we carry out the research. This makes objectivity of the social

world difficult, but within a feminist epistemology this is not even desirable (Smith, 1987; Oakley 1981; May 2002; Stanley & Wise 1983).

Social science as a dynamic discipline, allows openness to engage with a number of paradigms, as long as we are being explicit about these when interpreting the whole process. This study will have a qualitative approach with an insider view, situated from a feminist standpoint and I will suggest could also sit within a framework of complexity theory.

3.2.1.1 Framing the Study within a Qualitative Approach

It seems that a positivistic tradition does not sit comfortably with the view that values can be allowed a role and inquiry is not purely objective and scientific. The scientific view, starting with a theory and applying it to prove an outcome, appears too narrow and rigid for the subject I am studying. The opposite, inductive, interpretative paradigm, where theory will arise from the enquiry, exploring and gathering information rather than testing a hypothesis, seems to give more credibility to meet the aims of this study (Crotty, 1998; Bryman, 2001). Smith (1990) is clear that qualitative research as a method should not just be a procedural variation, but an application of an epistemological position, with genuine integration of both method and standpoint.

Silverman (1998) notes that theory can provide the impetus for research, however, theories are living entities, to be developed and modified by the research. Hence in this way they cannot be disproved, only found to be more or less useful. He emphasises that some theory of human or social action will inform any piece of social research and therefore theoretical assumptions must be specified rather than used unconsciously. He sees qualitative, or field research as depending on a variety of theoretical positions all with very different implications, but the research being driven by the theory rather than determined by any technical considerations. Silverman (2003) emphasises that one method should not be seen as good over another but that the method chosen is the one that is most likely to answer the questions asked. Neither is value free or superior to the other.

Hammersley (1992) acknowledges qualitative methodology as one that explores process as well as outcome, meaning as well as cause, studying people within their natural context in a flexible way. He tends to make generalisations about those who choose the qualitative method, stating they tend to be those who prefer to manage words and images as opposed to numbers and unstructured interviews as naturally occurring data, rather than experiments or structured interviews. He sees it as a search for meaning rather than explaining behaviour, with a rejection of science as a model. Alongside this would be the preference for inducting hypothesis rather than applying hypothesis to be tested. However, Silverman (2003) sees Hammersley's view as a vast over generalisation and leaving much room for criticism of the qualitative approach. He chooses to view qualitative research more broadly within a variety of approaches or methodologies that allow credibility and validity to be judged. Silverman believes qualitative work should be as rigorously evaluated with the same criteria as quantitative work, it should ask the questions:

- Is the method appropriate to the questions being asked?
- Is any underpinning theory explicit?
- Is the method transparent and sensitive enough to answer the research questions?
- Was there systematic and referenced collection of data and analysis?
- Was there adequate discussion of the findings and how they were derived?
- Are there contrasting arguments for and against the researcher's viewpoint?
- Has a distinction been made between data and interpretation?

This appears to be a valuable set of criteria that would give evidence of reliability and validity that could greatly benefit my own study. Silverman also has strong views on the research being seen to be rigorous and being made even more credible by making every effort to falsify initial assumptions about our data. He also sees the combining of qualitative with quantitative measures as a way of increasing generalisability. For my own study I have used national and local statistical and epidemiological data only as evidence of the need for the subject of enquiry and to contextualise the aims of the study and the findings, rather than undertaking any quantitative investigations myself.



Increasing credibility and validity within my own study would need to be an emphasis to allow increased acceptability of findings within the world of healthcare, particularly with medical colleagues.

Mays and Pope (2000) explore the use of qualitative research within health care and note that assessing quality in qualitative research is a mystery to many healthcare researchers from the world of science. Although as a method it is becoming more commonplace for health service studies, researchers from other traditions historically used by medicine in particular, have difficulty in scrutinising the claims of qualitative research. Mays and Pope believe that the same criteria used for judging the quality of quantitative research should be applied to qualitative, i.e. using two broad concepts of validity and relevance. They explore the tools that they claim will improve validity and relevance:

- Triangulation, using more than one data source, or even using different types of groups or interviews, such as clinicians and patients, ensures more comprehensiveness and corroboration of findings or interpretation.
- Respondent validation was seen as a way of improving credibility if used as part of the process. Giving a clear account of the process of data collection and analysis was seen as vitally important as the methods of inquiry will unavoidably influence the objects of inquiry.
- Reflexivity, being sensitive to the ways the researcher and the research process shape the data. This would encompass the role and influence played by prior assumptions and experience. They go so far as to suggest effects of age, gender, social class and professional status on data collection should be explored, particularly acknowledging the distance between researcher and the subjects.
- Attention to negative cases was seen as important, with an attempt to search for and discuss elements within the data that seem to contradict. This is seen as a refining process.
- Fair dealing is introduced as a concept that enhances credibility by ensuring the research design explicitly incorporates a wide range of different perspectives. No one group is seen as representing the sole truth.

- Relevance is applied when the study is seen to contribute to knowledge or increase confidence in existing knowledge. If findings can be generalised, by giving rich contextual information within the data, beyond the study setting, this again is seen by Mays and Pope to increase their relevance.

The tools and criteria of Silverman (2003) and Mays and Pope (2000) will be a useful gauge, as I work through and reflect on the whole process, with an aim of having credible outcomes within the field of sexual health, both for the clinical and non clinical world, that could be applied more widely to the sexual health service providers.

Meyer (2000), in an exploration of the use of qualitative action research in health care, notes that there are increasing barriers to the uptake of traditional quantitative biomedical research in clinical practice as acceptable to providing insight or solutions. As a very top down approach it does not fit with the emerging ethos of a modernising NHS, with a more democratic and participatory style of governance and regarding the contribution NHS research should make to social science and social change. Meyer talks of the increasing theory-practice gap, with practitioners relying on intuition and experience, as traditional scientific knowledge, such as randomised control trials, often does not fit the variable situations they work within. Qualitative research methods are more likely to draw upon and encompass the practitioners experience and generate meaningful findings. Improving the quality of patient management is an NHS driver that encourages an increase in qualitative studies. Insight into whether government policy is being translated into practice is more likely to be gained by the use of qualitative methods. Talking in depth with practitioners and service users, using these methods, to explore issues will identify whether it is mere rhetoric or reality.

Murphy et al (1998) reviewed the literature for the uses of qualitative research within health technology assessment, as they felt it was an area not always understood by commissioners. They noted the principles of this method should be identified and used to set benchmark standards. Setting standards in the NHS is fundamental to measuring quality. For their review they acknowledged that searches such as MEDLINE would not encompass important qualitative work in the social science

field and decided to categorise and organise within a time frame that allowed wide reading of books and journals across health care fields. Within their discussion of qualitative versus quantitative they state decisions about the most appropriate method should be made on the basis of which approach is the most effective and efficient way to answer the research questions. They identify that qualitative methods help to clarify the questions being asked and aid conceptualisation; this method will also qualify and illuminate findings of quantitative methods. By providing descriptive information and contextual understanding qualitative research was shown to be particularly useful for health care planners and policy makers. Murphy et al, however, did advise on more systematic sampling and an avoidance of opportunistic sampling, with sampling decisions made throughout the study, with underlying principles for the evolving sample being identified. This was seen as particularly important when building theory, making use of existing evidence to make predictions and seeking subjects that allow the testing of the robustness of those predictions under different conditions. However, this may not be possible in a small study such as my own and convenience will determine that opportunistic or purposeful sampling will be an aspect.

This team also agreed with Silverman (2003) and Mays and Pope (2000), that qualitative work should be assessed for validity and relevance, just as it would be appropriate to quantitative. Their comment on generalisability of results was that the generating of theoretical statements from each study could be tested in other contexts and will contribute to guiding policy makers. Handling of data, using systematic methods for coding and analysing was seen as evidence of rigour. Trustworthiness of data analysis was thought to be enhanced where it had been demonstrated that alternative plausible explanations for findings were considered. The researcher effect on the process, when acknowledged, was also perceived as contributing to validity. Their view on respondent validation and triangulation was that it increased the comprehensiveness of a study but was not a test of validity of findings. The authors of this review note the purpose of all NHS research and development is to lead to the greatest benefit to patients. Some methods used in qualitative studies in social science were rejected as unacceptable or constrained within health care, such as covert observation; this was seen as a gross invasion of privacy that would not be ethically acceptable.

It seems the issue of generalisability was historically not necessarily a principle always applied to, or expected from qualitative work, but accepted as studies showing a single slice of life and if richly described was valid for the insight gained. An antirealist position would argue that qualitative research represents a distinctive paradigm and should not be judged by measures such as generalisability, reliability or validity. However, research within health care demands usefulness, value for money, as for any resources used from the public purse. It needs to appeal to the wider audience of the public, policy makers and practitioners. Being able to apply findings more widely would be more likely to be of interest and attract sponsorship or support from the NHS. More anthropological work of distinct cultures would of course be less likely to discover more general laws of human interaction. Schofield (1993) discusses how generalisability, as a measure of external validity, would allow replicability of results, but notes this would be a nonsense as individual researchers will all conceptualize differently. The arduousness of qualitative work would make replication impossible. Findings and ideas should just stimulate further research.

Schofield (1993) explores the historical development over the last few decades of qualitative studies used for evaluations and policy-orientated studies. This can be evidenced in my own literature review particularly around gay men issues and service user perspectives. She notes that researchers are interested in finding ways for their work to be more likely to speak to many situations beyond their immediate study and will to some extent be generalisable. She sees the idea of sampling from a population of multiple sites in order to generalise to the larger population as unworkable in most studies. Whereas, developing the conception of generalisability as one of usefulness and appropriateness is more workable. She draws on the work of Guba and Lincoln (1982) who have modified their stance on this issue over time from one of seeing generalisations as impossible as every phenomenon is neither time nor context free, to one of applying the concept of “fittingness” as more realistic than former classical approaches. Schofield concludes from her exploration that there is an increased awareness of the need to structure qualitative studies in a way that enhances their implications for other situations.

Guba and Lincoln (1994) actually propose two primary criteria to assess qualitative work including trustworthiness and authenticity. Bryman (2001) feels that

authenticity as criteria that would represent fairness, appreciate better the perspectives of others and act as a catalyst to bring change has not been particularly influential. However, I would regard this as a fairly crucial for any NHS research and that change should be expected or aided by a robust study.

3.2.1.2 Framing the Study within an Insider View

Williams and May (1997) highlight that qualitative research is based on a complex relationship between the researcher and the subject, with the researcher needing to constantly examine their own identity and their role and the effect they have within the study.

Northway (2002) noted the fact that historically when a researcher has been outside the experience under study it has usually not been questioned and in most circumstances has been seen to promote objectivity. However, our identities and a range of personal and socially constructed characteristics will influence how we not only view ourselves as researchers but also how others perceive us. Our perceptions may not always be in agreement with others and we could be viewed as both insider and outsider at the same time, we will have things in common with those we research but also there will be differences that need to be identified. What is actually significant to being viewed as an insider would be the question I would need to ask myself throughout the process of investigation and analysis?

Bonner and Tolhurst (2002) imply that to work from an insider perspective it was not good enough to just identify as a nurse if studying a particular specialism, but that you would need to be a nurse of that speciality. Likewise Serrant-Green (2002) comments while being a black researcher other characteristics will mark her out as different, she is not necessarily accepted within a black community as having understanding, as she is also a middle-class professional. The research audience will need to judge the influence of the researcher on the process and therefore need to be aware of her position within it. Reflexivity and a critical self-awareness will allow more transparency throughout.

It is not unusual for researchers to be part of a social group they intend to study (Loftland & Loftland, 1994). Having some immediate understanding for the culture under investigation will be beneficial to talk flowing easily and generating appropriate questions, that may not be thought of by an outsider. There could even be a natural acceptance leading to more openness, which could promote the telling and the judging of truth (Bonner & Tolhurst, 2002). It has the potential to contribute significantly to the body of knowledge or specialist area under study with aspects that maybe an outsider would not be unable to unearth. Gaining access will be less problematic to areas that an outsider may not naturally have. The importance of areas, only known to an insider, will be an obvious benefit of researching the real world, knowing where and when to gather data. Expending time and energy to try to understand a culture is saved; Bonner and Tolhurst feel the researcher is already theoretically sensitive. Establishing rapport and acceptance is easier and, although ensuring not to take advantage of one's position when establishing the role as researcher, trust from former knowledge of you may develop quickly. The insider role will allow the identification of subtle differences and to gather rich and focused data.

Being too close could also bring its problems and Bonner and Tolhurst (2002) acknowledge that familiar patterns of practice and behaviour might be difficult to identify within a study as they may be taken for granted; there will need to be care not to make assumptions. They saw this particularly around over identification with a group which led to them being joined to that group and loosing the research perspective. Miles and Huberman (1994) also advise guarding against this and becoming non-observant participant. Being an insider researcher also requires the ability to step back and ask questions, at the same time drawing on intuition and sensitivity to familiar experience.

May (2002) agrees and talks of separating reason and emotion to produce rigorous research implying separating researcher from their subject. He acknowledges this is at odds with a feminist perspective which would argue it is a two way process and objectivity is undesirable as it disguises both the affect of the context on the researcher, as well as the unavoidable affect she has on the context, needing to be acknowledged within the analysis of findings.

Champ (2002) a researcher and user of mental health services, examines the importance of insider research and the increasing scrutiny of research generally by the consumer of health services. (My own literature review uses extensive evidence from organisations who specialise in work around gay men as frequent users of sexual health services and which is vital to the context of this study). Champ sees research, at the insider level, as an opportunity to demystify and debunk outdated and un-evidenced views, particularly in marginalised services such as mental health and sexual health. He sees insider research offering the power to capture stories otherwise missed and prevents experience being re-contextualised by outsiders; he refers to this as the colonisation of experience by researchers and raises the question of intellectual property. His perspective as a consumer possibly does not reflect that someone such as me working with consumer talk would be insider knowledge. He rather requires that the consumer is consulted directly about their realities and not through a conduit of interpretation as the researcher would be, as experts cannot speak for consumers. After all, the agenda itself is not usually determined by the consumer of services. Champ, however does reflect these views from a lens of seeing medical dominance as a frustration for his consumer group and voices that research should be used as a tool of empowerment for consumers, although the importance of research cannot be underestimated.

Serrant-Green (2002) sees there are advantages in being an outsider and perceived as a professional stranger, not restricted and able to ask naive questions that would be unlikely from an insider. She sees the insider role sometimes being contentious when mixing with the researched at a work or social level, where they may question if they are being observed and what they say reported on. Suspicion as to the motives of the researcher may also be an element.

Ethnographic work and participant observation, insider research, where gathering impressions of participant's behaviour, by not just talking but also looking and listening, is an accepted method for gaining inside information. At the same time balance is needed to establish sufficient distance to make sense of the observations and not "go native" (Atkinson & Hammersley, 1994). An ethnographic study within my local area by Barke & Turnbull (1992), which focused on the Meadowell estate in North Tyneside, put into historical and political context the influences that shape the

character of the estate and its residents. This place was perceived as a troubled housing estate, which caught the nation's attention in the late 1980s when riots broke out. Central to Barke and Turnbull's theory development within their ethnographic study is that places have their own dynamic and can effect change itself. They strongly suggest that policy intervention will only be effective if we begin to think very differently about the people within these places. Interpretations from the "outsider looking in" have previously decided changes in urban affairs, with no consultation or observation at the grass roots. They attempt to give an insider view to revolutionize understanding of external influences and future policy making.

This insider perspective is what I will give as a researcher for sexual health services with a background in nursing, health advising and manager for sexual health services and hoping to demonstrate how the influences and obstructions within these services can promote or prevent change, improving and reducing access to services. I will be linking this with complexity theory as applied to this health service.

Achieving the balance of being accepted with inside knowledge and understanding as a practitioner and manager of sexual health services and yet at the same time not being a threat and being impartial as a researcher was my challenge but also provided a unique opportunity. The insider–outsider research question can be seen to be a complex one and certainly raises the issue of constantly defining yourself within the process and the influences you bear within the process.

As this insider I have therefore not claimed to be naïve to the issues within the study and the analysis of the evidence using grounded theory will not be used in a way originally proposed at its inception, but will be a modified version as discussed in section 3.3.3.

3.2.1.3 Framing the Study within a Feminist Standpoint

Brunskell (1998) sees the theoretical framework also as the actual influence for the research topic, as well as the chosen methodology. This is particularly so when there is a political commitment to the identification and transformation of gender relations,

as in feminist theory. She sees research from this perspective as bringing into view areas of social life otherwise hidden or invisible, with her feminist stance this is namely the social organisation of women's experience.

The choice and study of a subject for research was also seen by Fortier (1998) as related to personal biography, covering life experience and including features that researchers will take into the field and that individuals from the social group that they enter will interpret in socially prescribed ways.

A positivist approach is also totally rejected by Oakley (1981) when proselytising a feminist view. She sees no place for objective or neutral views of the interviewer; this is seen as a sham and exploitative. They must come clean about research agendas, telling interviewees as much as possible about the purposes of their research and possible uses of findings. She even sees the interviewer answering questions about their own lives and opinions as an important aspect of developing a non- hierarchical relationship. The goals of finding out being best achieved when the interviewer is prepared to invest her own identity.

Oakley's views were criticised strongly by Malseed (1987), who says that she underestimates the extent to which researchers in the classical survey tradition have shown awareness of issues of trust as well as the influence of gender during interviews. She wonders whether Oakley's "romantic" notions, were getting past defences through developing trusting and honest relationships can sometimes be just an end in itself.

The work of feminists should always consider the power relations inherent in the interview situation because of the principled opposition to hierarchy and domination (Stanley & Wise, 1983). But Cain (1986) has doubts about whether it is possible to always ensure participants are made subjects and not objects of research. She claims to truly be a subject of research means involvement from formulating the problem to be investigated, choosing with the researcher appropriate techniques and participation in the ongoing process of theorisation. Her position also states that only those whose standpoint the researcher shares are entitled to be subjects in this sense. So where do men fit into the process? Stanley and Wise argue that men should be allowed to be

subjects of feminist research because a great deal can be learned about sexism from listening to them talk. Cain also seeks to include them but as a means to discovering findings to assist women. The status of the male researched would remain objective and she gives examples of feminist research on powerful males, such as High Court Judges, Members of Parliament, or even gynaecologists, which might note the absence of women, excluding them by not seeing or hearing them.

Traditional, quantitative methodology is explored by Jayaratne (1993) who suggests that it need not be rejected outright by feminists but that other options are possible. She justifies her enquiry by stating that feminist goals are more likely to be achieved by the use of both quantitative and qualitative methods, rather than the use of either method alone. She advocates that qualitative data can support and explain the meaning of quantitative work. Every quantitative research project should include qualitative information enabling the researchers to understand the participants better, but also for publications so that others gain a deeper understanding. A particular advantage of the quantitative approach is seen as its increased generalisability, since some qualitative methods do not permit this. Jayaratne emphasises the usefulness of this aspect to feminism for advising policy-makers of public opinion and for deciding on strategies for bringing about change in public opinion itself. She stresses no compromise in values but puts out a challenge to change traditional procedures used to produce the evidence with the aim of seeking increased influence and ultimately achieving the goals of feminist politics.

It is obvious that feminist researchers are not a homogenous group but a complex, differentiated one with the potential for influence in many different spheres (Olesen, 1994).

I propose to create an alliance for this feminist framework within complexity theory. Possibly this is perceived as a strange combination for some feminists. But the subject, as well as the context of it within the large organisation of the NHS and public health agenda, and myself within it as the female researcher, a nurse, and an NHS manager, as well as an insider, I would suggest creates a reasonable standpoint.

Pertinent to the research process, for myself, is a care not to infringe on the rights of others while pursuing my own ends. The feminist researcher approach in that people are met as equals and exploration is sensitive and as accurate as possible. Authenticity from self and to others is foundational. Values also have a role here in the acceptance of others in a non-judgemental fashion. But the values of the researcher are as important.

The possibility of making new discoveries is more likely when there is a willingness to empathise and to advance trust by showing a desire to understand. Responsibility to the research relationship and to the process can be communicated by congruence, showing you are fully present and interested. This approach is seen to offer advantage when probing may be deep and personal. But to achieve all of this, negotiation is vital, particularly prior to the interview. The philosophy of the person and not just technique should be important to the research interview, focus group and process. Understanding the frame of reference of the participant should be emphasised but I have a sense in the research situation this is quite different in that you, and not the participant, have introduced the subject. Actually, how real is that in a research interview? I can only attempt to apply these values within the interview relationship, but the reality might be that it could be in a limited way.

To juxtapose these two positions of feminist and complexity theory I personally would need to reject the claim of Cain (1986) where she proposes some participants would be treated as objects, rather than subjects, if they did not share the same standpoint. This does not fit with my personal philosophy. I value the uniqueness of each person and try to understand difference. For this I need to have some flexibility in my thinking and demonstrate acceptance. Doing research will mean merging academic reasoning with the worlds of others. Accepting the perspective of others is needed to bring more understanding and richness. Allowing and encouraging spontaneity, enables, a type of disorder that adds to the complexity.

What I will take from this perspective that fits my ethos and the practicalities of applying them in a small study, within a short space of time, will be the broad principles of feminist and complexity theory to develop a qualitative inquiry. I am hoping to enter into lived experience revealing richness, in contexts that are real

(Miles and Huberman, 1994). Creating cooperation and connectedness as an inside researcher develops this dual framework, with me as an individual with access to the subjects, because of the position I hold within the organisation.

The orientation of the inquiry could be seen as ideological, seeing the world through value laden perceptions. When values are deemed more important than other values, as in feminism, then the inquiry becomes political. In an ideal world this inquiry is also hoping to transform an existing structure. Guba (1990) would distinguish this paradigm as critical theory.

3.2.1.4 Complexity Theory and NHS Sexual Health Service Provision

I will be using complexity theory when discussing my findings as a useful framework. I suggest it will encompass what I have observed and been part of within the NHS for over thirty years and sexual health service provision for over 15 years. It is an organisation that appears to require detailed planning alongside efficiency and effectiveness, to gain the highest quality provision for the public and for the staff to work within it. However, it is the dynamic and evolving nature of this provision which occurs often due to minor tweaking that result in larger effects. Major change, usually as a result of more national or Government directive, will also cause dynamic change but tends to be over a longer period with not such immediate effects. This theory seems to give some understanding as to how and why change and effect manifest as they do, and why often the effect cannot be predicted. The findings from my enquiries will aim to demonstrate how they match this theoretical perspective.

Complexity theory, sometimes referred to as chaos theory, considers the idea of structure as dynamic rather than static. Complexity theory is the study of complex adaptive systems poised between order and chaos. Complex systems are open systems, open to their environment, inside and out (Byrne, 2005). It demonstrates how a few variables can interact, producing results that could not be predicted, moving from order to disorder, to a new form of order. It will show that natural phenomena are modelled by non-linear dynamic systems. McClure (2005) notes how within the field of epidemiology this theory has uncovered patterns of disease that

would otherwise have remained hidden. She also explores the idea that only a little complexity is needed in a system to produce quite complicated phenomena, but that this complicated behaviour is a fresh way to look at the world. So instead of it being seen as extrinsic and accidental, it is more purposeful and structured. Hence, this theory deals with loss of prediction, with small changes producing large-scale unpredictability. Nature thus has the ability to renew itself because it is rich in disorder and surprise.

Using fresh ways to look at the world is exactly what the NHS needs, particularly marginalised sexual health services, and how North Tyneside sexual health service in 1997 began to evolve. This service had been in place since the 1940s and had changed little in either how it served the public or the perceptions of it by the both the public and the NHS itself. However, with a little will from only some, there was now a chrysalis of a new approach that would gradually begin to consider needs of clients and the profile of the service, despite the systems and processes that had previously dominated within a much medicalised and almost secret world of sexual health.

Complexity theory sees self-organization and spontaneity governing. This complexity would not become problems to be solved but only aspects of a process by which living systems adapt and maintain themselves through self-organization and interdependence. This theory was argued by Byrne (1998) to identify a critical realist epistemology, but also a scientific ontology, thus boxed it up as complex realism, which he says will have methodological consequences. Cause does not derive from a single entity and arises from complex, unobservable mechanisms and consequences. Complex systems are made up of pre-existing variables and do become systematically organized knowledge, which is open and pays attention to interactions and the organization, but it does not deal with surface. These complex systems tend to be robust and open to the environment, exchanging information and energy with it. Byrne explains that analysis of the whole can only be understood in view of the whole, parts and of the interactions among parts and the whole. Context dependent interactions will result in the emergence of a non-linear system, and most definitely not from single simple entities.

Using this theory, Rosenhead (1998) makes the difference between stable and unstable systems, for example the solar system as stable, although constantly changing does so in a regular manner. Unstable systems will move further and further away from their original condition. However, in between stable and unstable there is chaotic behaviour. This behaviour may have some regularities but it defies prediction. He uses the weather to demonstrate this factor. The holding conditions will determine the behaviour or outcome. Some conditions allow systems to operate at the boundaries where there will be exhibited a phase transition or the ‘edge of chaos’ or bounded instability which is unpredictable. Before complexity theory emerged this was referred to as randomness and treated as probabilities. This would have been used where the cause could not be explained by the effect. Rosenhead explains this as non-linear dynamic systems incorporating both positive and negative feedback loops. Similar starting points for elements but with the slightest of difference will cause quite different trajectories and outcomes; sometimes referred to as the butterfly effect. Although these are indeterminate meanderings they can be plotted over time and show patterns to movement. A pattern of trajectories is called a strange attractor. There are also stable attractors, which is a state which the system returns to if disturbed. These are termed complex adaptive systems. Some see this theory as bringing the end of determinism.

Byrne (1998) suggests that complexity science should always be used in context. He considers intuitive induction as a method of exploration that does not rely on independent variables as causes. This suggestion of intuitive induction as an ability to see that which is essential, a matter of insight, a “taxonomist” who knows what to look for, appealed to me as an inside researcher.

This integrative method combines measurement and description not as a set of prescriptions but as an aid to social action, it has paid attention to interactions and the organisation. Byrne (1998) again would describe the system by mapping its position. He also describes these complex systems as robust and that small changes will not necessarily produce indeterminate effects. The methodological consequences of this then will be, as Byrne says, not in its specification of method but in relation to the way we understand how we use the method. So he claims integrated accounts constructed around a complexity frame offer an excellent opportunity to describe

change. He takes it further by suggesting it can even shape change. He also notes an ethical dimension given by Cilliers (1998) that complex systems shouldn't be reasoned about by those on 'the outside of them' i.e. expert knowers not engaging with what they describe. The argument that Byrne takes is that complexity science is inductive, integrative, engaged and different. All of which fits with myself as the researcher and of the subject of sexual health service provision. We shall see how the evidence engages with it.

Paul Cilliers (1998) sees self-organisation as a process integral to this theory, where a fairly unstructured beginning can develop into a complex system. But he talks of modelling complex systems through two approaches. He sees the traditional scientific viewer wanting to predict and control the behaviour of a complex system. From a philosophical perspective this modelling should allow more understanding and be rich in information. Once we have this understanding there is room to identify similarities and differences and strengths and limitations of the different models. I could now see this theory being a practical tool for examining different services across the nation. But Cilliers uses two perspectives, the scientific and the philosophical. He claims that science without philosophy is blind, and philosophy without science is paralysed. What is needed is co-operation from both; acknowledging that our understanding of complexity is still limited. But he says of scientific knowledge that it has a history of requiring verification to earn a place, if it cannot be proved then it is thrown away, hence making the body of knowledge leaner. On the other hand the non-scientifically proven was viewed as uncertainty or unpredictability, or if too complex was left aside. The consequence has been a disregard for a large part of human knowledge as unscientific. Even the idea of consensus is seen as impoverishing. There is no place at all for the marginalised voice.

Gatrell (2005) sees complexity theory as having much to offer around the inequalities in health debate, spatial diffusion and risk. It presents a new paradigm? for social sciences. Everything in the world is linked to everything else, a complex universal puzzle, but that complexity theory does have a strict architecture, which I have already explored. Gatrell's interest in human geography leads him to demonstrate the theory in practice. He considers examples of emergent properties at a collective level that cannot be reduced to statements about individuals, such as the health of a

community emerging from the activities and health of the local population and the facilities located there. So the morbidity or prevalence of certain disease could be described as emergent properties.

Could all of this framework then be applied to poor sexual health, or risk-taking and sexual health? Could complexity theory demonstrate that the education input or the poor sexual health provision and a culture of risk-taking behaviour, and many other factors around economics, culture and social processes are all interlinked, however, are only significant through their interaction? Each factor is unaware of the other and the effect on each, developing into unknowable futures for individuals, being unpredictable.

There would be some emergence with no obvious effect, although operating at the edge of chaos and others with serious impact such as teenage pregnancy or HIV. These result from complex interactions that cannot be reduced to simple linear models. Gatrell identifies the trans-disciplinary possibility of this theory as applicable to health geography. It could draw upon epidemiology, statistics, sociology, psychology, medicine, cultural and other areas to inform the work of sexual health, fusing the boundaries and yet allowing separateness.

Using this framework to analyse my findings may prove this is so as I utilise the dynamic nature of this theory, allowing for evolution and change, most appropriate for the field of sexual health work and its changing nature. NHS, Local Authority and other large organisations' lack of investment and disruption of local communities and their networks has public health consequences due to reducing interactions between individuals, extended family and community. The result is often ill health and unhealthy behaviour; this is adequately demonstrated in studies carried out in North Tyneside on the Meadowell estate (Campbell, 1993; Barke & Turnbull 1992), showing evidence of a marginalised community impacted by wider social, political, environmental and economic forces, a complex, dynamic system.

Indeed just considering the spread of disease and sexually transmitted infection in particular, the elements of a complexity theory are all contained in the process of the transmission of disease. Any change introduced in the structure of the network could

halt or increase the spread. Epidemics, pandemics or outbreaks could be modelled by this theory, all affected by time and space.

Complexity theory could explain why some strategies in healthcare work and others do not. Miller (1998) considers complexity theory for primary healthcare practice particularly in relation to delivery of preventative work. He notes the resistance in physicians to changing behaviour and the government investment in tools to implement change such as in education, policy and guidelines, all having limited effect in changed practice patterns of behaviour. He suggests this theory could give new understanding to change interventions that would meet the unique configurations of individual practices. He notes particularly that complex adaptive systems change or self organise in relation to other complex adaptive systems, referred to as co-evolution. He uses the example of the butterfly's wings in Brazil influencing the weather in Texas. Similarly the core functions or models within a GP practice, such as giving attention to psychosocial aspects of care as well as biomedical, also send out trajectories, which achieve several endpoints or attractors. He sees the attractors as the motivators. An attractor can be changed by transforming it, whether that is through hammering, wedging or shocking, all tactics used by government towards health organisations. Each carrying its own risk regarding sustainability, but they could be powerful attractors such as income generation for a GP practice. They can be small changes that impact and gain over time.

3.2.1.4.1 Complexity Theory and Feminist Theory

McClure and Jay (2005) draw together a feminist exploration of complexity theory. There is a sense that this theory fits with a feminist epistemology and that it is less gendered, breaking out of the constraints of traditional objectivity and patriarchal assumptions about nature and knowing. It is even perceived to give a voice within science to feminist concerns about the masculinity of this traditional science. They see the application of it to public management and administration makes possible the realization of feminist values within this arena. Using this theory there is an end to objectivity; it is a world that possesses agency, rather than being inert or mechanistic. Objectivity often just masks dominating interests. Difference is seen as meaningful,

spontaneous and self-generating as resourceful. It is poised between order and chaos. Dialogue is open-ended and inquiry is seen as fallible and understanding only ever partial, we learn to value the contribution of other perspectives. Emergence itself stands in direct opposition to reductionism. Chaos and complexity are not problems to be solved but aspects of a process by which living systems adapt, maintain and transcend themselves through self-organisation. Knowledge will emerge through mutual interactions in which subjective things of the world have been invested, and difference is seen as meaningful. It allows investigation and methodology to attend to difference.

A feminist understanding of this theory sees great possibilities in medicine. With an understanding of the chaotic dynamics in the body there will be better diagnosis and prediction of illness and by attending to difference and variability they will gain more information. Feminists insist difference does matter. McClure and Jay (2005) propose a relationship between complexity and feminism as one of mutual reinforcement and its application within public administration allowing for actualisation of feminist values and modes of cognition.

McClure and Jays findings from feminist writers allow them to take it even further by suggesting this theory originated in a cultural context where there is emphasis on connectedness, conversation and cooperation, where previously there had been separation, domination and control. That is, in a feminine style of reason that values cooperation. This fits with many management and effective leadership texts around public administration. They note that Douglas Kiel (1994) saw good management as developing systems and processes that supported the agency's capacity for self-renewal and self-organisation. The effective leader should relinquish control, freeing up employees to use all of their skills. Heavy management mode is perceived as an inhibitor to change. Government agencies that are allowed to self-govern and that are bounded by instability, instead of equilibrium, will function better. These authors also suggest uncertainty and risk within organisations must be accepted by managers and crises should be seen as opportunities that will bring innovation and a new responsiveness. In fact they suggest when an organisation becomes too stable they should create disorder so that they become comfortable with instability. Acceptance of ambiguity and uncertainty is seen as a distinctive feminine style of knowing and

coping with the world. It is suggested we should be satisfied with the rule of thumb and give up reliance on the certainty of long-term forecasts. Rule of thumb was said to preserve relationships and unique needs of individuals. Diversity and democracy are values that are reinforced by complexity theory and consistent with a feminist style of reasoning, also contributing to a workforce that is flourishing within creative disorder, bringing everyone into the decision-making processes.

McClure (2005) decides this theory takes us away from the mechanistic, patriarchal, worldview, which would give permission to dominate over nature, and from her feminist perspective, also over women. As a non-reductionist theory it will allow fallibility in inquiry and teaches researchers to attend to difference; breaking out of the constraints of traditional objectivity. Testing predictions against experimental outcomes is seriously challenged by this theory. The complexity of nature will not be limited by Newtonian regularity and linear dynamics. Complexity theory allows a world that possesses agency, is spontaneous, resourceful and self-generating, not at all inert and mechanistic.

Gatrell (2003) noted that complexity theory does have a domination of male writers and that often the human voice or the implications of the theory are missed. He states that the human voice and gender are often missing from this discussion around complexity, with little example of lived world experience or female comment about it. But it also seems to offer more explanation and understanding rather than just problem solving seen in earlier systems theory. He does, however, note its usefulness around the health inequalities agenda, spatial diffusion and risk. Application of complexity theory to the organisation of sexual health service provision appears to encompass all of these aspects.

3.2.1.4.2 Complexity Theory and Large Organisations

There appear many different slants on this theory from many different fields, although all encompassing the main concepts, there is an emphasis on different aspects and generating different priorities. It has been used by organisations to give a framework to management practice. Un-know-ability of the future is a main finding for systems

of any complexity and it doesn't seem to fit well with the strategic direction of managers who may be intolerant of ambiguity and need stability to prevent anxiety from information overload. However, Rosenhead (1998) notes that theorists have discovered this revelation of the role of creative disorder. That the universe does not operate like clockwork and rationalist thinking around contingency, visions, consensus, long-term planning and the like, all becomes turned on its head and illusionary. If we don't know the future then planning becomes a hindrance.

Rosenhead draws on Stacey (1993) who makes a distinction between ordinary and extraordinary management. He claims ordinary management is having control at the centre to achieve the organisation's objectives through an established hierarchy. However, if the organisation wants to transform itself then extraordinary management is required. It requires informality, encouragement of spontaneity and self-organisation. Long-term vision and plans should be done away with and room made for emergence of an evolving agenda of aspirations. Intervention should only be selectively done and sensitively without controlling it. The ideal would be permissiveness with challenge. There should be small changes, steering away from equilibrium, and any chance events should be amplified. Long-term planning does not play a role and senior managers should only be facilitating processes of dialogue that will result in innovation.

Stacey (1996) advises that systems theory, predating complexity and management writing, which operates within an equilibrium paradigm with notions of efficiency, effectiveness and control, is now outdated by the findings of the science of complexity which gives more coherence.

I will also explore with Rosenhead, Stacey and Byrne, taking the opportunity to consider how the evidence from my own research fits in to this theoretical framework and how it is validated by the evidence, or if this perspective validates the findings. I will take account of Rosenhead's comment that management writers have a tendency for large generalisations supported only anecdotally. As well as the statement that operating at the edge of chaos could imply degenerating into crisis management. Also Stacey's case that a single vision statement for an organisation intended to motivate

and guarantee cohesion produces a culture of dependency, restricting expression and individual flair and therefore more reason to introduce a complexity ethos.

Complexity theory presents us with an unknowable future and therefore an inability to plan. Kaufmann (1995) also talks of breaking down large organisations to prevent this hierarchical planning. He suggests that biology, organisational and social issues may well be governed by similar fundamental laws. He shows that random variation and natural selection are only partial explanations for order in the natural world and that there are sources of self-organising, spontaneous order at work. So, just as the Adam Smith body suggest that the self-interested interacting with the market is highly efficient in economic terms, then complexity theorists suggest self-organisation will produce survival techniques where central planning would fail. Could sexual health service modelling provide evidence for this? Does it demonstrate emergence as a product of coupled, context dependent interaction, non-linear in nature and difficult to account for the behaviour of the overall system by examining the behaviour of the constituent parts? Not all of its aspects will be observable and the elements do not necessarily exist separately or can be analysed outside of the system. Complexity theory pays attention to interactions and the organisation of elements. Change can be a result of variation internally, externally, or a combination of both and some things may matter more than others (Byrne1998).

In a symposium on chaos theory or non-linear dynamics, written up by Goldoff and Jay (2005) ramifications on administration and management were considered by a number of commentators and asking the question was this “old wine in new bottles” (a quote from Morcol, 1996). Morcol had noted the foundation of this theory within the hard sciences but also its usefulness and relevance to social science and administration and decision analysis. Hence our image of an organisation such as the NHS should be of a self-organising system, even in times of massive change, which appears as chaos. Changes in professional perspectives within the organisation itself towards sexual health will be a factor interacting with many others that force radical change, and will be evidenced from the fieldwork. But that factor alone would not bring change but could add to transformational change alongside other societal, political and organisational change. Sexual health service provision as an unnoticed, un-modernised model was a stable attractor, until things changed around it. Sexual

health services over the last few years have been reaching crisis point with an inability to deliver or meet the needs of the public could be described as in crisis, a Greek medical term for a turning point. If ill you can either get better or die describes a complex system in an unstable state (Byrne, 2005).

Tsoukas (2005), in his study of organisational epistemology, recommends we view organisations as systems of knowledge. This would move us beyond thinking about individuals to explore a broader social base to include social practices, forms of interaction, values, routines, power structures and the organisation of work. This opens up the possibilities of exploring how individuals in context make use of tools, communicate in systems of authority and draw on institutional beliefs to carry out their work. He sees the questions within epistemology, i.e. what is knowledge, how is it obtained and justified, as no longer only the prerogative of philosophers and social scientists but also of organisations. He sees them as places creating new knowledge, as users and makers of knowledge that arrive in the public arena. He notes the importance of looking at organisations from both within to see how they construct different forms of knowledge and draw upon them, with what effect, and from outside to justify their claims to the outside world. This brings in Byrne's statement (2001) that this theory of complexity will affect the methodological approach. It justifies my own stance as an inside researcher, unusual in this specialist health field, to allow me to challenge some outside perceptions maybe created by a previous medicalised organisational structure. Tsoukas refers to this as investigating complex forms of knowing, capable of surprising observers, its behaviour unable to be reduced to constituent parts. This complex social system within an organisation is sensitive to time, change, events, beliefs, power and feedback loops. It will be grounded on an open-world ontology that is in the process of becoming, capable of turning into something different. The future is unknowable, making management complex. Most interestingly he emphasises the practitioner's use of organisational knowledge to be connected with the researchers' modes of knowing.

This theory is a study of patterns and relationships, which allows qualitative description that captures circular texture of organisational phenomena. It does justice to history, interacting agents and the occurrence of chance events. Tsoukas emphasises that this theory allows us a new language to re-describe organisations with

the use of concepts of non-linearity, iteration, sensitivity to initial conditions, unpredictability, emergence, self-organisation and open-endedness. It provides an alternative to classical mechanics.

This theory throws into disarray strategic planning and forecasting of organisations attempting to deal with the future, that is closed world ontology. An unknowable and open-ended future will mean organisations have to move away from a preoccupation of forecasting, as most events cannot be anticipated. Therefore they will need different skills, as was discovered with the beginning of the AIDS epidemic of the late 1980s and early 1990s. Tsoukas (1998) notes the need for organisations to shift from predicting to an ability to perceive. That is having foresight to connect the past, the present and the future, not always looking at outcomes but at processes. Fear of uncertainty means it becomes the enemy, rather than being seen as the challenge or the creativeness of an organisation, its dynamic nature. In fact he suggests organisations need to recognise the continual changing texture as a result of individuals accommodating new experience and new possibilities. Managers need to be sensitive to this and give it legitimacy. Although the manager has institutional power they can take opportunities to allow others to engage and make connections.

Paul Plsek, a consultant in innovation and complex systems, comments that despite organisations over the last decade talking about whole systems transformation, there has been little evidence of it within the NHS (Plsek, 2004). He notes that complex systems comprise of structure, process and pattern and that interaction must be considered in all three aspects if we really do want transformational change in a complex system. Much of the focus on change in the NHS has been around structure; organisational boundaries, resource responsibilities, new roles and responsibilities, a target driven NHS, provider and commissioner split are some of the examples. Plsek notes that even where there has been some success on redesign of processes, particularly around care delivery, transformation does not naturally follow. To have true fundamental change in complex systems then patterns must be recognised as important drivers of thinking and behaviour. He relates patterns to such things as values, how groups communicate and levels of trust. Underlying patterns that remain unchanged or unchallenged will result in failure to achieve fundamental change, despite the introduction of new programmes.

To address the culture of a complex organisation, to bring transformational change in a whole systems way, Plsek suggests five key pattern areas:

- Relationships; these should generate energy and innovation, and not drain the organisation.
- Decision-making; rapid decisions by people with the most knowledge of the issue. Blockage occurs with position, authority and hierarchy.
- Power; is this exercised in a constructive way towards a collective purpose, or is it coveted and used for self-interest and self-preservation? Ideally a management style should influence rather than force and one without necessarily having the detail.
- Conflict; embraced as difference that could lead to discovering new ways of working, or negative and destructive?
- Learning; is new thinking viewed as risky and threatening to the status quo, or is the system curious and eager to learn more about itself?

In fact Plsek (2004) introduces even more challenges, using this theory to allow us to recognise the value of individuals within organisations who aren't necessarily self-interested information processors, but actually have connections, affiliations to others and communities. The emotional side of human beings will affect what they do, with organisational implications of gender and race. It allows for broader patterns of meaning, which may not be anticipated as everyone brings their own beliefs and attitudes. Organisations will need to embrace broader complexity and consider these micro patterns that will really make a difference to the outcomes, maybe even the targets, but certainly to the transformation of the organisation. It can only result in the emergence of new patterns. Plsek claims change will occur more frequently and naturally when structure, processes and patterns are all embraced, but that the five key patterns need more honest dialogue. From his view it seems a cultural shift in the NHS could be what is needed to bring this change. Order will leap out from this butterfly effect, which is according to complexity theory, large unpredictable consequences flowing from tiny, microscopic systems change that are unpredictable. Every organisation having its own culture, created unconsciously, based on the

founders or people, who built it up; their own world, open or closed to outside influence. This culture is an acquired body of knowledge about how to behave and shared meanings, differentiating it from other organisations. It is this organisational culture that Edgar Schien (2004) sees as key to organisational excellence, or not, it does not even have to be logical or consistent. It is a non-linear world, one of complexity where knowledge is contextual and local. There are no first principles, as in a reductionist theory, from which everything else will be derived. Byrne's (1998) work around the welfare state, poverty and mental health care justifies the use of complexity as "a frame of reference, a way of understanding what things are like, how they work and how they might be made to work". A dance of complex systems, we couldn't possibly understand every cause and effect, some things coming from previous actions and yet others from outside the cause and effect we notice.

This will be a useful framework for my study, however, the complexity of a system will also depend on me, the observer and how I describe and interpret it, as it will be grounded in the narratives I construct about them. As an insider this could and should be quite different to how sexual health service provision is described by anyone from a differing standpoint or position within or outside of the organisation of the NHS. May (2002) notes that researchers should be aware of the way their own biography is a fundamental aspect of the research process and that the experiences of both the researched and the researcher are relevant. Hence, allowing me the opportunity to make a unique contribution to this body of knowledge and maybe encourage more complex thinking about the issues.

3.3 Exploring The Methods Chosen to Answer the Questions

The aim of this study is to uncover the modernisation processes that are either levers or barriers to what is taking place to improve access for the public to sexual health services, in an effort to contribute to improving the nation's sexual health.

"The problem itself often dictates the methods and the methods will often shape the solution" (Williams & May, 1996, p130).

3.3.1 Gaining Access and Authority to Take the Study Forward

As stated I am an NHS employee and would be working within Department of Health research governance guidance (2001) and required to make an initial approach with a formal research proposal to my own director and research and development manager for the Primary Care Trust. Once agreed, I was then able to apply to a local research and ethics committee (LREC) for ethical approval. This is a very robust procedure with an extensive application form to be submitted alongside my own research proposal. This went forward to the North Tees LREC accompanied by the participant information sheet, copies of letters to participants, consent forms, posters to be used to inform of the study or to be used for recruitment into the study, my own C.V. and the C.V.s of my supervisors.

It took a couple of months to be given a slot to attend the committee where I would be questioned on their areas of concern. The aspects they focused upon were my experience to explore this speciality and to handle such a sensitive subject. There was particular questioning on my ability to manage young people and other vulnerable groups and what support mechanisms would be in place if the participants needed them. I was able to reassure them that my experience of 15 years within the field of sexual health had equipped me for most eventualities. I had access to other professionals who were willing to provide support if needed, in both the statutory and voluntary sector, around care, psychology, youth work and social work. My previous qualifications, professional and academic, should also ensure I was capable of applying robust standards and completing the study. They gave formal approval and I was allowed to proceed to make approaches for fieldwork.

I was part of a national “smart group” for sexual health leads. It had only been initiated a couple of months prior to this ethical approval. This was an internet forum where service leads could pose questions or interest areas. I decided I would use this avenue to test interest in taking part in semi-structured interviews for my study. I posted a smart mail request and followed up anyone who replied showing interest in the study information. Although this was purposeful sampling, as the study developed I identified more sources and gaps in the work and sampling would become more

theoretical (Glaser & Strauss, 1967). Once a prospective interviewee engaged with the process I would email consent forms prior to setting the interview dates. I needed to make extensive travel arrangements to fit around work commitments and those of the participants, all of whom had very busy diaries. I had to also gain further permission for access to their departments by further submission of all documents sent to LREC, alongside their approval letter, to be sent to their local research managers and any department managers. Only after their approval would I be allowed to do the interview and I would be followed up with monitoring forms from each regarding the progress of my work. This whole process was at times tedious and frustrating but one that will provide strict governance for those under study as well as a safeguard for me.

I interweaved these interviews with setting some dates for focus groups. Approaching projects that I knew would value contributing to the process and would have an interest in the subject. These were also projects whose work was focused around the vulnerable population identified through my own experience and practice and the literature review. Other focus groups were made up of professionals who had sexual health as their main work or as a significant aspect. The coordinators displayed posters that advertised the purpose of the focus group and asked those interested to ask for a participant information sheet. The coordinators had been briefed and would give further information. They would also gain consent, ensuring it was informed, which was checked prior to commencing any group work.

3.3.2 Choosing Interviews and Focus Groups as a Method

As Williams and May (1996) suggest, my focus of looking at models of sexual health services and issues around access to them was not going to be productive by just considering statistics produced from services and epidemiology of sexually transmitted diseases and adolescent pregnancies. These alone will provide some context for the issues under study but to gather more rich information and insight the design would need to be a qualitative study with semi-structured interviews and focus or group interviews. This was an iterative process gathering evidence alongside a literature review that also evolved with the evidence gained. These methods should have the outcome of shaping what solution follows (Crotty, 1998; Bryman, 2001;

Silverman, 1998 & 2003; Hammersley, 1992; Meyer, 2000; Mays & Pope, 2000; May, 2002; Gilbert, 2003; Guba and Lincoln, 1982; Miles and Huberman, 1994; Strauss & Corbin, 1990; Glaser and Strauss, 1967).

Semi-structured Interviewing

“Narratives are but one structured performance through which everyday life is re-enacted” (Atkinson, 2005, p6).

Interviews are viewed by advocates of qualitative social research as opportunities to bring rich insight from generating conversations on specific topics that will draw opinions, values, attitudes and aspirations as well as their biographies (Guba & Lincoln, 1994; Denzin, 1989; Silverman, 1998; Bryman, 2001; May, 2002; Oakley, 1981; Gilbert, 2003).

May (2002) suggests semi-structured interviews will bring fruitful insight and a depth that could not be gained from a more structured approach or from a survey. Understanding the dynamics of the process is needed to achieve this; having the ability to move from a pre-determined schedule to deeper probing, responding iteratively to the respondent and bringing more diversity and creativity. The interviewer constantly seeks clarification and elaboration from answers given. This will maintain the aims and focus of the study while being flexible in discovering more meaning and context for them. I would always be the interviewer and so would have some control over how the probing evolved. Audio-taping would be consented to and may initially cause a discomfort or sensitivity, but usually as time goes on it becomes less noticeable for both.

The trust and rapport that is developed between the interviewer and interviewee could either enhance or detract from what evolves, prior knowledge of the interviewer from conversations and the study information will contribute to this process (Williams & May, 1997; Bonner & Tolhurst, 2002; Miles & Huberman 1994). However, within one to one and half hours, the researcher needs to work hard at establishing trust, as in this study it was professionals who were offered interviews and it was not the subject of sexual health that caused sensitivity but actually the issue of how they would be

perceived by others when giving views about services. (Participants often required reassurance within the interview that it is indeed confidential.) Singleton et al (2005) note face-to-face interviews are more likely to divulge more hidden things, not normally spoken of, and what would not be revealed on a more impersonal survey. They also identify the response effect, where the interviewer influences, in a myriad of ways, what is being said. Gender, age, profession, even mode of dress can play a part. An interviewee being aware of my own work area and the type of service model I work within will possibly be construing answers around that information. Maybe wanting to show their own work area in a good light, wanting to impress, or giving explanations of being under-resourced and over worked as justifications, for instance. Singleton et al suggest the participant will be looking to the interviewer for clues to the appropriateness of responses. I would argue this is not always the case, particularly when interviewing highly confident professionals with views they want to air, they may be content to take little queues from the researcher being intent on being heard.

Atkinson (2005) talks of personal narratives as representing many social contexts, not independent of culture. He says even the most personal of stories will reflect collective and shared cultural conventions, therefore stressing the importance of grounding what is said within the analysis. He suggests talk, such as in interviews, or within ethnographic work, is social performance, that is embedded within multiple contexts, such as that of organisations, work, family life, and many other social processes. He stresses this talk should not be represented by the researcher analysing just transcribed material within a social vacuum. Atkinson's work is known for his ethnographical attention but gives important understanding to all work with people perspectives encompassed within their situation. Considering a complexity perspective this would also include the person within time and space (Gatrell, 2005; Byrne, 1998).

Many of these interviews were booked months in advanced to fit in with very busy diaries. I travelled across the U.K for some, as well as holding many within the North-East of England. Those outside of the North-East had been in response to a "smart mail" enquiring if there was interest in being interviewed, from an internet smart-group of NHS and Department of Health sexual health service leads. I approached the

more local interviewees directly.. This was an example of the insider knowing where to find accessible and useful insight. As a quantitative survey this approach possibly would not hold much value as there was no randomness built in to it and there is obvious bias (Byrne, 2003; Blaikie, 2004). However, Blaikie remarks that what is counted as reliable and appropriate methods and data will depend on the ontological and epistemological assumptions that are adopted. As already explored, as a qualitative study, within a feminist and complexity framework, with an insider view, this should be sound. Byrne asserts that operationalisation should be provisional and reflexive, as in true complexity, until things emerge, also stressing the importance of saying what we are measuring. I was using a diverse group of professionals, not a single cohort, but they were representative of senior management positions; they were from clinical and non-clinical roles, from providers of services and commissioners of services. In this sense they are a population that will be able to hold up explanations on the context that emerges. Byrne states that randomness alone would not protect against selecting a sample far removed from the population from which it is drawn. Sorting into categories or stratifying will sort a sample that looks like the population and to do so you need to use existing relevant information about cases; I was able to do this as an insider. A more marketable version of this is quota sampling by searching out people who fit. For this small study that is the approach that is taken, aiming to produce “a *part of the real world which looks like the real whole in significant ways*” (Byrne, 2003, p7)

Focus Groups

Gilbert (2003) identifies focus groups as a key method for the collection of qualitative data. Cronin (2003) introduces the notion that the focus group differs from individual interviews, as it is dependent on reactions to each other or interactions between participants. Barbour & Kitzinger (1999) and Curtis & Redmond (2007) view them as ideal for exploring complex issues in-depth that would not be possible in a survey. The focus group should not be a replacement for single interviews but used also to triangulate the findings and explorations. It is also useful to establish people's level of knowledge of a subject and although does not give the depth of a single interview it may be broader in content. Parahoo (2007) suggests the purpose of focus groups is to identify differing views, whether supported by the group or not. Cronin notes there

would be few topics unsuitable for a focus group as long as there is sensitivity to the composition of the group and those with shared experiences or social identities will be more successful than those with obvious opposing backgrounds.

Barbour and Kitzinger (1999) encompass factors to consider within sampling strategy. Obviously the focus or questions the study is considering must be appropriate to the group and so judging carefully who would be included, but also allowing for time and resource constraints. Applying these issues will mean more purposive sampling rather than random or theoretical sampling, certainly as the study commences; they note this is common to focus group work. Parahoo (2007) also considers that just using a convenience sample would not allow generalisation of data.

Howatson-Jones (2007) and Happell (2007) consider eligibility for entering a group into your study needs to be drawn up clearly with rationales for doing so. Engagement with the focus groups was purposeful as I had knowledge and some access to groups across the local district that would have an interest in sexual health services, either because they were workers with sexual health responsibilities or members of the public within projects, viewed as vulnerable groups regarding their sexual health. Burningham and Thrush (2003) when exploring research with disadvantaged groups, note that researchers with local knowledge are not only able to find appropriate groups but are more likely to be sensitive to local issues and concerns that an outsider would be. The procedure was to approach the project lead, either by letter, or initially by phone-call followed by a letter or email, to inform them of the study and assess the level of interest. They would have access to all study information regarding participant information sheets, written in lay language for projects and professional language for others, posters to display to identify interest and consent forms to partake in the study. There was usually ongoing discussion with myself either visiting or via telephone. When all issues were understood I would arrange a time that was mutually convenient to everyone for the focus group to take place, usually within their own buildings, which would allow a greater degree of access, comfort and less distraction (Cronin, 2003; Happell, 2007). The session would be informal but everyone would either have read the information or a group leader would have spent time going through it; this was particularly so for the African women group and the younger people groups. There were opportunities to ask questions, ensuring everyone understood the purpose and their boundaries. I gathered consent forms prior to

facilitation of the group and only when satisfied that it was informed consent. I had also created an area in the room with health resources such as sexual health brochures that could be browsed as we were preparing to set up and would be left behind for the groups' use. On every occasion I facilitated or acted as moderator, although there was usually a project lead also present. Hence, when the terms researcher, moderator or facilitator are used they refer to me.

Depending on the make up of the group, I begin by introducing who I am; this is not an easy task in itself, as I explained my multiple roles in my professional life and now the purpose for this particular visit as the researcher. An explanation of the term sexual health service provision and improving access to them was given to those who weren't working within them. Everyone was aware the session was being audiotape and someone would also be taking notes. It was also made explicit that all of this data would be anonymised and stored securely. Anonymity in the writing up of the work was stressed. The focus group would take one to one and half hours.

May (2002) stresses the importance of rapport in focus groups being of paramount importance to be able to establish the perspectives being offered. The managers, or project leads, may have previously expressed quite different views to their own service users, or employees, maybe wanting to give an organisational image that their users or workers don't necessarily fit into. To find out how things really are trust will need to be in place (Bryman, 2003). Building up rapport and trust in this short time frame will need to be constructive. May suggests starting with descriptive questions, so possibly asking what they know about services in their local area, are they convenient and well advertised. Obviously this sensitive subject matter meant people could be breaching their own confidentiality, giving the game away, if they were service users and answering very knowingly. This is where the stating of boundaries prior to the facilitation is imperative in both establishing that people take responsibility for what they say and in preserving the confidentiality when outside of the group. May suggests moving from description to exploration, a more inclusive opinion-seeking mode. He considers that this will naturally progress to a third stage of cooperation, where people now know what to expect from each other. Although the examples May considers work with groups over weeks and not just one session, as mine were, I felt the principle if applied assisted the process. May reminds researchers

of the importance of preparation, to understand the situation you are going into and the groups' own purposes of why they are a group and be equipped with prior knowledge. Reflecting back with them, when the group move away from important areas, is thought by May to bring a natural element to talking in a group, rather than throwing questions out in a very structured way.

As the study progressed I decided on more theoretical sampling of focus groups. An example of this was when I identified a gap in professionals who work with young people in North Tyneside, in similar settings but for different aims, but all to do with sexual health. This focus group brought them together into a mixed group. This group was made up of mostly school nurses/school health advisers and youth workers from the local authority and voluntary sector. This demonstrated many similarities and diversities in perspectives and brought out a depth that maybe would not have occurred in single professional groups. Giving an example of where reaction and interaction worked well when listening to each other.

Returning the transcription of the proceeding, usually to the scribe or the group leader for verification of the account was usually returned with no changes and acceptance of what was written.

The problems in group facilitation of keeping everyone on track, ensuring everyone is included and that the group is not dominated by one or two is quite an art. Parahoo (2007) identifies how existing groups can provide comfort and confidence to group members that assist interaction, but within such group there will be power structures and norms already set. She suggests if such power differentials strongly influence the group dynamics it will throw into question how reliable and valid the data is that comes from it. Howatson-Jones (2007) however, views embedding the focus group within existing group structures will provide a greater opportunity to explore how they construct reality, draw out understandings and open up hidden meanings.

Drawing out opinion and thoughts can also be quite challenging in groups where people are not empowered or confident and may be part of a project because of this issue. For some participants of a youth offending group, they depended on encouragement from workers to speak out at all, or just to agree or disagree with an

issue. The subject of sexual health, I realised for some members of this particular group, was causing discomfort and embarrassment, which I will discuss further in the findings. Cronin (2003) advocates that the researcher keep a low profile and that their own talking or discussion is kept to a minimum, once the broad topic is introduced. Although Curtis & Redmond (2007) do state that the moderator or facilitator role is a not passive one, as they will influence group dynamics through intended or unintended behaviour. Even mode of dress can influence how the group respond, but most importantly an ability to relate to them will enhance decisions about what level of information they disclose. Low level of moderation was not always possible. Possibly this approach would also be perceived as detachment or disinterest of the researcher. My experience was usually that motivation was needed to stimulate the group into further, deeper explorations of the issues. A high level of moderation is thought by Cronin to not allow in-depth material to be gained, which I would possibly agree with but is not always practical and it possibly needs to be accepted that not every focus group will be successful in gaining such depth. Verifying the fact that it is important to keep a reflexive account of the context and observations I made and not just about what is said.

May (2002) points out interviewing is about understanding how people make sense of the world, for some that is maybe when in a group they do not feel included, or actually emotionally exclude themselves. I found not just asking questions, taken from a planned schedule, compiled prior to each group, but actually drawing on counselling skills that I had been trained in, were useful tools for group facilitation. This allowed me to use reflection, probing and interjecting, having a structured beginning and endings (Mearns & McCloud 1984), all enhancing disclosure and taking discussion to a greater depth. Commencing a session with broad criteria and funnelling to more specific elements required active listening and careful balancing with the creation of a non-judgemental and safe place for the participants. As I developed work with groups I built up greater skill in moderating and was able to conceptualise and scope issues and aspects I'd heard previously that were compatible with the study aims. The role of the moderator is not something to be engaged with lightly and carries huge responsibilities regarding care of the participants and the level of skill needed to be successful within it to achieve the aims (Happell 2007).

When arriving at analysis there will be management issues of large amounts of data from focus groups. Barbour and Kitzenger (1999) remind the researcher to take into account the group context as a unit not individual participants, distinguishing individual and group opinion, considering areas where there is agreement and disagreement, drawing out themes and issues and comparing different focus groups.

Electronic Surveys

In grounded theory style (Glaser and Anselm, 1967) analysis started from the beginning and was applied throughout the collection of data and any gaps identified. When time was running short I decided on a different strategy to gain access. As busy professionals need good notice to give interviews it was more acceptable to five respondents to use the internet to give in-depth responses to the interview schedule. I rated these as second best to face-to-face interviews but at least meant I captured information that allowed more triangulation, of not just methods but from a wider group of professionals.

This is a method fairly new to the qualitative research community there is little published about the use of the internet for interviews. My experience from this study showed that these responses were sometimes concise and going back to the person for more verification or depth was not always possible when you had already needed to remind them, maybe on several occasions, to find time to respond and return it. Despite asking for proliferation in writing and depth of views, one responded as if answering a structured survey, with only short remarks. I had approached these participants and we were known to each other as professionals across this specialist field, with mutual respect for each other's work and there was an element of them wanting to support my aims. Singleton et al (2005) points out the convenience and reduced costs of this method, although they also acknowledge that a high non-response rate is common. Another advantage is the question schedule was basic. It could be modified each time it was forwarded, as part of the iterative process. They note the increased use of this as part of a mixed mode of methods, with it particularly appealing to young people and the level of privacy it gives.

Bampton and Cowton (2002) identify electronic surveys as a compliment to other established methods and recommend more interactive on-line conversations rather than sending the schedule as you would in a structured survey. They identified that finding mutually convenient times to do the on-line response was very difficult and respondents requested they just send the question areas, often losing momentum with the time lapses. There are strengths and limitations with this method and Bampton and Cowton also highlight the importance of time and space, as there will be context lost from lack of face to face work and reflexivity will be limited.

Rodman and Gavin (2006) note ethical issues when planning and implementing on-line data collection are no different to those when using more traditional approaches. I always attached consent forms and participant information sheets, prior to sending questionnaires and allowed time for consideration, not coercing and pressurising for responses within short time frames, in particular. They state that this method is used increasingly within psychological literature but it still remains in its infancy and methodological rules of conduct will need refining with time.

3.3.3 Analysing Data Using Grounded Theory

I used grounded theory to analyse the data, often described as a bottom up approach. It is a tool of theory building and testing and an appropriate creative activity for this interpretative approach. This methodology is used predominantly with qualitative data and was developed in answer to criticism by positivists that qualitative research was lacking in rigour and was unscientific. The discovery of grounded theory by Barney Glaser with Anselm Strauss in 1967 was a result of work with research on dying patients. It is said to be an adaptable methodology that allows a way of thinking about and conceptualising data (Strauss & Corbin, 1990). I had used this method previously in another study and felt it could offer an acceptable evidenced approach to the NHS world I was accountable to. Constant comparison of themes or concepts will be developed throughout the data collection. It is thought to produce theory of great conceptual density that is fluid and embraces the interactions of the multiple actors. Professional and personal experience of the research context is seen as adding sensitivity to the drawing out of the theory, with less contamination with

preconceptions (Rennie et al, 1988). The use of memos helps identify any assumptions being made during the process. At the same time this approach is demonstrating the informants perspective that is uncontaminated by theory. I also become increasingly theory sensitised as I immerse myself in the data by listening to the tapes and reading the notes, as well as other literature.

The grounded theory is a blend of descriptive and constructive categories, with a core-category that is the most saturated with the elements (concepts). Each other category is associated with the core-category (Strauss & Corbin, 1990).

Glaser (1978) claims if the theory is inductively tied to the data, without omissions and that it is a plausible explanation, then it should lead to hypotheses and additional investigations. (See Appendix 3, concepts taken from interviews and allocated to a core-category and sub-categories, which makes up the evolved theory).

The epistemological assumptions of grounded theory are derived from symbolic interactionism according to Denzin (1989). This explores processes of interaction between people's behaviour and their social roles. The emphasis is on interpreting the way meaning is derived in social situations. Hence, to an outsider the world may seem irrational, while others within can make sense of it and order their social worlds in ways that may be in common with those in similar situations. McCann and Clark (2003) note researchers using this theory base their work on these assumptions that groups have social and psychological issues in common that are not always articulated. These are discovered and made explicit around the framework of the research process. However, Glaser and Holton (2004) voice concern that this perspective, as well as others taken, when using grounded theory erode the classic methodology aims as they become mixed with qualitative data analysis. They state it is not underlined by symbolic interactionism or any other constructionism. They suggest this downgrades the goal of this conceptual theory as it is remodelled and takes away its power. This selective application of discreet aspects, they refer to as cherry picking, they say is not compatible with grounded theory methodology. Glaser and Holton (2004) emphasise the generation and emergence of concepts and theoretical codes, with constant comparison until saturation, rather than imposed concepts and frameworks on to the data. They suggest it is a trap many novice

researchers fall into as they follow more experienced researchers who take this track using it piecemeal and note unless grounded theory rigorous procedure is followed it will not produce substantive or formal theory that is relevant. Their discussion advocates grounded theory as a stand-alone conceptual theory, one with simple procedures that are not aiming to produce factual description.

McCann and Clark (2003) suggest this diversification is a maturing of grounded theory over time with differing epistemologies, which has occurred in most other methodologies. They suggest researchers will continue to contribute to this process, just as Glaser and Strauss and Corbin themselves had original approaches that were differing and continued to develop with difference. I have stated that I am an insider researcher and not naïve to the issues of the study and therefore will not be using this method in its original conception of 1969 but from my own epistemology.

Each interview and focus group was recorded and transcribed. My notes from the interviews were also quite extensive, as Glaser and Holton (2004) suggest this is the preferred way and that even tape recording is not really necessary. Focus group facilitators, sometimes staff members or overseers of the group, also took comprehensive notes from the discussion. Reflexivity and observation following each interview and focus group was built into this process.

Mays and Pope (2000) and Thompson (2002) identified handling of data, using systematic methods for coding and analysing as evidence of rigour. They did not perceive that using computerised packages was important to improve rigour, as although they offer an efficient way of handling data, they merely facilitate coding and retrieval and do not analyse, it is not an analytic strategy in its own right; this depends upon the theoretical sensitivity of the analyst. I initially considered using the computer programme NVIVO but on examining its use I came to the same conclusion and decided to work within Windows. I used these principles exploring transcripts line by line, drawing out concepts systematically and coding them, building them up into common themes and further categories, referring back to my notes and reflections throughout the process. This did generate concepts that required constant comparison until saturation of a theme and then a category, without imposing concepts or any of the frameworks to be used in the discussion on to the data at this stage.

Drawing on the principles of grounded theory, from the work of Strauss and Corbin (1990), who originally suggested that the field should be entered with no preconceptions from the literature or elsewhere. One should be open minded and flexible, allowing theory to emerge naturally from the data. However, unlike Glaser, they modified this view to one that a preliminary review of literature before data collection begins would enhance theoretical sensitivity. The main review would be undertaken as the fieldwork progressed. Extensive reading is thought to unduly influence the pre-conceptualisation of the substantive area. Empirical verification of the hypothesis takes place with further collection of data. This allows testing of the data as it is inducted and deducted, providing a cyclical approach, in contrast to a linear method, happening throughout data collection and not at completion, with constant comparison (Becker, 1993). This means the theory will not be predetermined, even though the researcher is immersed in the data, as well as in the culture and setting being studied. Denzin (1989) proposes this will enable a clear portrayal of the issues. McCann and Clark (2003) in contrast suggest that to obtain conceptual density grounded theory methodology requires an insider approach, such as I am taking, where there would be empathetic understanding that allowed an uncovering of the meanings. Rather than imposing an outsider view they are able to give feelings, experience and perceptions to the evolving findings.

My approach encapsulated most of these concepts. I have proclaimed myself as an insider, with many years within the speciality being explored. I could not claim naivety, or having no assumptions. I have read widely and been part of what I am exploring prior to this study. However, more in-depth and wider reading was required as I immediately started on basic analysis from the very first interview, using what I was inducting to build upon for material for the following interviews, to consider where other interviews were needed and for further reading. The sampling had been initiated at the outset as purposeful, however, as it progressed I needed to make theoretical sampling in response to the developing categories and I made approaches for more interviews or focus groups. The literature also generated more ideas to introduce into the fieldwork i.e. this became a process of induction that allowed theoretical sensitisation, sampling, comparison, coding and categorisation and integration into a theory. Glaser and Strauss (1967) originally identified this whole

process as bringing greater conceptual depth; my particular use of this approach is more akin to McCann and Clark (2003) as uncovering meaning.

The main founders of this theory view evaluating grounded theory research differently. Glaser (1978) considered four key elements to be important:

- Work; the theory should explain and interpret what is taking place within the context.
- Fit; categories must directly relate to the data.
- Modifiable and adaptable; to apply to a changing world.
- Relevance; the core problems and processes have been allowed to emerge from the data rather than imposing preconceived theory on to the study area.

Strauss and Corbin (1990) suggest using the standards of other methodology and apply:

- Validity.
- Reliability.
- Efficiency.
- Sensitivity.

I consider that all of these elements should be used to evaluate my own study as evidence that it is robust and performed rigorously. I have not entered this field free from preconceived ideas and bring my own disciplines and perspectives, hoping to contribute further to the development of grounded theory and its use within the field of sexual health. Kirby (2007) contributes to this theme by stating a poem is never completed only abandoned and that there is no right or wrong approach to grounded theory, only a maturing, a branching out that brings uniqueness.

3.3.4 Strengths and Weaknesses of the Approach

“If both the strengths and weaknesses of different methods of interviewing and approaches to their analysis are understood, they can provide us with an essential way of understanding and explaining social events and relations” (May, 2002, p145).

Silverman (2003) evaluates the strengths and weaknesses of the approach by asking key questions. Firstly is the method appropriate to the questions being asked? I have used this insider qualitative approach, as it would otherwise be difficult to gain rich in-depth knowledge and understanding of this NHS service provision from surveys or as outsiders looking in. I can only suggest it is sensitive and useful enough to answer the questions asked and brings new areas for exploration, it should arrive at a unique place. I was systematic in the collection of data and use of the proposed methods for analysis. The subjects used are fairly representative of providers and possible users of sexual health services. I was able to gain some respondent validation of what was said by returning transcribed interviews both to individuals and to focus group facilitators. However, not everyone wanted this. This adds to the credibility and the authenticity of the methods used (Bryman, 2001; Crotty, 1998; Silverman, 2003; Mays & Pope 2000).

Bryman (2001) suggests there is often a lack of transparency in sampling as an aspect of qualitative work and often a resorting to convenience sampling. I have made it clear as I charted the method used, how respondents were recruited and exactly how many came forward. Acknowledging that there are time constraints, actually knowing where to go to gain subjects when working on the inside should be an advantage to gather quality information. Adding theoretical sampling to gain saturation alongside this should add to the credibility. However, Bryman emphasises it is not about statistical adequacy of the sample and to just acknowledge if saturation does occur early on.

Silverman (2003) considers qualitative research as having little appeal to a policy-making audience, although he acknowledges this may be changing with time, particularly as practitioners are more open to influence and are often interested in the identity of the researcher. This will bring its own influence on policy makers looking

for change and innovation. This may work in my favour as a longstanding insider. Silverman notes researchers too readily assume that some topics are private matters, such as this one around sexual health, or even healthcare provision, historically the domain of the doctor, for which we cannot achieve access. Once we are free from such common assumptions we will reveal detail and open up new arenas, offering new perspectives on defining what the problems are within sexual health services. In sense with this subject of sexual health services I am reaching aspects that possibly have not been reached in previous studies and opening up what has previously been quite a closed area for study.

Lofland and Lofland (1994) and Henwood and Pidgeon (2003) make a point that the greater time spent with a group the greater the adequacy of description and understanding. They note the sensitivity to language and the closeness of the observer. Within the fieldwork I needed to make clear reflexive accounts immediately after holding focus groups in particular, but also after interviews, exploring how I encountered social openings and barriers and identifying any reactive effect to my presence, where a role may be adopted specifically for the benefit of the researcher. It is of course impossible to identify all reactive effect, but possibly it is less so as an insider, or one with knowledge of the subject area, where there was an acceptance that I would understand the background to issues around service provision for the professionals and for the service users have immediate empathy for their views. I would need to be aware that I wasn't creating a willingness to please, where people may regret revealing too much detail after the intervention. My skill as a professional could be wrongly perceived as a coercive technique. I was aware of protecting individuals, particularly in group situations, and created group boundaries prior to the work around containment and confidentiality. Reactive effect can be to both the researcher but also to other group members and any inappropriate talk or revelations would need to be sensitively handled, as in any group facilitation work.

The processes and frameworks identified throughout should contribute to a considerable amount of trustworthiness as integral to this work. Bryman (2003) proposes this as criteria for quality research and says it will be related to credibility, transferability and dependability. Trustworthiness I feel should also fit within the feminist framework of ensuring respondents feel heard, that there is as little as

possible power imbalance and where there is potential for a degree of reciprocity these were adhered to (Oakely, 1981; Smith 1987; Stanley and Wise, 1983). These were always at the forefront of my work and mostly achieved. Taking care not to step over boundaries as a researcher but drawing on my skill as a practitioner when requested. Many of the professionals being interested in talk about the model of service in my own work area and many of the possible service users having enquiries about services, was responded to appropriately, usually when my research work was complete. Often such questioning gave more insight and opportunities for my own reflections and observations. Bryman (2003) does suggest ecological validity to improve a study. This relates to findings that are applicable to everyday life, from social settings that capture conditions, opinions, values and attitudes. This study was very explicit in all of these aspects.

The use of triangulation of methods, with focus groups and interviews from professionals and user groups, and possible service users, worked well in cross-checking the context and improved validity and confidence in the findings as well as enhancing the concepts that were drawn out. There would be methodological weakness within single interviewing or just of focus groups. By using both methods and placing them alongside the literature, policy and national and local statistical information, improves confidence in the findings and strengthens credibility and validity. This strategy seemed to mutually reinforce concepts and dovetailed a number of aspects. I suggest there is also strength in the findings as they demonstrate relevance and usefulness when the study is seen to contribute to present knowledge or increase confidence in what is known and what needs to change. By applying rich contextual information within the data, beyond the study setting, this is again increasing the relevance (Mays & Pope 1990). The subject under study was demonstrated as an important focus for the nation's health from the literature review that evolved, with my own baseline knowledge underpinning it and knowing where to unearth aspects as an experienced insider.

I suggest there is strength gained in placing the findings of access to sexual health services into a complexity theory framework. It gives a fresh approach that gains new insight and understanding within the findings as they evolve into a theory, as Byrne (1998) encouraged us to not just look at the superficial issues, but scope its position

within the wider NHS. Using this design and multi-method approach I sense there will be success in achieving this. Alongside the grounded theory for analysis it is strengthened and fits well as an integrated account constructed around a complexity frame, providing a tremendous prospect to describe change. Atkinson (2005) agrees that complexity theory provides a powerful analytical vehicle for understanding emerging elements of social interactions with diverse levels of order and meaning. He emphasises the need in contemporary research to use formal methods and formal analyses to enable us to grasp the complexities of representation. Maybe, as Byrne implies, the evolved theory of findings will even shape future changes. Reinforced, because those on ‘the outside’ have not reasoned about it, but there has actually been engagement with what has been described. The argument that Byrne takes is that complexity science is inductive, integrative, engaged and different. All of which fits with myself as the researcher and of the subject of sexual health service provision as well as with the method chosen for analysis, grounded theory we shall see how the evidence engages with it.

A weakness of this method of research could be resources, if it was to be paid for it would possibly prove costly to send a field worker across the nation to interview individuals and to work with focus groups, it is labour intensive. Alongside this, only being one researcher puts limitations on this study and provides only a snapshot of what could be possible with a wider study considering the same issues and would bring in more perspectives.

Representativeness (May, 2002; Bryman, 2001; Gilbert, 2003) of participants could be seen as a weakness as a relatively small study, with some self-selecting participants within it. However, interview participants came forward because of their interest in the subject of providing integrated sexual health services and were a cross section of a clinical and non-clinical senior management staff. This was a unique opportunity offering a “slice of life”, with generalisability across the nation being limited. I approached projects where I knew sexual health was of concern for them and gained the focus group interest. Displaying a poster to gather interest did also add self-selection to the process. The literature review added evidence that these were the vulnerable groups who should have improved access to services and have a say in how they are developed and therefore fairly representative.

Facilitating focus groups requires a degree of skill and is best supported by a group leader who knows the respondents and can be a positive influence on them to encourage engaging with the process, as well as being aware when things need to close down, or for participants to withdraw if uncomfortable. However, I have already stated this was my agenda and not necessarily theirs and some took the opportunity to air issues of concern and to move away from the focus. This can be a weakness of this method and requires tactics that are respectful of the participants and also keeps them on track. Reiterating the researcher effect is well known as a downside to focus group work, where reactivity and interactions with each other and the facilitator needs to be considered as a weakness within the approach, as people will weigh up what is said depending on their social situation at the time. How motivated they are to participate can depend on how valued they feel or how much value is placed on their responses (May, 2002). Equally, occasionally there were workers present with service users, which I found could have a knock on effect of withholding views, or it could be supportive and gave confidence to share views. My practitioner skills were utilised in being sensitive to the group dynamics and to individuals, gaining cooperation and knowing whether to draw out if someone was quiet or hold back when someone tried to dominate. Overall there is some control possible to achieve my aims for the groups.

3.3.5 Ethical Considerations

In the UK, all research involving human subjects, data, tissue samples, NHS staff or facilities must take into account the requirements of the Research Governance framework for Health and Social Care (DOH, 2001) hence my own proposal of research had to undergo scrutiny and be approved by the Local Research and Ethical Committee (LREC) before I could commence any aspect of the investigation. Included within this was an independent peer review that also promoted it as a valid piece of work with acceptable aims and objectives. Each NHS research site across the UK also had to give approval from its local research department as well as from each management area. All of these procedures are an attempt to promote the quality of research and prevent any harm being done; it all contributes to informing research development and producing ethically sound research. Within this framework it is

important that I also reflect on my own professional responsibilities and codes of conduct. Throughout the process I would be referring to the Nursing and Midwifery Code of Conduct 2002. Ethical codes, as well as my own moral principles, also serve as guidelines for behaviour that has become well integrated into my professional and personal identity. Ethical problems will be recognised from my own experience and understanding, as well as from these codes, but also from an ability to identify my own and the respondent's feelings of discomfort. Collaboration is important in situations of ethical dilemmas, both with the interviewee and with a supervisor. All of this is in an effort to do no harm and to do the greatest good i.e. non-maleficence and beneficence, within principles of autonomy and justice. I am bound by these codes, which are always implicit within my work (Leathard & McLaren, 2007).

Alongside the professional codes for Nursing and the DOH research governance framework I will also need to encompass the British Sociological Association statement of ethical practice (BSA, 2002). This statement requires professional integrity and responsibilities in relation to the participants as well as to sponsors and funders. This statement recognises that there will need to be choices made and maybe even ethical and legal dilemmas faced when there are competing or conflicting interests or obligations. They stress that researchers must work within their professional boundaries and with due regard for the well being and rights of others. This statement is not at odds with any of the frameworks I propose to work within.

Ethical codes are suggested by Homan (2006) as a common currency of ethical values that are rather more for the security of the investigator than for the benefit of participants. He contrasts this proliferation of professional organisational codes of conduct with the Nuremberg Code of 1946. This code was a response to the prisoner of war internees subjected to experiments without consent. He suggests this code is a model for honouring the rights of participants whereas today codes are about indemnifying the researchers and results in the voluntariness of consent being belied by the skills of the investigator to break down defences to pry and invade. Homan considers the make up of codes is due to the new world of litigation and professionals needing clarity on what they can and cannot do. He suggests codes should not be just prescriptive allowing a passive adherence, where the ideals have been formulated by others, but should be integral to education, allowing professional judgement in the

mutual pursuit of good practice. I entirely agree with this stance and it fits well with my own experience, but it would be difficult to apply to a research student with little practitioner experience with no base of professional experience or judgement to draw from and therefore guidance and codes are imperative.

Allmark (2002) considers that ethical practice in research rests on the two pillars of the honourable researcher acting in accordance with ethical codes and the ethical committees reviewing proposals thoroughly. He notes the areas of concern for the committee as scientific validity, the welfare of participants, and respects for dignity and rights of participants. He notes the DOH (2001) stance of ensuring quality is integral as otherwise there is a waste of resources and a fooling of participants in thinking they are serving a use.

The inclusion of vulnerable groups within my work will be perceived as an ethical concern and indeed an area I was questioned about when the proposal was reviewed. Those I would particularly perceive as young people, asylum seekers and in some cases gay men. These groups are frequent users of sexual health services and to be excluded from this study would also have raised ethical issues, marginalising their experience and knowledge. Exploitation or coercion in research relationships is an issue vehemently raised in feminist writings reporting how researchers should not treat interviewees (Oakley, 1981; Finch, 1986).

Beauchamp and Childress (2001) comment on the ethical requirement of consent for healthcare research and divide it into three areas: the consenting person must be assessed as competent to give it; there must be adequate information given to allow informed consent, both written and verbal may be needed; that consent must be given voluntarily and there is no coercion involved. Ensuring consent that it is informed was vital to my work. This was both in written form prior to the interview or focus group, so participants were able to opt out, but also through discussion prior to the interview. They may not be aware of any possible harmful effects and these needed to be clearly identified. If any young person were to take part, under the age of 16 years, I would need to ensure I applied best practice guidance and I applied Frazer guidelines and assessed them as competent (DH, 2004). This was an every day procedure for me within sexual health services and one that I felt confident in assessing and applying.

Williams (2006) explores the appropriateness of using Frazer guidelines within the research process. These guidelines were produced in response to medical interventions, even medical research, but he suggests it may be stretching the point a little to apply them to social science research. He does acknowledge though the rights and responsibilities given to children under the Children's Act 1989 and the limits of the powers of parents over their mature children. Also children and young people are no longer viewed as inarticulate, but increasingly seen as informed experts on their daily life and they need to speak for themselves. The principles involved in undertaking ethical research with young people being no different from those generally applied, ensuring consideration of need for support should they become distressed and providing leaflets that signpost to appropriate services. Constantly reflecting ethically and acknowledging no code will give all the answers.

There is a responsibility on the researcher to balance facilitation and protect the rights of individuals. Sexual health is a very sensitive issue and was perceived by the LREC as such. They needed reassurance that my experience of 15 years, working within the speciality, was sufficient to be aware when support for subjects may be needed and indeed to be sensitive to the area I may be probing. However, also not to consider sexual health as a subject that should not be researched because some people find it a sensitive area (Silverman, 2003). Maijala et al (2002) explored the ethical issues of the subject selected to research and noted that justification was needed that the topic was asking valid questions; would the process offend or disparage some was an area they suggested the researcher needed to be sensitive to; would the chosen method actually answer the questions asked was another aspect of ethical concern. Maijala et al also noted the importance of describing the research process and reporting the findings fairly, justly, confidentially and comprehensively, that would reflect the real life circumstances, as practitioners results would also promote practical developments in the field. Within this process will be a prerequisite to recognise and solve any conflicts of interest that arise between the research aims and what is best for the informants, ensuring no breaches of trust or emotional harm are inflicted on those who contribute to the study.

The insider researcher role, pertinent to myself as a practitioner, is acknowledged by Williamson and Prosser (2002) as causing ethical confusion as it surrounds the potential conflicting roles of a nurse (or manager or health adviser, or specialist in the sexual health field). They note that the multiple roles of the insider may make it unclear to the informant who they are disclosing sensitive information to. Working within one's own organisation or geographical area will make this unavoidable and requires explicit discussion with supervisors and informants. Within these roles they also explore the ethical protection of the multiple roles should give around confidentiality, anonymity and doing no harm. Clarification will be required throughout the process of the project and needs to be negotiated with the informant.

Protecting confidentiality may be an aim of the report writing but within an organisation others may know who has agreed to an interview, or who has spoken out. Protecting transcripts and other data is routine but needs to be explained to the informants. Disclosure by informants of bad practice, or even abuse, becomes a dilemma in these situations but ethically the professional researcher would need to follow through with this, informing the participant that she is doing so. Williamson and Prosser (2002) suggest in an ideal world transparency to a steering group allows external scrutiny and gives protection to all involved.

Bonner and Tolhurst (2002) note as an ethical issue that research is often published in forms not easily accessible to service users or from the very people that have contributed to it, both in language and types of publications. They suggest meetings and talks that disseminate findings at a grass root level. Taking the trouble to do this will benefit everyone and acknowledges the need for reciprocity and the researcher not just taking from the field but giving something in return and acknowledging the value of the contribution of participants. This also contributes to the concept of regarding participants as equals and they have an active role to play in development and change (Meyer, 2000).

Some of the informants approached me to take part in this study as an area of their own interest and were keen to be involved. Others had been directly approached by me and the focus groups had been recruited through the use of posters. It was important to ensure an ethical stance and reciprocate with a responsible research

approach, one that would encompass all the feminist research principles around sensitivity, being genuine and investing some of my own identity, aiming for more equal power in the relationship and not misusing the trust given, particularly as I had this insider role. Ensuring the participants were fully informed of the aims and objectives of the study and being explicit regarding confidentiality. Many of the interviewees were male and their perspective was of great value to this study, they would not be treated as objects of research, but their views would be encompassed as I try to free myself of my own preconceptions. I would be aiming for engagement and rapport but not over-intrusion and interactions that are authentic and aware of the possibility of exploitation or manipulation (Oakley 1981; Malseed 1987; Stanley & Wise 1983; Cain 1986; Stacey 1996; Smith 1990; Mies 2003; Olesen 1994; Skeggs 1992).

Some of these principles were particularly important when working with more vulnerable people within focus groups. The African HIV women's group were one such group that I needed to be particularly sensitive to. Statements about confidentiality and anonymity and signing papers for consent, are western concepts and were going to be culturally unusual for these women. McGee (2006) explored this very issue and stresses the importance of operationalising this in an appropriate way. These women may not be empowered and may just comply with my wishes; they may have fled from oppressive regimes where they have been intimidated and even tortured. They may particularly fear their HIV status being leaked. Using the workers who oversee this group to explore the purpose of the research prior to them giving consent and allowing them to opt out was vital to the integrity of the study. McGee also noted that such groups often experience research fatigue and they perceive little difference in the status quo following it. A white researcher is also automatically seen as different, although he claims this could work to your advantage, as someone from their own cultural group may be assumed as more likely to breach confidentiality and also they may go to greater lengths to explain references that you couldn't possibly understand as a white person from the UK. Research governance (DH, 2001) suggests the agenda for the research subject should be set in collaboration with such groups but the pressures on time and my set aims did not really allow this. Reciprocity was generated by my interest in their concerns outside of the agenda and in giving some time to give guidance from my professional stance.

It is obvious that this research will be contaminated by my values; Silverman (2003) noted that it is only through those values of the researcher that certain problems become identified and studied in particular ways. The conclusions I draw will in the main be grounded by my own political and moral beliefs, hence, the reason for clarifying them within the framework. Throughout the whole process I will be reflecting on the ethical issues I have identified and ensuring my approach is rigorously grounded in them.

4.1 Introduction

Taking the four question areas identified in the fieldwork schedule, i.e. improving access to sexual health services and modelling those services, policy and practice, sexual ill-health and the nation, as well as acceptable services for service users, I found assisted my exploration of what modernisation processes are taking place, or indeed why they are not taking place, the enablers and the barriers. The questions (shown within the schedule) flowed from these strands as the common ground I held with the participants allowed early rapport to develop. I was exploring if the access to sexual health services is improved and if the public found these services more acceptable and easier to use, then could this make a contribution to improving the nations' sexual health.

Using grounded theory as a method to explore the findings as Glaser and Strauss (1967) originally identified this whole process as bringing conceptual depth; however, my particular use of this approach is also more akin to McCann and Clark (2003) as uncovering meaning. It involved in an inductive, iterative process that investigated the body of knowledge, alongside the fact I was an experienced practitioner, an inside researcher. This helped me to develop ideas and find relationships between ideas to take to the fieldwork when asking how services are modelled and determining the accessibility for the public. Good access would suggest there is an ethos of promoting improved sexual health for the community and empower them to take care of their sexual health. An integrated model of service provision was explored as a way forward or not and possibly meeting the needs of the public by providing much improved access. Good access was defined as user-friendly, non-threatening and empowering for the service user, or for all groups in society. Reiterating this is not a deductive scientific hypothesis but an exploration that enquires of qualitative material, gathering rich evidence, triangulated from a variety of sources and methods.

This study has 20 single interviews, 7 focus groups and 5 electronic interviews, in total 89 participants. A wealth of data was generated and formulated into a grounded theory, as discussed in chapter 3.

The Process of Developing the Theory

I followed the Glaser and Holton (2004) emphasis to aim for the generation and emergence of concepts and theoretical codes, with constant comparison until saturation, rather than imposed concepts and frameworks on to the data that produces a robust theory. Also Strauss and Corbin's (1990) suggestion that the researcher should be theoretically sensitised, which provides an ability to give meaning to the data and to detach the relevant from the irrelevant, however, they should differentiate this from the use of concepts that impose an existing framework on the data.

I was continually aware of these principles as I code line by line, as suggested by Glaser and Holton (2004), forcing me to verify and saturate categories. I developed my own charts and highlighting, cutting and pasting to code and develop categories that would build up into sub and core categories that are saturated with the concepts, constantly comparing concepts to concepts, identifying gaps, collecting more data, or theoretically sampling, and again coding, eventually integrating to a dense theory.

There are levels of coding identified by Bryman (2001) as moving from a basic level to a higher one, or from concrete to the abstract, as detailed by Glaser and Strauss (1967). As I gained more awareness of the content there is a moving away from what is said towards a concern for analytic themes. I was taking care not to fragment and de-contextualize the text. **Appendix 3** illustrates the charts that identify each concept taken from the transcriptions and from which source. The analytic themes are formed into categories, one being core, and evolved into a theory. Each transcript was searched for similar words patterns and themes and then charted. Re-listening to tapes at times was necessary to validate the categories created from the concepts. Data fell naturally into the core category and sub categories, with some overlap of concepts.

It was a meticulous approach at all stages of the analysis, an iterative process of micro level data being built up to form relationships and explanations. This procedure allowed testing of the emergent theory. It was a structured and logical approach, where the steps could be retraced and gives a transparent account of decisions made (Woods, 2003). I made memos as a continual process to develop ideas that raise

description to a theoretical level. Each memo generated new memos and the sorting and writing generated more, avoiding a thin and incomplete theory.

Themes were identified and levels of meaning, values and ideologies will be drawn upon in chapter 5; other people's interpretations of the same material could be different to my own, my perceptions and the frameworks I work within will constantly inform how I interpret the talking material, being highly sensitive to it as an insider also. Triangulation by the use of interviews, focus groups, reflection and observation and the literature, all as data collection, prevented me from just concentrating on the lived experience of participants and not bringing in the social processes that are taking place, this will assist in uncovering the meanings of the participants and encompasses broader structural influences on the phenomenon. It allowed more inductive thinking, not just deductive, and drew more on the abstract (McCann and Clark, 2003).

The substantive theory that evolved should be applicable to a variety of situations. However, there must be a high enough level of abstraction, so there is movement between concrete and abstract reasoning. The users of the theory should be able to predict its starting point, how it progresses and the outcomes (Glaser & Strauss, 1967).

This theory was grounded in 363 concepts taken from the data (Appendix 3). A core category emerged with a theme of **deteriorating sexual health alongside an increasingly sexualized society**, which saturated quickly, dense with concepts.

Sub-categories emerged identifying further themes. These often interacted as well as showing different emphasis and dimensions of the properties of each concept. A hierarchical structure emerges around the core category with the sub-categories. Seven main themes emerged, demonstrating the growing complexity of sexual health care provision.

The 6 sub-categories beneath the core category of deteriorating sexual health alongside an increasingly sexualized society were:

- Sexual health used as a political field.
- Power, obstruction and influence.
- The influence of the commissioner and sexual health service provision.
- Modelling a sexual health services as an integrated service.
- Insufficient workforce fit for purpose.
- The new public health agenda alongside inequalities in health agenda.

Within this chapter I will present the 7 categories, or main themes, using only the raw data as evidence, without comment from myself or analysis within the frameworks of complexity or feminist theory, which I explored within the methodology chapter and will apply to the emerged categories and concepts in chapter 5.

This qualitative research style however, as already identified, accepts that what I choose to use as evidence will be subjective with the lens of an insider, a feminist and using grounded theory to draw out the concepts.

4.2 Deteriorating Sexual Health Alongside an Increasingly Sexualized Society (The Core Category)

The More You Look the More You Will Find

From the 89 participants there is almost complete consensus that deteriorating sexual health alongside an increasingly sexualized society is the main issue within this study when considering the modelling of sexual health services, or how services are provided. This category had populated with 36 concepts (Appendix 3) ranging from relentless numbers in clinics and an inability of the NHS to meet this demand, to higher risk-taking behaviour spoken of by service users. Although the number of concepts within this category was smaller than in others it underpinned most of the concepts in the other 6 categories.

NHS services are identified by all participants as a necessity to meet the increasing needs and demands of the public. Staff and service lead talk is around escalating

numbers of people requiring more services and resources and services not always being available to meet this need as quickly as the government was demanding. This problem was said to be unsolvable in the short term, as when considering sexually transmitted infections then the more you look the more you will find. Hence, they say screening services are victims of their own success as they generate heavier workloads, demonstrated in the following:

“even syphilis has made a come back, this takes a lot of your time to manage on top of very busy clinics, we just are not coping with the sheer numbers coming through the door. The more we look the more we find, numbers keep going go up every year” (GUM consultant A).

All service providers and leads of service talk of having difficulty in offering quick appointments. Many have waiting times of over 2 weeks in year 2005, and some are up to 5 or more weeks. All of the practitioners, except the GP, and some service users, emphasise this issue as a serious problem (74 out of the 89 interviewed). The practitioners note how the government now recognise this as a crisis, as this meant untreated infections are being transmitted in the community and imposed a 48-hour access target to be achieved for all by year 2008.

This was intended, and seen by the service leads, as an opportunity to raise the profile of these services within Primary Care Trust agendas which had been concentrating on cancer and coronary care targets. This new access target is talked about by these same providers as a lever to gain resources for these stigmatized services throughout the process of doing the fieldwork. Some reveal game playing with the interpretation of the target (service leads A, B, C, D, G) to tell the government what they wanted to hear, and maybe to prevent changing how they have always provided services. It appears to take at least another 12 months, into 2006, before service leads start to talk about reacting to this waiting time target, as they realise they can not wait any longer trying to resist change and gain more resources for what they perceive as marginalised services.

Clinical Work Now More Complex

This is background talk as 43 service provider staff, who all had long careers in this specialty, also speak of what they are seeing before them today as causing much more stress and complexity within their work. (A,B,C,D,E,F,G,H,N,J,T,U,E1,E2,E5).

Their conversation is of clients who are younger, as they feel the government health message of delaying sexual activity is not yet a message taken onboard in society; multiple infections, recurring infections and more serious infections they say are becoming more routine. They identify in particular that almost 45% of pregnancies diagnosed, particularly in the under 20 yr olds, are resulting in abortion; there is increasing asylum seeking community with very complex social and health needs alongside serious sexual ill health; stigma and prejudice is still experienced by gay service users, which often compounds their poor sexual health; there is increasing complexity in managing young people within the protocols of safeguarding children and young people, but ensuring their entitlement to confidential services. They speak of rapid change, such as this, over the last decade or so.

A service lead in a large city service (B) seeing 10,000 attendances each year talks of the increasingly complex problems that come through their doors. Modernizing services he felt would make only a small contribution to the nations' health. There was much more work to do across the whole public health agenda with other issues of alcohol and drug misuse being major contributors to deteriorating sexual health:

“We know sexual activity is taking place at an earlier age. Alcohol and regretted sex, exposure to abuse and assault are worrying trends. But unless society changes we aren't going to make a great deal of difference” (Service lead, interview B).

Sexual Health Services Not Always Accepted Within The Community

Some service leads and practitioners voice their concern that the public and media view them as part of the problem, particularly around a notion that they are encouraging young people to have sex by providing these services. However, service providers also note the role of the media in creating an increasingly sexualized

society. They voice that the media creates a dichotomy of blaming and yet also being a root cause of young people becoming sexually active at a younger age; their constant theme of sex within television and magazines, both implicit and explicit. They identify that on one hand they are breaking down barriers and helping society to see sexuality as an aspect of everyone, normalising. On the other hand exposing society to what is possible to experience and raising expectations to have it available, without constraints or context.

“These, services are just not seen as normal, not like cancer or cardiac care” (Lead medic contraception, interview F).

Sexual Health As a Speciality Is Stigmatised /Marginalised

A national commissioner (R), with many years experience within the speciality, emphasises that sexual health is very different and could never be considered alongside other major diseases of the nation such as cancer and cardiac disease. She noted that marginalisation of the subject had implications for the profile of service provision and that discrimination and stigma and the complexity of human relationships impacts on how individuals view themselves and how they use services. This diversity, she thinks, affects how the services themselves are perceived by those who do not have insight to this specialty, clumping together anything vaguely linked to sexual health. The following comment demonstrates the strength of her views:

“They should rename it, “it all started with a shag” because the minute it starts with a shag it’s all banded the same; and of course its not. You know a 12 year old having sex is not the same as a gay man dying of HIV, or an asylum seeker with AIDS. It’s all very, very different” (Commissioner DOH, interview R).

Young People and Sex, Resistance from Adults to Provide Services

School health service nurses talk in a focus group with youth workers (T, with 22 workers) of the need and importance for clinical sexual health services within the

school setting. Where these services are established they are well utilised and young people often advising their friends to attend.

They discuss how these services have often been set up with resistance by some in the parent governor boards and usually only became a reality when an insightful head teacher paved the way for the service. There is concern expressed at the younger age of sexual activity but also the need for expert input to young people who would be assessed under Frazer guidelines to be mature, competent and would be sexually active, despite any input from a sexual health service. The lunch-time allocation of most of these sessions and the environment given to do this complex work is voiced as often unsuitable, with little privacy and pressure to give quick interventions before the school bell rang; these and other difficulties are demonstrated in the following:

“The environment is important. Sometimes these school sessions are in really bad environments like domestic science rooms, or tiny rooms. It doesn’t always feel safe or private for the young people. Sometimes they are called names by other young people when they are accessing the service. Or they just don’t want to access in case they are seen. A young woman coming to the sexual health session said “they think we are slags because we come here”. We have a lot of work to do just to change the attitudes of some young people. We need the privacy for them and to reassure them that we are not judging them.” (Focus group T multi-disciplinary workers)

This group go on to say there is obstruction from staff members who want to keep young people out of the school at lunchtime, or even want to know their business to allow access. The ideal is seen as offering general health sessions everyday in schools and even after school.

Young People Workers Require Changing Roles, Not Always Invested In

These youth workers and school nurses speak of the lack of investment in their services and the limited resources they have; they note that many youth workers do not work evenings or weekends, when they are most needed to be seen on the streets.

They have many years of experience among them of working with young people, but in the main feel their voices are unheard amongst the national strategic approach to young people's sexual health. They identify that services they provide to young people have a wide focus across the whole public health agenda and yet the issue of sexual health, with its complexities and problems, takes up a good proportion of their time. Many of the school health nurses have taken up advanced training to be practitioners for sexual health and are keen to put this into good use. They say when they had first been employed it was not a requirement that they specialize in sexual health and yet it is now fundamental to their role in high schools, both for sex and relationship education and for developing clinical services. They talk of playing a major role in the modernisation of services but feel their value is still unacknowledged by managers of schools and services. They have increasing concerns that the government agenda is also driving young people to have their needs met within the pharmacy, rather than by specialist sexual health services, particularly around emergency contraception and chlamydia screening, illustrated in the following quote:

“Emergency contraception to be dispensed in pharmacies is a bit worrying. It's not addressing so many issues, who's going to talk to them about risk, alcohol, consent and all those things that are aspects of what we do. It could make things worse and be quite dangerous. Pharmacists are not trained in sexual health advising.”

(Focus group T, multi-disciplinary workers)

Young People Workers Feel Overworked and Disempowered

This multi-disciplinary group talk of their experience of working with young people and sexual health issues. They express being at the coal face; placed within schools, youth settings and in young mothers units and yet still feel there are issues that are not being addressed. They are unaware of any authority or power they have to bring change themselves and they feel frustrated that those managers who do may not have interest, or take the time, to listen to what they have to say. They cite good practice models that are transferable to other schools and situations, but of few opportunities to share good practice. They talk of a lack of investment and the pressure of work on

everyone making it difficult to raise heads above the parapet for more creative solutions.

“We would like to give more time to this work in schools, but it is only one aspect of what we do, the kids there need so much more, an hour clinic is not how it should be.” (Focus groups, T multidisciplinary workers)

Clinical Services Often Do Not See School Health as Their Business

4 out of 19 service provider leads speak as if they do not engage with school health (N, H, M, E1) either to work in partnership or to contribute to equipping them for their role in schools. They do not see it as an aspect of third level service providers, despite the evidence of large numbers of young people accessing their services. Many areas have yet to develop school sexual health services and some are aware that school health advisers themselves may be reluctant to take on this work, in some cases they were resistant to it. A national lead for the Family Planning Association (S) has a view that this should be identified as it would impact what was on offer for young people, demonstrated in the following:

“Access could be improved with extended school models, resistant school health advisers should be made to do something else if they marginalise sexual health. None of us want 13yr olds to have sex, but they need support and advice. Those staff who resist should work elsewhere. Young people programmes should be in place, prevention messages are crucial to improve life chances.”
(Interview S, service lead national FPA)

Young Women Talk Of Early Sex Regret and Taking Responsibility For Contraception

A focus group of 6 teenage mothers (W) talk about boys not taking responsibility for contraception and still leaving it to the girls.

“The boys still expect us to go to the clinic.” (Focus group W, teenage mothers)

They observe that even in their generation little had changed between the genders. Fatherhood is also said to be just accepted by them and not cause any great anxiety. Delaying early sex as a government message was thought to be a good thing by this group who talk of regrets at having sex at a very young age. However, over 15 years is not perceived as particularly young by this group who averaged 16-17 yrs. They talk of having gained most of their sexual health information from the school health service; however, they did note parents were quite easy to talk to in today's society. Girls asking for condoms and having access to condom schemes they see as fairly normal and not too embarrassing. However, they also note there should be more sex and relationship education in schools that encompassed emotional issues. They identify that sex and relationship lessons still concentrate mainly on the mechanical aspects of sex, with no mention at all of how sex involves emotions and relationships. Gaining sex education and access to services, they emphasise, does not encourage young people to have sex at an earlier age.

Excluded Young People Miss Out on Information and Take More Risks with Health

Another group from a young offenders project (X) speak of not having sex education. These are excluded young people who acknowledge missing out on the traditional lessons, even if the lessons were not particularly adequate. Within this group the young women are very vocal and the young men quite shy and quiet, one even leaving the room when he became too uncomfortable. The girls admit going to the sexual health service but the boys are trying not to engage with the subject. The girls also say the waiting area in clinics is intimidating, even just by the fact that there could be boys waiting. Their solution was to have condoms available within this project so you did not have to go too frequently to these clinics. The admission of being sexually active is not hidden and seen as normal by the girls.

Another group of workers for a disadvantaged area (Y) spoke of the lack of self care seen amongst these young people; alcohol and drugs played a large part in the risks

taken with their sexual health. They say condoms provided by the scheme are not always taken or seen as important. The young men they work with are perceived as particularly high risk takers and they related this to their lives generally. They state that health was not high on their agenda when living on state benefits, with few aspirations and second and third generation unemployment not unusual within these families, alongside second generation single parenting.

Gay Men As Service Users Value Health Promotion Input From Services

A Focus group of 12 gay men (V) talk openly about their more frequent need for sexual health services. Their lifestyles not always, but often, mean they take greater risks with their health. Health promotion and prevention for this group is seen by them as vital and not just the provision of clinical services, although they have a significant role to play in the prevention of ill health. Their need for services to meet wider needs is demonstrated in the following:

“We need much wider health promotion services though, but with a talking service included, not exactly counselling, just somewhere to go to talk. That would be a good aspect of services all in one place. You know, more care for emotional and mental health issues connected to your mental health rather than just sorting out your genital area. When you’ve taken a few risks, maybe you just need time for seeing the health adviser, even when you’re not that worried about having an STI. ” (Focus group V, gay men.)

Gay Men Want More Accessible Sexual Health Services, Risk-Taking May Be Part of A Lifestyle

They talk of the culture they are part of that gives permission for many casual partners. That culture they say is also investing in promoting staying safe, but risk implies not always being safe and unprotected sex was a frequent aspect of the lifestyle, even if awareness is high. They emphasise that good, accessible services are vital to quickly identify infections that not only are a risk to themselves but also to their future partners. This group talk of being very aware of the dangers of HIV and

the present syphilis epidemic, alongside other STIs that are prevalent in the community and increasing each year. They say about how they meet regularly as a group, being long established with a health promoting and awareness aim, but also with an empowering focus to equip them to cope with the marginalisation and prejudice they face daily in their lives. They mention society frequently stands in judgment of them and they need to gather together and support each other in their struggles.

Practitioners Talk Of Changes over Time and More Open Talk from Service Users

The 6 integrated nurses (U) speak of the changes they see from their clinical work. Their experience of caring for gay men shows these service users now talk more openly about chat rooms and the increase in levels of sexual activity in an open “market”; some using cheap air travel to have sex weekends in Europe and not all of it safely. They say they are now seeing more serious diseases than they used to, such as syphilis, an infection thought to be rare until the last few years. They comment:

“Young women talk about how they make a living as escorts; these young women can be educated and middle class. Sex in the open, voyeurism, swinging, involving heterosexuals, it often comes up, they don’t seem to mind saying so.” (Integrated nurses, Focus group U)

The normality of talk or disclosure is what staff, who have been longer in post, are expressing. Other new work they were remarking upon, from the last few years, is an increase in African community with HIV who were seeking asylum. Although they noted these service users are not openly talking of sexual partners, as it takes time to build rapport; they say it would often be at a later stage that some disclose that sexual partners have been put at risk of HIV and that there is fear of speaking of their status to other Africans. They remark that they carry shame and guilt and because of it risk infecting others.

Everyone talks of major sociological changes that staff, service leads and service users thought needed to be considered when planning how sexual health services are provided.

4.3 Sexual Health as A Highly Political Field (Category 2)

Sexual health as a political field is raised by 43 practitioners and service leads, from a possible 52. They all explain the issue of their speciality being highly political affects what resources would be allocated and hence how services could be taken forward or modernized. There are 66 concepts drawn out that fit this category. These range from government targets being unrealistic to these targets bringing new resources. The changing culture and fear of change from clinicians features strongly.

Marginalised Services and Fighting For Resources in a Changing Culture

These service leads and other practitioners say they have introduced change because of this common theme, lack of resources, using a cheaper workforce i.e. nurses, and integrating contraception and GUM skills and how services were provided, because they have to reconfigure everything they have to gain better value for money. They have not been able to attract any resources during this process. The marginalisation of sexual health as a specialty is said to be obvious to those who had worked in this field for many years. This is illustrated by the following service lead:

“The resources we have in the way of buildings, rooms and specialist nurses are so limited and under resourced. The politics of sexual health have become difficult as historically these services were pushed into a corner, a Cinderella service. Moving from a charitable family planning service to the NHS (contraception service) it hasn't really been resourced appropriately. The aspect and level of specialty around contraception is never really acknowledged.” (Medical Lead contraception, interview G)

Sexual Health Services Lagging Behind Other NHS Services

Two leads speak of historical evidence of Trust boards not mentioning sexual health in annual report activity and of scathing or joking remarks made about the service by senior personnel. Also, that resources are seen as needed for more worthy causes and sexual health services as somewhere that was accessed by other people, not normal people. They also note because of this lack of investment technology, as an aspect of modernisation of most other NHS services, is lagging years behind all other departments and there is a desperate need to bring things up to date, to modernise and to meet the needs of the new NHS agenda. This service lead illustrates the level of frustration felt by most of them:

“Organisationally it is very complicated, we are straddling 2 PCTs and 2 SHAs. The two Trusts have historically never trusted each other. The service is caught in the middle. The service is under resourced and the PCT is financially driven. There has been a business case for integrating sexual health service; the building alone will cost £750K. Presently that is incompatible with local politics. One PCT is in very serious financial difficulties. This is the worst accommodated sexual health clinic in the country, but investing capital is too risky for a Trust in financial problems. We presently only have 3 rooms and no space for counselling. Such a large organisation doesn't share information with us because of the lack of trust. It is a difficult environment to work with. The sister service is in a porta-cabin, we would welcome more integration here but we feel we are going backwards. Regarding the Choosing Health money, there is no confidence that the Trust listen to the service leads, although there is a gesture to set up groups to look at it. Organisational change is dispiriting. I am not cynical by nature but after 11 years I have lost the energy and feel demoralized. Over that time STIs have increased by 800%. I am constantly asked for data but I am never given anything back, we only recently installed an I.T. system for this department.” (GUM physician, interview D)

Genito-Urinary Medicine Not a Popular Speciality

Others mention that the careers of GUM medics progress very fast, as it is not a popular area and hence, as there is little interest in it they are often left to get on with it, with little outside interference (E, F,G,H). They note how the marginalisation of the service often matches the marginalisation of their client group. The GUM leads (A, B, C, D, E1) are aware how the early 1990s saw changes in services, they are now seeing clients with HIV/AIDS. It is frequently referred to that GUM services are engulfed in secrecy and confidentiality, which strategic and national leads (P, Q, R, S) and some contraception leads (E, F, G, H) think the GUM physicians themselves pursue when any outside interest is shown to look at internal processes.

GUM Services Have a Legacy of Secrecy and Poor Environments

Just as the clinician voiced, other service leads say it is not unusual for these services to be housed in poor environments, with inadequate space and staff, within inappropriate locations at the back of hospitals or in porta-cabins, long overdue for re-location (A, B, C, D, R). All the service leads and practitioners felt there is a lot to recover from when suddenly the nation's poor sexual health becomes important news and NHS organisations are beginning to look at this area to produce results. Although they also feel organisations are still reluctant to give it the resources needed to bring that change about quickly to really have an impact on the community's health.

However, 5 highly motivated service leads speak of lack of resources not holding them back from modernising. (I, J, G, L, M) demonstrated in this quote:

“But the present lack of resources hasn't stopped us from making the best of what we have by reconfiguring where we can. We give real value for money. We try to normalise services.” (Medical lead contraception, interview G)

Some NHS Trusts Still Not Taking Sexual Health Seriously By 2006

Encompassing the sexual health targets of reducing teenage pregnancy, reducing STIs and improving access, within Local Delivery Plans for PCTs and health partnership with Local Authority plans is a question area asked of all the service leads and it was said where Trusts recognise this as a priority area resources are beginning to flow, or certainly change was expected; however, there are 4 leads who have not been invited to contribute to that plan or are acknowledged within it. They say many Trusts by 2006 still do not take seriously the target to reduce waiting times for a GUM appointment to 48 hours (B, C, D, E, G); illustrated by this service lead:

“The waiting times within the GUM service is inhibitory to the public and referrers and it’s maybe taking 2 to 6 weeks for an appointment. We are doing more and more GUM within our contraception services, as they don’t seem to realise they have to change, so we will just get on with it, doing screening as well.”

(Medical lead contraception, interview G)

People with Power Not Using It

The service leads and some practitioners imply belligerence on the part of their senior management in the organization rather than at provider level is a key to not getting resources allocated appropriately. It is voiced that the targets government have set are unrealistic and lacking in evidence as needed in the first place. They identify that the work-force are also not totally onboard with the government drive which is putting increasing pressure on services; targets bring performance indicators and published results and hence competitiveness, which has not been evident previously, bringing more pressure. Some senior clinicians (A, B, C, D) think opinions of those working in the field are not encompassed within the political agenda, as seen in the following quote:

“I feel unlistened too and that other agendas are driven by those who don’t know much. I am tired of talking shop with no outcomes and

rubbish projects. People with power, but what are they actually doing?” (GUM Physician, interview D)

Practitioners Not Convinced Modernisation Plans Are Evidence Based

The models of service that are being developed to meet the increasing demand are not always felt to be evidence based by one commissioner; his personal view is diverse from a mainstream view:

“We need to analyse what is the modernisation process, is it allocating resources to GPs and would an integrated sexual health service embrace that sort of development or do they see it as a threat or diffusion of service. There should be discussions regarding level of investment or even disinvestment to develop more GP services.

What does modernisation mean? A euphemism for delivering what the government want. It means delivering the principles of this particular government, then that means personalised services, community services and choice is actually what captures those policy imperatives. Would they sit comfortably with an integrated service? I think you would have to show greater diversity and more choice to respond to that agenda.” (Commissioner, interview P)

Allocated Resources Not Filtering Down To Services

Funding that has been made available through the Choosing Health agenda of 2004 to address resources within sexual health is frequently referred to as not going to be filtered down to services in 2005. All 19 service leads talk of Choosing Health priorities, in the first year of its release 2005, raising hopes for the specialty, but because the money is not ring fenced, cash strapped PCTs use the money for other things. The following comments capture the commonly expressed low expectations for investment or for involvement:

“It is unlikely Choosing Health funding will make a difference because of the Trust deficit and money will be used for that. I

haven't been asked for my opinion on modernising services, or about the LDP targets. There are no real plans for sexual health, no strategy." (Medical lead contraception, interview H)

"There will be misappropriation of funds from Choosing Health money allocated for sexual health nationally to shore up the PCTs." (Service lead, interview J)

A Suggestion of Underlying Gender Issues

Within this political field gender issues are also voiced. The 4 contraceptive service leads (E, F, G, H) note that across the nation, their services are headed by female, usually part-time, associate specialist medics; whereas the genito-urinary medicine side is led by medical physicians at consultant level. They point out:

"Females doctors doing contraception mostly do not warrant consultant status." (Lead medic contraception, G)

They also raise the issue that contraception services are accessed mostly by female patients and that this built on the gender aspects. They note this as another area of marginalisation and unacknowledged areas for investment. This gender issue is also seen by them and two physicians as preventing services working together easily. They feel this all contributed to themes of power and politics within sexual health services.

Primary Care and the Politics of Sexual Health

16 out of 19 service leads refer to the Government's attempt to involve Primary Care and GPs more in sexual health, making specialist services a level three service to equip and train GPs to become an enhanced level two service. However, they also note that five years on there is little movement in this area. Unless GPs had a special interest that they wish to develop within sexual health, this issue remained static. They comment on the increasing workload for sexual health specialists that appear to be relentless, as other areas are not keen to take this work on. They identify this as an

example where the specialist services feel they have not been asked for their opinion before the policy was driven; as illustrated in the following quote:

“Primary Care is saturated with work; they don’t need to look for extra work. Why would a GP open a can of worms when they can refer on?” (GUM Physician, interview C)

Training GPs Puts More Pressure on the Specialist Services

All of the clinical practitioners and some service leads (52) refer to this constant training of GPs to provide level 2 service as bringing extra pressure at a time when numbers of service users are increasing dramatically. They say this training rarely results in GPs providing enhanced service for sexual health, but actually more often they begin appreciating the complexities of it and refer patients to them. Finance is said to be the most likely reason why a GP would choose not to work within sexual health, it was much less lucrative than primary care work. They explain specialists within sexual health provide a cheaper service for the PCTs and do not gain funding that would have been given to GPs if they had provided this same service, or if they had attended a gynaecology department. Practitioners feel this all impacts a sense of sexual health service providers not being valued (E5, B, D, E, F, G, H, I, N, O, Q, R, T, U, V); demonstrated by what these contraception leads say:

“There needs to be more support where there is little enhanced services being picked up by Primary care and the GPs. The PCT should be able to use that same money for enhanced services when it is not being utilised by the GPs.” (Senior clinical service lead contraception, interview E)

“GPs haven’t become second level service providers as predicted in the sexual health strategy. There is just nothing in it for them. Very interested practices are quite rare. They see small numbers only. It involves quite a time commitment in training. They would probably rather commission the service from elsewhere. Practice based commissioning will only work for certain specialties. Probably

where there is long waiting time and chronic illness. Even the principle of practices working together will prove to be difficult.”
(Medical lead contraception, interview F)

GPs not Engaging with the Opportunity to be an Enhanced Sexual Health Service

A GP (E3) notes how second level service provided by GPs is still being pursued but it is questionable whether this will contribute to a Local Delivery Plan when as self employed businesses they do not have national targets and performance indicators to meet. Other service providers question what is the lever to motivate them? As seen in this service lead’s view:

“How will the data from GP sexual health enhanced service be captured to see if targets are really addressed?” (Service Lead, interview I)

A GP with a special interest in sexual health (E3) identifies that practice based commissioning or enhanced service for sexual health has not been taken up in her practice because they are located next to a sexual health centre providing integrated care. She describes the high standard that was provided in this service and that patients could be seen promptly. Specialist skills around partner notification are said to be unappealing to GPs, alongside other very specialist skills that would be required before they could work as a second level provider. This same GP spoke of the political emphasis now given to sexual health that had left other specialties in the shadows, such as respiratory services.

The Service Users View of GP Services for Sexual Health

The service user’s point of view that the GP would be convenient however, would not necessarily be the first port of call, or the place they felt safest with their sexual health. This is demonstrated in an extract from the gay men focus group:

“I am wondering how will the reorganisation of PCTs affect services. I mean does anyone know what is going to happen, will they be combining all the services into one? It’s no good just having a city service you need local services as well to make them accessible. It would be good if you got a decent service from GPs so you didn’t have to travel, but the way things are you would still have problems getting appointments. For gay men that could be a particular problem as many aren’t “out” to their GP. They would need huge amounts of training anyway; and GPs are often more embarrassed by sexual health issues than the patients.” (Focus group V, gay men.)

This group voice their vulnerability to poor sexual health and their need to access sexual health services more frequently. They feel their experiences need to be listened to more closely to hear the detail of their worries and some of the solutions they would like to see materialise in their local areas.

A More Objective View of GPs and Sexual Health Service Provision

A lead for university education for the professionals (E5), who has specialized in sexual health education for 13 years, has clear views why GPs are not taking enhanced services forward to any great extent. She notes that the National Strategy for Sexual Health did not match the General Medical Service contract. This is alongside GPs having little awareness of what enhanced specifications were required to develop comprehensive sexual health services and lack of confidence around sexual history taking and assessing for risk. However, she also points out:

“There was little gain for GPs in monetary terms when the recent framework of quality assurance allocated only one point for sexual health and that is the crux of why it is not pursued.”
(Education provider, E5)

Targets Used As Levers to Gain Investment

Service leads note change for some sexual health departments, over the last few years, has been dramatic and rapid and they also point out that many have been slow to admit it needed to happen, but that over a decade it is significant change for those who have embraced it and frightening for those who still need to go through it. A service lead validates this by saying:

“Change is difficult. But the services are very different to how they were 10yrs ago. When you think we were just duplicating GP work and nurses were just hand-maidens to doctors. The documentation used to be very poor. We weren’t really accounting for everything we did. But nurses have been keen to get on and work on their own. The changes have been more difficult for doctors. They after all, no longer have the hand-maidens. Getting rid of white coats was even difficult for the doctors. New nurses are more prepared to move into more senior roles. More prepared to challenge and not accept the status quo.” (Senior clinical lead contraception, interview E)

Some service leads speak of a recent government decision to invest limited funds in sexual health service buildings, which meant only some were successful in the bidding process. This process, however, has relied on motivated service leads and commissioners to pull together a business case within a time frame. For some of those that were successful it brought sudden capital for investment and an ability to plan holistic services (A, I, J, K, L).

One area lead speaks of success in bidding to become a pilot site for an integrated service, because of the drive of a very motivated commissioner; but she is aware not everyone was onboard with this vision when it was applied for and she regrets there was not more partnership work at the bid stage (K). This caused her more difficulty in getting modernisation accepted by the team that now have to work within a new model of integrated service instead of silo-centred contraception and GUM. This commissioner ensures that the senior management form a steering group and the chair

of the PCT is a member. This then gives the authority and continued drive for the project.

Informing and Including the Hierarchy to Get Services Noticed

Another area lead talked of shouting long and loud to ensure the board of directors are aware of the work that they do (J). This is found to change their perspective of the whole service and they have become more included in planning and are held up as an example of good practice for others developing new models of working. This service lead feels because of the politics of sexual health they had been left behind when other NHS services were progressing; but over more recent years by taking this strategy there is obvious rapid change, with their needs now being well resourced; she illustrates this in the following:

“The service has grown and modernised over recent years and is highly regarded. Previously seen as a soft area, low priority. The targets have helped get us here. This government has taken a big risk and the momentum has grown. But there is always more to be done. With waiting times and access issues, we all need more money for capital for estates to provide more and better environments. Normalising sexual health services will really help to improve access. We ensure the board of directors are here at least once a year, once taking a service user with us, it really makes a difference. The job is to sell this service. Issues change. The focus changes. What young people are saying changes. We will need to keep it on the agenda or it will drop off.” (Service lead, interview J)

She also goes on to explain that targets are good levers for change but possibly a little unrealistic to achieve, she says they are the carrot for everyone to work hard for and to invest in, nothing more than that can be done. Her pragmatic approach is illustrated in what she says next:

“I don’t see the targets as my personal responsibility. We don’t have the ultimate control of stopping kids from having sex. I just do my

best to improve things. I am not really convinced we will achieve these targets.” (Service lead, interview J)

Informed Choices that Affect a Target

The focus group of 6 teenage mothers (W) is talking about the government target of reducing teenage pregnancy and the recent message of delaying early sex. Their views express that they also think it is important to wait until they are in a stable relationship and have somewhere to live. The average age of this group is around 16-17 yrs and they view very young sex as regrettable; whereas they see themselves mostly as mature enough to make their own decisions. In fact they take advantage of the researchers’ sexual health knowledge and three of them ask to have contraception implants removed that evening, as they are planning second pregnancies. They explain just as most parents want brothers and sisters for there babies, so do they. They talk of having all the information, of being aware of what they are doing. They say they are not being caught short, as in their first pregnancy, but are planning this one, even though their babies are still just weeks or months old, demonstrated here:

“I’ve talked about it with him, we want that implant out, might as well, by the time it comes this one will be toddling.” (Focus group, W)

Commissioners Struggle with Sexual Health Politics

Sexual health is talked about as a particularly difficult political arena by the 3 commissioners, who identify they constantly check things out with those who are providing services, who are more experienced then themselves within the specialty, as seen in the following extract:

“Commissioners can have little or no expertise which allows the service leads and clinicians a lot of power. No-one else will have an opinion and everyone will defer to them which adds to the marginalisation of the service. Only a small number of people have the information and able to talk about sexual health. Hence, a small

number of people are fighting the corner of sexual health. Amazing that it is not seen as a core service yet is an aspect of everyone's life. It's not cross-cutting strategically in policy, it is always separate." (Commissioner, interview P)

Entrenched Views within GUM Services Could Be Helped By Networks

Entrenched views and practice within GUM services is a common theme from all working outside of GUM and even some within it. A suggestion by a commissioner (Q) for moving this forward is to use the network of regional sexual health services where senior service leads, clinical and non clinical came together for support and development, illustrated here:

"As a regional strategic health authority lead for commissioning sexual health I can ? this as a vehicle that could bring much needed change. Networks are important to changing people's views, in people seeing the benefits and peer pressure helping to move it forward. Networks could also function badly, benefiting only the minority, such as the consultants if the forum is allowed to focus on their professional needs and only to reinforce their own views. It would need to develop and may need to reform as wider broader issues are encompassed. The dynamics of networks can be difficult if they do not have clear objectives, this is particularly so because they don't have any authority. As a group, to develop good practice it is a forum that could work well or they could become a bureaucracy in themselves." (Commissioner, Q)

An Integrated Sexual Health Network Could Support Modernisation Plans

However, this commissioner noted each organisation does have its own responsibilities; a network could be set to fail if the model is not understood. She felt a network should give added value in terms of the overall picture and practice and that networks have been a big part of the NHS. She identified there would need to be a lot

of relationship building with mature relationships and trust built across the partnership. Her example of a Manchester sexual health network that had spent a couple of years planning and had become very functional with the right people on board, even those with the entrenched views. But it required good management, with a good chair, someone who is respected. This S.H.A. commissioner notes the complexities of such a forum which could not be imposed on anyone if it is to function well. However:

“I see how a network that is integrated with all the links would have added value around practice and modernisation, rather than just for SHA strategy.” (Commissioner, Q)

Service Users and the Politics of Sexual Health. Issues of Asylum and HIV

At the other end of the scale of politics and sexual health are the service users who were greatly affected by this as an issue. 10 African women, with HIV and seeking asylum (Z) talk of needing sensitive services who understood and to whom they do not have to relay their stories too repeatedly. The Home Office is the biggest worry for them in their lives; it affects everything, more than HIV as illustrated in the following:

“The Home Office is a sickness without medication.”

These African women are keen that people tell others about their plight, they want people like me to know how it is and how they are treated and how it affects them. All speak out about the fear of not knowing when the Home Office will come for them. When they see a police car approaching the hostel they worry who it is coming for and where will they be taken to next? One said:

“If I get sent back it will be a death sentence. ”

They also talk of trying to stay well and healthy but identify the strain of all these worries:

“You cannot afford food in Africa never mind paracetamol or anti-retroviral treatment for HIV. These worries take your strength away and affect your CD 4 count (immune system measure).”
(Focus group Z, African women with HIV and asylum)

They discuss not always having a good reception in the UK and say general NHS services often feel unsafe when their diagnosis was disclosed. They ruminate about fear when GP receptionists open sensitive letters and ambulance crews ask about diagnosis in front of neighbours. Using an interpreting service for one lady had resulted in her neighbourhood and child’s school being informed of her diagnosis. There is pressure to move away and hide away, but she is persuaded by the group to take courage and see it through. They are telling me how the politics of sexual health and how services are provided does affect the most vulnerable.

4.4 A One Stop Shop: Modelling a Sexual Health Service as an Integrated One, Bringing Services Together (Category 3)

A key question area of the semi-structured interviews is around views on integrating services, principally bringing together contraception and genito-urinary medicine (GUM) departments, under one roof and practitioners being multi-skilled across the service. I drew 55 concepts from the transcripts that fitted this category with a wide range of views from this model offering more choice and meeting needs to modelling not being top priority among the pressures of the workload.

Mixed Views on Integration Even Within a Service

This is often a subject the service leads are keen to talk about and it reveals a mixed and varied interpretation of the meaning of integration, for example:

“Integrated sexual health services are a good idea, after all contraception and GUM share a common client. Reducing infertility and STIs are targets for both of them. Physically integrating services results in better use of resources and, in the long-term, better

capacity, use of buildings etc. The staff are all talking to patients about the same subject, sex.” (GUM physician, interview A)

“Someone giving up half a day of their life to come to a service, might as well have a full service and have all their needs met, getting maximum health gain.” (GUM physician, interview C)

“I feel integration is essential for good practice. Many patients require both services concurrently and integration allows for opportunistic screening and contraceptive provision. You need to maximize the opportunity and engage the patient quickly.” (GP with special interest in sexual health, interview E3)

Some Professionals Restricted by Views of Colleagues

10 out of 19 senior clinical service leads voice they are keen to take forward an integrated model of provision but they themselves are restricted by their colleagues’ entrenched views on single centred services, often perceived as silo-centred and stuck in a historical mode; (C, D, E, I, J, K, L, M, N, O, Q,) demonstrated in the following:

“Integrated sexual health must be the way forward. It’s needed for all groups, it allows complex needs being met. Especially for the hard to reach groups such as the black and minority ethnic groups and young people. The evidence is there, people want holistic care. If you refer on you know they often won’t arrive. People want all the services at one point. That’s how I would want it. We’ve been slow to move forward with this way of providing services in this district because there are professionals holding on to their own single specialisms. There is resistance to change, and others are just passive.” (Contraception lead, interview E)

Unclear Direction for Service Models and Using the Workforce that is Available

Comments generate from 11 commissioners and some national leads around a notion that services evolved over time to suit the service provider rather than the service user, or service leads thinking they know what the service user needs. Some service leads express there are few examples of using evidence to develop models of service and that it all seems to depend on the change agent and their professional background or experience, even their ethos or personal politics as an underlying driver to how change will or had taken place. There is talk of levels of integration, possibly meaning a personal interpretation (B, C, D, H, I, J, N, O, P, S, E1) . Integration is even talked about as a part of future plans by two service leads yet they are advertising for single trained specialty staff and running separate clinical sessions and just meeting present service demand. Working with what is available in the employment market is said to be a possible reason, illustrated by the following:

“Some places advertise for separate staff groups and provide very separate services. After all, there isn’t a lot of staff around with the skills needed, therefore just meeting the immediate need is what happens. Some staff groups such as school nurses are often keen to get involved with sexual health services and offer services within the school settings. But the culture of the organisation has a lot to do with it.” (Senior clinical lead contraception, interview F)

Nurse led one stop shops are mostly spoken about

One-stop shop is an aim of most, although not all, of the clinicians and service leads interviewed. Having a sexual health centre is definitely seen as the way forward, although they note that clients would not always get every need met at one consultation. Identifying an area, environment or new build, for the specialty seems to be the main focus, with an expectation that this will raise the profile of the work and the service users will come to it. 14 service leads, out of 19, and 6 specialist nurses, are determined that integration is on their agenda, in whatever way it is modelled, and are aiming for a nurse led service as a major aspect of that model.

Integration Model Often Driven by One Person

25 service leads and practitioners identify that the way this model of service is presented is often driven by one person. It is also implied good value for money and quality of provision is what justifies their interpretation of a model of integration. These were the concepts that are thought to help achieve an improved outcome for the public. One commissioner voiced where the actual model is validated was questionable, but it seemed the desired goal of a service model is very open to personal influence. The following quote demonstrates this point:

“The Government refers to this model frequently but they don’t say how to do it. People start to concentrate on waiting time/appointment targets and don’t really address the real issues like integration; it takes the focus away from the how we are providing services, just requiring that we provide them quickly enough. Also we need to tackle barriers, why do people resist? They don’t say, they don’t talk about it rationally without giving personal opinions. It requires good leadership to tackle the barriers.” (GUM physician, interview A)

Integration May Not Be Seen as Core Business in Light of Achieving Targets

This aspect of an unclear government directive around integration was implicit in much of what was said around this subject. A health adviser (E2) also notes that there are many differing views on what the definition of integration is and a supposedly integrated service which she had visited is providing separate services on separate floors of a building. Another lead nurse for a GUM service (E1) expects her nurse team to be trained also in contraception, but then they work in the single specialty of GUM and are given no opportunity to apply that aspect of their skill. This is a very busy specialist STI department and they say they just can not see the wood for the trees. The government target of achieving 48 hour access for a GUM appointment is seen by this lead to not allow indulgence in other aspects of what the client might require. She would have to go elsewhere for any contraception needs to be met. This service did not believe it is part of the government agenda to work in an integrated

way. It is therefore not seen as a priority within the heavy workload to meet all the client's needs. She thinks this also applies to other target setting by the government. Those around teenage pregnancy are seen as irrelevant to this service lead of GUM, as she sees them as unrelated to her core business of the screening service.

The education provider (E5) has formed more objective views as she has facilitated many sexual health modules to a variety of staff groups and visited many services across the region over 13 years. She illustrates this in the following:

“I believe integration with services under one roof is the only way forward; inter-professional learning between doctors, nurses, health advisers and even voluntary sector and social work, would enable learning from each other and break down cultural barriers and bring more understanding of what the service user wants. My view is that this should bring celebration of different skills and philosophies of practice.” (Education provider, E5)

Primary Care/GPs and Levels of Service Integration

As noted in the second category of the political nature of sexual health a level of integration should have been possible around Primary Care and GPs, as they developed enhanced specialist service. Since the roll out of the National Strategy for Sexual Health (2001), this was perceived by the government as an answer to the shortage of staff and skills. All of the NHS staff interviews reveal that the last five years has achieved little in the recruitment of GP interest. 3 commissioners interviewed start to question if it is the specialist clinical staff creating a protection around their field and not encouraging others to get involved.

Clinical Staff Committed To Getting Others Skilled Up

The clinical staff speak of heavy responsibilities around training and education of doctors and nurses while they are also providing a busy service to the public. They talk of commitment to getting others skilled, but also of a lack of understanding by

commissioners of some of the clinical complexities that are barriers to diluting or devolving the work to primary care settings, or health centres.

Specialist Service Perceived as Dominant and Championing

One commissioner (P) agrees that integration was a good model but not necessarily the only model and may even take choice away from the public by the fact that primary care would be less likely to provide specialist service if it is all provided at accessible and specialist third level. The third level service he perceives as dominant and championing, but is not prepared to dilute what they provide and primary care service or pharmacy, second level service, are not giving the quality or in-depth service, is demonstrated in the following:

“Integrated or integrating, is there an ideal type? It’s about the process, the management, or the change process. I am convinced it is in the interest of the service user that staff are dual trained. But the actual process of integrating is it necessarily the best outcome for the service user, if there is an imperative to commission in general practice? There is a need to establish diversity, a plurality of service provision with other providers and settings. All could compromise or compliment an integrated provision. Finite resources would want to maintain the centre, the hub, but it may have to be taken away to develop a model that wants to drive primary care commissioning. Hence there are some contradictions.”

(Commissioner, interview P)

Integration of Service May Not Achieve GUM Waiting Time Target, but Meets the Needs of the Service User

This commissioner feels integration could take the eye off a government target to be seen within 48 hours, even though providers also want to give quality services. He has some reservations about the integrated model not always being as pragmatic, being less able to compromise quality, as it set out to meet all the needs of the service user and not just some of them; his perception is that it is less flexible and therefore more

Specialist Nurses Feel Poorly Represented and Not Valued

These specialist nurses voice celebrating their progress as a profession and what they provide for service users but also show concern at the way nurses are often presented by the media and perceived by the public; demonstrated in the following:

“Of course the nurses provide a cheaper service than employing doctors. But the NHS doesn’t have the money to be employing doctors in the way they used to. We are the evidence that nurse led service can be achieved and provide quality in a way that the patients want.”

“The quality is definitely better since we became mainly nurse led. Patients are seen more quickly, we give them more time, listening to all their needs, and we don’t constantly check the time. If they need contraception sorting out when they come for screening we get on with it, or when they want contraception and we identify they need screening we provide that opportunity for them, we don’t just tell them to remember to get it sorted out. Young people often would just not follow through.”

“When we think about how this service was seven years ago, you couldn’t even give a return patient a depo injection without it being written up by a doctor.”

“Most of us were midwives, we had been delivering babies for years, we used to stand around handing swabs to doctors, absolutely crazy, just like they presented nurses recently on that Panorama programme showing a traditional GUM department. It was horrific, archaic, presenting nurses in that light, so the public continue to think we are handmaidens to the doctors and that we haven’t got university education and are highly skilled, it made us furious.”

“But then some clinics still operate like that, some even have separate male and female waiting rooms. They need to get real and start to normalise their services. They are living in some sort of strange clinical world, far removed from the real world of the service user.” (Interview U, focus group integrated nurses)

An Integrated Service Provides More Interest for Nurses Working Autonomously Providing Total Patient Management

These nurses say this integrated model and the nurse’s role across it provides more scope and interest for them to be autonomous workers. They note that they enjoy the challenge and that empowerment is the ethos that allows this model to evolve. They identify that it could not develop under a strangle hold of control and obstruction

This nurse group note throughout that there is a knock-on effect for young people and other vulnerable groups of having total care management and not being sent elsewhere to complete their care, when often they would not follow through with this advice. The service has become more accessible because of what they offer. They develop this further in what they say next:

“This service is very evolving; it’s constant change, ongoing, no let up. We have developed as a group of expert practitioners and we are able to influence the change, we do have a great deal of autonomy and influence.”

“We know we would be seriously limited if we worked on other departments, its all part of the ethos here of empowerment. We have challenged the system and as we prove we can take on more we challenge more.”

“This job would be so boring if we worked in a single specialty service. Being dual trained and working across the specialties makes the job so much more interesting and worthwhile.”

“There aren’t enough doctors anyway, so they need us to be multi-skilled. Nurse led service has really helped this service provision and made it so accessible, reducing waiting times, we just couldn’t manage without specialist nurses now.” (Interview U, focus group integrated nurses.)

Professional Development Needed for the Integrated Model Allowed New Ways of Thinking and Normalising of the Service

The nurses identify that this integrated model has taken years of investment and commitment to nurse education, which has also achieved an increase in throughput of service users, but that it allows them to think differently and to provide a completely new approach to patient management. They explored further how it made a difference for them and service users:

“The dual training of nurses in GUM and contraception is what allows this enhancing of the service we provide. We don’t think separately, that would make you so narrow in your practice, we take things further, nurses take things further.”

“Such as when they come for emergency contraception we suggest having a screen for infection. I don’t think that happens in many places. Having the expertise on this unit allows that. But if someone is seen by a single trained doctor or nurse they just won’t get the same level of intervention.” (Interview U, focus group integrated nurses)

This group note that there are other issues that add to the ethos of holistic care and empowerment. There are no uniforms, to reduce any perceived barriers, and to take away assumptions around judgmental attitudes. They claim this makes them work harder at improving communication with the patient; there is no hiding behind a uniform. The environment is seen as important to support patients feeling highly sensitive about attending; they talked of the use of music in examination rooms and the television in the waiting room. Taking away stigma is seen as important and the

integrated model identified as having this effect; being a sexual health centre within an innocuous integrated model is perceived as progressing vastly and is demonstrating many benefits to the service user and to the staff who worked within it. It is described by the nurses as more normal than a “clap clinic”.

Some Services are Silo-Centred and Not “Normalising” the Image

14 service leads talk of the historical place of most sexual health services (A, C, D, E, E5, F, H, I, J, K, L, M, N,) as blinding the possibilities of integrating; very separate buildings, separate training and separate background requirements for the lead doctors did not assist in an ability to see what would help local communities to improve their sexual health, illustrated by what is said by this service lead:

“There is an evidence base already for integrated sexual health service. But the historical, the way services are placed in separate buildings and the way the training is done has not helped integration. Although the contraception diploma now encompasses STI/screening issues and we have built on that. Particularly around developing the nursing staff. It’s not only not cost-effective to have single service but it is inappropriate. People having to consult often three services, when one integrated service would have completed the job.” (Clinical lead contraception, interview E)

“Most nurses in the sexual health services whether in GUM or contraception, are practitioners and only around 10% refer back to the medical staff. We look at the hard to reach groups and see the complexity of what needs to be provided. Providing choice to such service users is important. The consumer surveys are usually positive regarding the service they are accessing at the time.”
(Clinical lead contraception, interview E)

These service leads talk of moving from silo-centred services and blurring boundaries to more seamless care provision. The contraception leads (E, F, G, H) see moving a service from an acute secondary trust into the local Primary Care Trust as often an

aspect that will bring rapid change in thinking and culture with a more community perspective, instead of hospital, clinical perspectives. They suggest this fits better with the new health, preventive, health promoting agenda instead of the post war ill-health agenda. However, they also identified such is the power of some GUM consultants, or the fear of the senior management to challenge the views of this medical stronghold, that they could even prevent this move of service within the community; illustrated in the following:

“We are an acute Trust working with PCTs having difficulty with the budgets. GUM, it should be in the PCT, but the consultant went mad it was like a major earthquake. It’s a deeply ingrained culture. Normalising sexual health services isn’t really happening. There is obstruction around. GUM always feels threatened. Being in the same building, all services together would be the ideal model, with merging and blurring of boundaries. The service would evolve. It would all be easier for patients to access.” (Medical lead contraception, interview H)

Thinking Wider; Implementing Sexual Health Promotion and Consultation with the Public.

One service lead (I) talks of developing good prevention services despite lack of specific funding; she says this district has used HIV prevention funding, provided over a decade, to build up more robust sexual health promotion services and maintained this with teenage pregnancy funding. She suggests it has allowed extensive young people work within the community, integration can then be modelled quite differently; despite there being no physical one stop shop some areas integrate the teenage pregnancy prevention work, the HIV prevention work and contraception services. As time goes on provision of emergency hormonal contraception in pharmacies and chlamydia screening is to be encompassed, leaving only the absence of GUM as a specialty missing as a service.

Using Choosing Health Funds to Modernise

To access GUM service, in two of the districts where interviews took place (I, J), people need to travel out of their own area. However, these leads talk of plans for Choosing Health funds to bring change and to even add drug and alcohol prevention work to their model. Encompassing a wider model with school health and health visiting, they will take on contraception and sexual health as an aspect of their day to day work. In the areas that lack a GUM service they speak about ensuring the future plans include what consultation with the public demonstrates:

“The National Strategy has the evidence for integration and local evidence from the C.A.S.H. (contraception and sexual health) service users shows we need to go for a seamless service. So patients don’t have to move between locations. Giving a better client experience. It allows the staff to develop a whole range of holistic skills. CASH staff see a definite advantage. It’s certainly advantageous not to have belligerent GUM staff. There needs to be layers of integration with school health advising/public health nurses, integration is still happening despite no GUM service. The only complaints we get from service users are the limited services.

Service user consultation will form part of the modernisation. It will be also important to include staff consultation.” (Service lead, interview I)

Non Clinical Service Leads Have Vision and Drive for Integrated Service

4 Service leads employed outside of the clinical remit, particularly in areas setting up new services (F, K, I, J) speak of a clearer, more objective vision of integration as a definite need for service users and the only way to modernise. They say it is important not to be entangled with how a practitioner would prefer to provide a service or what they personally felt equipped to provide. They talk of also envisioning wider levels of integration with other staff groups and services. They consider seeking out more partnership working to add creativity to the model. They express wanting to move

forward meeting the needs of service users and an awareness of the most vulnerable or marginalised within the community. They are not fearful of clinical staff digging in their heels and resisting change illustrated in the following talk from a service lead within a new service:

“Where there is rural community there are different issues to consider. An integrated provision gives both benefits, to the organisation and to the service users. It makes pathways simpler, clearer and easier. Financially it enables us to maximise the resources. Patients are more positive about it. There is shared protocols and understanding. Silo type services only want to protect their boundaries. Setting a service up from new, from scratch, there is much more willingness, and desire to see it work, less resistance. It’s important to involve staff and even going at a slower pace to include them. It’s about getting people onboard and containing the resistance. Integration should help reach the targets through improved access.” (Service lead, interview J)

Micro-Processes Need Attention to Change the Culture

Three service leads (L, M, O) identify micro-processes that need attention to bring accepted culture change for service providers. Other service leads speak of a major leap forward being needed in the thinking of clinicians to consider a different model of provision and not all of them are prepared to give time to this part of the process. This lead is striving for success in this very area, demonstrated here:

“To move it forward we try to listen and talk. Treating everyone as an individual, as well as a team member. Trying to understand the others perspectives. But also challenging what they know, hopefully this will all lead to integration.” (Service lead, interview L)

The same service lead acknowledges this will take time and small steps will gradually lead to the major changes they are hoping for:

“A change programme has been engaged with, it focuses on nurse led, a micro system change. But we have needed outside facilitation with weekly meetings. It has helped progress with some issues and address barriers, it is helping change. We have patients turned away here even without triage. GUM is just seen as doctor territory, they keep reverting to unilateral decision making. We have to improve access, but in the meantime we have to maintain the service.”
(Service lead, interview L)

This service lead notes that the vision to integrate should not be halted by anyone but she is aware that this could happen if she was to leave. She identifies again that it is often a motivated character that will drive change. Another lead suggests a more insidious process to achieve this model of service:

“To get integration you need painful attention to detail and taking small steps, it all allows worthwhile progress. Integrated reception areas are particularly important.” (Service lead, interview M)

The Change Process must be Inclusive to be Successful

This is a service that the lead says has achieved complete integration within one building, but is not actually providing dual services within one appointment. She feels they have achieved an enthusiastic team simply because everyone has been included in the change process. Information is not with-held and everyone is informed as modernisation progresses, but also implementing their own ideas, illustrated in the following:

“There was little resistance. We were all very keen and over enthusiastic. Everyone had involvement in a steering group. Directors wrote up the proposal and then consultation with staff and independent consultants were brought in to interview every member of staff. We were asked what we would look for in an integrated service and what we thought our role would be, what we thought the priorities would be and any concerns we would have. The

independent consultant wrote up a report. This was followed by feedback.” (Service lead, interview O)

This service lead speaks strongly about this as the correct model of provision to bring more people into services and eventually improve the nation’s health. She claims it offers more choice and improved access and less stigmatization of the service itself. To achieve this improved model she believes it will take a change in the culture of providers.

Strategic Lead Observes Integration Ticks all the Government Boxes and Gives Quality Provision to the Service User

A strategic health authority (S.H.A.) lead (Q) with regional responsibility for sexual health talks with a wider perspective on how services should or could be modelled to achieve both the government targets and quality services, based on her experience of what she was overseeing:

“The integrated model is the way forward from a patient perspective rather than separate services. It makes sense from efficiency and access point of view. It is certainly supported from current reviews and evaluations. The MedFASH review shows it is the favourable model identifying links between contraception and GUM with dual training suggested. The future capital funding from DOH. of GUM was to assist with integration, pushing towards it as the way forward. You wonder how services will achieve targets if they don’t move forward to integration. They will have a long way to go. Particularly around nursing leadership and nursing roles, which is a good place to start. Silo-centred services may be sustainable but will miss many opportunities to improve public health. In some places there is so much resistance to the integrated model with views that the two services shouldn’t be working together. Patients should be able to access all their care without there being barriers. Using capital development funding should be used to bring services together. It’s really about entrenched views, some just don’t think

about change. If the services were brought together they would realise the common ground.” (Commissioner S.H.A., interview Q)

A Common Goal to Improve Access, but Remember HIV Service Users

A national lead for sexual health (R) presents the view that integration is not necessarily the best way forward for very specialist services around HIV. Her background was around London services that were in demand around very complex work, where there was a disproportionate effect on gay men and black and minority ethnic group. Then having a designated service for HIV was viewed as perfectly acceptable. She notes the complicated arena in terms of adherence to drug treatment and how people as individuals cope with those drugs and with what is now a chronic long-term manageable condition.

Give Service Users Services What They Want, Where They Want it

However, for every day sexual health services this national lead is an advocate for giving services users where and when they want them:

“But for the bread and butter punter coming through the door who wants “knickers off once approach” they just want to be able to go in and get sorted, they shouldn’t need to go from place to place.”
(Commissioner DOH, interview R)

This same commissioner recognises that integration was not necessarily about having all services in one building. She spoke of it involving the multi-skilling of staff and particularly nurses; it should be about taking services to patients, or to localities, that are convenient for patients. She sees that the consultants actually only need to be involved in the very complex cases and that there is more value in the integrated model with more people skilled to provide more services and improving access.

Integration and Modernisation of Sexual Health Services Brings More Choice

A national lead for the Family Planning Association (S) notes the new ways of modelling services brings with it more choice for service users as well as a better utilisation of resources; this alongside more enhanced service within Primary Care she thinks is the ideal alongside robust education and training opportunities for GPs. However, she notes the ideal model would be an integrated one that included a full range of contraception, STI screening, psychosexual counselling, HIV services and a termination of pregnancy service on-site. She sees this as a real comprehensive approach within a one stop shop, offering appointments and drop-in facilities. She notes a whole systems approach. She acknowledges that to get the GPs up to speed with the necessary specialist education will be a challenge. However, all of this she says will improve access for the public in the widest sense of this term, user friendly, convenient, specialist and non-stigmatising.

Service Users Want a One Stop Shop, Giving Anonymity and Breaking Down Stigma

The focus group of 12 gay men (V) feel integrated service provision gives them more anonymity than sitting in a GUM clinic or an HIV department and they talk of how difficult it is to sit in that waiting room, waiting for the staff to call out your name; well demonstrated in the following:

“Services should always be user-friendly. People still feel there is stigma attached to STIs and they get worried who they will bump into in the clinics, it’s embarrassing. Maybe integrated services would help that, ‘cause you could be there for anything, it would help confidentiality and anonymity.”

“Integrating sexual health services with HIV services would definitely help the stigma. It’s hard for people to sit in those HIV clinics, everyone knowing what’s wrong with you. You need to consider the needs of the patients. When you visit these places regularly you’re looking around to see who might know you. It’s all

embarrassing. Even when you go to pharmacy confidentiality seems to go out the window, you know when they are checking drugs with you it can make you feel very uncomfortable. These pharmacies should have private confidential areas.”

“You hear a lot of horror stories, it makes people nervous.”

“There is so much lack of privacy in those clinics, the waiting room is bad enough but when they call out your name, it’s the worst. People need to be made aware of their options, you know, pseudonyms or real names, so they can consider which they would prefer.” (Focus group V, gay men)

However, they (V) voice concern about many aspects of service provision and particularly access issues. This would not just be access to a building but also to professionals that could give advice and support and not necessarily just for clinical care:

“If you’re talking about good access in the broadest sense of the word for services then there are lots of aspects to it. Mostly it’s got to be in a good location, accessible to public transport, its needs to be a fairly anonymous centre.”

“These professionals also need to be in outreach services where people already go. It could be a non-clinical setting with no crowded waiting areas.”

“Opening times of these places are often not convenient for people working. Appointments are difficult to get on top of this. There should be an option of drop-in sessions, not just appointments, it needs to be a choice of either, with weekends and evenings times as well; people don’t want to tell employers why they have to have time off.”

“But even when waiting for an appointment you should be able to talk to someone about your problems. You need to put your mind at rest. You need to get that advice by phone, quickly.” (Focus group V, gay men)

Service Users Just Want Good Access from Non-Judgemental Services

Modelling of service provision is also not something that would be initially verbalised as it was not high on the agenda of all service users:

“It’s not always helpful when you go to these services that there is often students and trainee doctors looking on. It’s not always comfortable and feels invasive. Sometimes some of the attitudes of staff do feel judgmental. Have the services ever thought about a meet and greet service to help put people at ease.” (Focus group V, gay men)

Some Vulnerable Young People have a Positive Experience of a One Stop Shop

A group of young people and their workers in a youth offending project (X) found an integrated service locally is just what is needed when they voice a need to be seen. They judge this as usually needs are met in full, they are not sent from service to service, and they are seen within a reasonable amount of time. The young people are accompanied by the worker but feel respected and unembarrassed at the reception when all that is required is to tick some boxes and write their name. This had been important to them that they would not have to disclose personal information in public. No appointment was needed when they wanted an implant, they had previously discussed it so it was dealt with straight away. This impresses both the young person and their worker. Time is said to be important to them. Another young person says he arrived there, it was busy, so he was not going to wait as he had other things to do.

Teenage Mothers Say Services Do Not Always Understand Their Difficulties

A focus group of teenage mothers (W) within a Sure-Start project do not want to talk about how services are modelled but they do want to verbalise how it is for them when accessing a sexual health service. There are difficulties just getting there and then they are not always satisfied with the service they receive:

“It’s important to have walk in service; you can’t cope with appointments when you have a baby. I went last week took all morning to get the baby dressed and when I got there they said they were closed for lunch and to come back after lunch. You should be able to just walk in at any time.”

“We prefer female staff, even the GP; I wouldn’t ask a male doctor about those things.”

“It’s really important that everyone is friendly, willing to help you. We feel judged by everyone when you’re pregnant older people tell you to cover up when you’re pregnant. Even when you go in those places the people in the waiting room judge you, looking down their noses at you. Receptionists and some of the workers can be really snotty as well.”

“The reception can be too close to the waiting area. People can hear what you’re saying. Older people make you feel uncomfortable, boys make you feel uncomfortable. It would be better if the place was bigger, so you weren’t on top of each other. You need more distractions in the waiting area, as many as possible. Some places have play stations. I don’t mind how they call you out of the waiting area, first name, second, number it isn’t really important.”

“Because you’re young the nurses and doctors don’t always listen properly, they’re too busy asking their questions. You feel judged.”

“We need to just be able to drop in any time with the babies; it would be good to have help with the babies during the appointment.” (Focus group W, teenage mothers)

There are Basic Expectations of a Service User That Should be in Place

Other focus groups for African women with HIV (Z) and workers of youth in a disadvantaged community (Y) all note the difficulties of getting to appointments and how having a drop in facility is more suited to meeting need and not identifying this as only focusing on infections or HIV, but being generalist around sexual health is spoken of as more acceptable and less embarrassing. They voice these as basic expectations of a service user that should by now have been put right.

4.5 Power and Authority, Influence and Obstruction (category 4)

There are 53 concepts forming this category of power and authority, influence and obstruction. These concepts range from identifying the historical context of services, to fear of loss of position and a deeply ingrained culture (See Appendix 3). This is widely voiced as a key theme that determines whether services are modernizing or attempting to modernize, 23 participants talk about it, mostly the non GUM service leads, but also 2 who are leading GUM. This theme is focused around the roles of medical consultants.

Medical Consultants Role Forceful with Set Agendas, Much is Hidden

They note these roles are strong and forceful, with set agendas, some wanting to introduce change, others resisting it, and some beginning to give in to the external pressure. Much of it they do not speak about openly at the beginning of the interview, but only as it progressed, they spoke of it being a taboo area in other forums; this service lead acknowledges the secrecy:

“There are hidden aspects within GUM, there is work not being done that should be done.” (Service Lead, interview I)

One lead notes how her acute Trust started to consider modernisation and integrating both contraception and GUM services, taking a lead from the National Strategy for Sexual Health (2001) MedFASH (2004) they started to experience problems from the lead clinicians; their service lead when exploring this says:

“Clinicians, consultants, began blocking and de-motivating others.”
(Service lead, interview M)

Another senior practitioner has a similar theme:

“There is professional protectionism from the GUM consultants, creating barriers. Change is common place in this department, but it is only in response to audit findings related to GUM. It is only a traditional medical model that determines how we provide services and driven by the high level of patients with STIs in this city service.” (Health Adviser GUM, interview E2)

This Stronghold Has Been Static for Decades

26 interview and focus groups of service leads and practitioners (40 participants out of 88) speak of things being static for generations, maybe even since post World War II years, within this GUM specialty. However, similar to most other areas within the NHS, they said also that the ground is being shaken as others in the organization, particularly those non-clinical such as commissioners, are being held to account for achieving outcomes; demonstrated in the following:

“The idea of integration sounds excellent, but it often doesn’t happen because of historical barriers. The contraception service was historically more in the community and nurse led whereas GUM was always in the acute, hospital service sector.” (GUM physician, interview A)

Where There is No Stronghold Modernisation is Evolving

Leads and practitioners from departments that are not under such a tight stronghold by a medical consultant, they say this is because they are not seen as important city centre services. They talk of modernising years earlier and give an impression of constantly evolving with the changing public and government agenda. They talk of rising to the challenge and relishing new barriers to break through. They voice that they expect change as a feature of who they are and what they should provide (A, U, I, J).

Obstruction can be Insidious

But obstruction to a service wanting to develop is expressed by many service leads as an insidious process; this is demonstrated by (L) where a non-clinical lead articulated she is being “blinded by science” by the medics to prevent things changing. In the main it is medical obstruction but there is also evidence of senior nurses playing their part in it, and colluding with the medical model of service provision (O).

Unspoken Fear and Belligerence. Protecting Territory

There is also an unspoken fear from experienced physicians confirmed by one of them:

“Resistance depends on who you speak to. For those in large organisations it is even difficult for them to understand, or they have an unrealistic understanding. They often fear the integration as their background and training doesn’t encompass the other specialty. Could it result in people losing jobs? This may not be a realistic understanding but an underlying fear, people don’t really express that but it is there in the background. GUM physicians are basically hospital doctors trained in disease and not really preventative medicine. Not really public health. The curriculum in medical school needs to change, you rely on someone happening to mention contraception, it isn’t actually part of the training. Disease talk is

what the training is all about not prevention. So in a sense it is easier to train GU. doctors than contraception doctors as they are disease focused throughout the medical training years. But it still remains an issue in some clinics, nurse led, colleagues discuss it, they are starting to realise they need help and the person is right next to them, the nurse, and they just need equipping to do the job. They just need to shadow for a while and then they are independent. The doctor can just be there for the complex cases. But even some of the most obstructive of doctors are starting to move forward.” (GUM Physician, interview A.)

Using Belligerence and Targets as Leverage to Get Resources

One commissioner perfectly understands the belligerence of clinicians, used as a tool for leverage when the government is requiring targets to be achieved. His own portfolio has been difficult to drive through a Trust board agenda and he spoke of using new strategies for them to take it seriously:

“Have we got the attention of the clinicians? They exploit the targets as leverage to get more resources, but I am not convinced they will deliver on those targets. But I have to ensure they do deliver on them. I do understand their approach as poorly resourced services in the past they need to use any leverage available to them. Until sexual health is more centre stage in the NHS you expect to get this reaction. They will use every tactic at hand.” (Commissioner, interview P)

Clinical Staff Blinding With Science the Non-Clinical Service Leads to Stop Change

Non-clinical leads frequently refer to clinical staff as protecting their territory and they thought this to be a root for trying to blind them with science. It is obvious in another service, where there is a dynamic non-clinical lead (M), when a specialist nurse lead who is determined not to have a staff group used for public health work

and partner notification, health advisers. It is revealed during the interview that she is convinced these posts are not needed as the nurses themselves would be able to carry out this function. This view of the nurse is created because of a personal negative experience of health advisers, of negative hierarchical relationships in a previous post:

“We don’t use health advisers here, the nurses can use contact slips to give to the patients if they have an infection.” (Lead Nurse, N)

The manager is being blinded by the specialty and starting to express this. She identified that the public health work is not followed through on. She acknowledged their only strategy is to hand out contact slips to those who had positive results as they do not have time to take any other tack, such as to instigate partner notification procedures. She notes that their service is often bypassed, when outside professionals are signposting the public to sexual health services in a larger city service. This manager identified that this blockage has resulted in the service not having health adviser posts responsible for community education and containing and preventing infections. Exploring this within the interview she realises that if they are not in place then the whole profile of the service is under threat, as well as the infections not being managed within a public health model, just as they voice. There was a dawning on her that further changes are needed.

Some Clinicians Honest About Lack of Skill

Three lead physicians are quite honest about fears from colleagues if they are to join with contraception services and noted it is often about their own lack of skill in that specialty; as illustrated in the following:

“Big part of the threat for GUM consultants is that they don’t have the expertise in contraception. But it’s really just back to the cook book. Although integration must stop somewhere and where does it stop?” (GUM Physician, interview C)

Consultants Fearful of Letting Go of Patients to Nurse Management

The fear of consultants within GUM of letting go of patient management to nurses is a dominant theme, even in departments that have a will to move to integration:

“We don’t allow nurse led service without a medic on the premises and nurses are not doing full examinations.”

And yet also saying:

“It’s all simple medicine, both GUM and contraception, looking at people as people.” (GUM physician, interview C)

An optimistic national lead for commissioning is more realistic about what it is possible to change in services and what has to be worked alongside:

“You’re not going to change the person who thinks that the world owes them a living. You know the dinosaur mentality exists in every profession. You only have to look at the police and teaching. It requires a jump out of your safe box, leaping into the unknown. And God forbid that a nurse can do what I do. The fact is a lot of people are shifting; there is some serious good will out there to expand the role of nursing. There is some shocking situations but there is some good stuff as well, places where people are taking it onboard, where people realise they can work much better in partnership than they can in isolation.” (Commissioning DOH, interview R)

Blocking Nurse Led Care Blocks an Integrating Service Evolving

However, this theme of not allowing nurses to do work that had been always done by doctors is very strongly expressed and often linked to the reason why a model of integration and modernised service did not evolve, as demonstrated in this extract:

“The GUM consultant found the nurse led service difficult. Lots of insecurities and personalities became evident. But nurses prepared

to challenge will bring change. It is classic partnership working, the culture needs changing. It will take time for nurses to open their mouths.” (Medical lead contraception, interview H)

Disempowered Nurses are not Working Within Own Professional Codes of Accountability

Non-medical service leads identify that medical staff do not understand or have knowledge of nurses’ codes of conduct and accountability to their own professional bodies and not to the medical profession. Nurses are aware of it but note many do not operate from within this level, having historically in this specialty taken a lead from the dominant culture of medicine; this is articulated in the following:

”The obstructions come from the GUM medics who believe the clinical safety issues are different for doctors and nurses. The nurses are just not empowered. The deputy lead nurse just is not coping with the lack of empowerment. The nurses are more or less told to know their place rather than to professionally develop, incredible, this is the 21st century!” (Service lead, interview L)

More Partnership Work is Needed

The commissioner working nationally (R) also has insight into the obstruction and that there is a need for big change. However, she recommends that people are not dragged kicking and screaming. Rather, she suggests, evidence of good partnership work is needed and providing a space where people can explore their difficulties and develop insight into a broader partnership agenda. She acknowledges this requires serious levels of trust and relationship building before innovation and creativity evolve.

Determination to Modernise, Despite Obstruction.

The obstruction or belligerence spoken of is mostly around the GUM departments. Service leads expressed that contraception services have a willingness to move into

integration more quickly, even starting to do some GUM management themselves rather than waiting for those departments to catch the vision; this is illustrated in the next three extracts:

“The resistance within GUM tends to be higher up; there is worry about dummying down the specialist. Being able to provide the service to more people rather than a platinum service to a few is what we need. We need to be looking at services that do work well like young people services. As a contraception service presently we would welcome integration. Commissioners want an integrated service. We could manage screening for STIs, whether symptomatic or simple.” (Medical lead contraception, interview E)

“But usually it comes back to personalities; the GUM consultants alone can either block or promote an integrated development. As a dual trained practitioner I think much more broadly and give a better service. My colleagues in contraception have in the main taken up GUM training and usually followed that up with sessions working in GUM. As clinical assistants, you don’t see GUM medics doing the contraception work! Although as a service lead you do need to keep your own areas of expertise.” (Medical lead contraception, interview F)

“Family planning has always been very compromising, giving up a lot, to get integration. Because GUM are just so rigid.” (Service lead, interview O)

Strong Management Needed to Challenge the Obstruction

One large city service lead, who has put contraception and GUM under one roof, and frequently presents at national conferences this new integrated model, talks of the ongoing attitudes that still tried to create blockage to having open access to patients. She suggests without strong management this attitude would maintain small clinics at inconvenient times for the public, she expresses this well in the following:

“Every where you go GUM consultants are moan, moan, moan. I say open that door, you are creating the waiting list, it exasperates me, I don’t want to listen to it. We have a 2 week wait for an implanon even. A lot of people you give an appointment to they won’t keep it. You need a mix of appointments for those who need them and drop-in for the others. There is this power thing with the GUM consultants, I don’t see them trying to address it, just constantly moaning about needing more money. What are they going to do when they get this money? Take these nurses and train them to do their jobs! There’s nothing complex about it. Our nurses aren’t even allowed to see symptomatic GUM patients, or do implanons. It’s the GUM consultants that block. We need more value for money. There is laboratory diagnosis in a couple of days so what is the problem. Nurses recognise the conditions when they work in the area for a period of time. GUM consultants need to get their act together and look at innovative ways of solving the problems.” (Service lead, interview O)

Feelings of Rail Rolled into Modernisation

It is also voiced by 8 clinicians that there is a sense of specialist clinical staff being disheartened as they see themselves rail rolled into modernisation models decided by people who had never worked within the service and may not understand the detail of provision. This may be an aspect of why there was resistance to change. This issue is illustrated by a service lead brought into a service because of the team’s resistance to modernisation plans:

“We need a different approach for a modernised service. The vision of the service leads wasn’t initially shared with the team and therefore it wasn’t signed up to. There was no talking through the changes with the team. There was no challenge of the consultants when it wasn’t followed through. They are totally unaware of the

modernising agenda. There was controlling attitudes even at the lowest level.” (Service lead, interview L)

Professional Protectionism and Unilateral Decision-Making

A provider of education to sexual health professionals across the North East of England (E4), who has watched from the wings of the university for 13 years how services had struggled to modernise, easily identifies a medical discourse that creates a strong power imbalance. She notes how decision making is often unilateral and difficult to influence with a mighty professional protectionism guarding the territory. Her theory is that if there was no strong non-medical leadership, where there is no vision, or who easily waned when hitting adversity, then things will stay static. She blames the different training of the two medical groups for contraception and GUM and the lack of insight into anything other than a medical or clinical model of service provision.

A Culture of Disempowered Nurses

The specialist nurse focus group and other service leads (38 participants) frequently refer to disempowered nurses. They acknowledge where a model of modernised sexual health services is to thrive, it is necessary to have mostly nurse-led provision. Most interviewees refer to NHS resources being limited and the nurse being a cheaper work-force in the main. The role of the registered nurse is seen by these participants as key and was thought to need to dramatically change from a doer of tasks that support the medical team, to a fully fledged clinical practitioner with responsibility for total patient management, from beginning to end of the process, as a medic would have. Where service leads are facing the changes they acknowledge it will not happen without this nurse-led aspect; they identify there are not enough specialist doctors to meet the demand, and the NHS could not afford the cost of employing them if there were. However, where resistance to this is raised as a feature there is said to be slow change, if any, and very low morale among the staff team, demonstrated in the following 5 extracts:

“Nurses were deskilled by the medics.” (Service lead, interview M)

“Still doctors see all patients without any triage. Now the nurses are allowed to see follow-up patients only. Nurses need to learn to challenge without confrontation.” (Service lead, interview L)

“But some change is so slow, such as working with the GUM staff. Putting in a new lead nurse has made a difference, moving forward from the mind-sets, finding new ways of working. We need new staff, it is a slow process, drip feeding.” (Service Lead, interview I)

“The GUM service has not quite progressed, modernisation, nurse-led service is not yet happening, although it has to eventually.”
(Service Lead, interview H)

“Modernisation of CASH service will mean nurse led. The aim will be to have dual trained staff (i.e. GUM and contraception). The service so far has relied on nurses and it has worked well. They are a fraction of the cost and good value for money, service users like it. The new GUM service will start out nurse led.” (Service lead, interview I)

A Paradigm Shift is Required

A dynamic service lead (L), herself recruited to move modernisation forward, could see that disempowerment within sexual health service is widespread and ingrained in the culture for every member of the team, not just the nurses, illustrated within the following:

“Staff have just been disempowered. The key to this disempowerment is lack of appreciation of skills and knowledge and to be valued, this has a wide impact. People working unilaterally, managing themselves, just getting through each day. Huge amounts of this dysfunction is due to culture. Consultants working very traditionally. Negativity embedded within the team. A blame

culture preventing risk-taking. A lack of support, praise and acknowledgement.” (Service lead, interview L)

One Department of Nurses so Disempowered they are said to be Frozen With Dysfunction

Service leads speak of nurse disempowerment as insidious and said by one lead of a large GUM department of it being almost frozen with dysfunction:

“We appear as a very dysfunctional team. Unhappy and with constant conflict and then apathy, it’s a very complex situation. It is a very negative unsupportive environment. The nurses are unwilling to challenge, they have no power to challenge with. It is a very closed organisation. Nurses just resigned to getting on and not really engaging. There is no lack of skills and knowledge, just lack of motivation. The larger organisation claims to want to empower but the team is stifled. It is wrapped up with an internal world. It is very destructive, with no energy to sort it out. They didn’t know how to sort it out. Senior management had been unsupportive and had caused their own problems. There was lack of awareness of how they should support.”(Service lead, interview L)

Difficulty in recruitment of specialist doctors, alongside the known politics of managing them, led this service lead to go with what she knew worked well, nurse led service and to bypass the doctors.

Moving Forward, Taking Risks with Nurses

In other instances there is talk of nurses moving forward fast, taking onboard academic training and new skills in preparation for taking on new responsibilities (U, G, F, I, J, K, L). The pace of this process of implementing those skills again is said by these service leads to be determined by the culture and level of medical dominance and who is deemed an expert is an aspect of that culture. They express knowledge is

not always impacting practice, but seems to be sometimes used as a wedge to prevent change.

A few forward thinking senior leads say they want to let loose those who have the ability, seeing it as the only way to increase staff along with the high demand for service and the limited resources available to cope with it. 6 managers refer to nurse practitioners and nurse led service all fitting with the NHS Plan (DH, 2000) and the Patient Led NHS (DH, 2002). Should sexual health services be any different? The following 2 extracts demonstrate this point:

“We would crumble without the nurse led service. We rely on them to run all the school services, refer to termination clinics, do implants and now they are doing coil fits. They are the way forward. Around 60% of our complex work is carried out by nurses, and this is a big city contraception service. They tend to just need to pass things by the doctors, to check things out and that is becoming more rare as time goes on. From their case-load they would ask doctors questions for only around 10% of it.” (Senior clinical lead contraception, interview E)

“Nurse led service is the only way forward, doctors are a very expensive asset, although very valued. Its about getting skills deployed where they need to be deployed, it has been challenging to get this nurse led work in place, but nurses are early adopters of change. You need nurses who are risk takers. The service wouldn't move forward without them. Doctors and nurses working together should be seen as a partnership, with the nurse empowered, but it takes time. Most of our service is led by nurses, all working under P.G.D.s, doing implants, in the future they will do coil inserts.”
(Service lead, interview J)

A GP with a special interest in sexual health (E3) is keen to see nurses take on these responsibilities alongside the many others they would do within primary care:

“There are nurse led services in other clinical areas such as diabetes, hypertension, cytology, using protocols and overseen by the medical staff. Nurse led service run locally works well. If suitably trained, supported and confident, nurses should be able to provide a robust and flexible service valued by patients. As long as referrers are confident that standards are good then there is a sustainable place for nurse led services.” (GP with special interest in sexual health, interview E3)

All Stakeholders Should Have Equal Say, Including Service Users

The non-clinical service leads refer to the many stakeholders within the NHS as organisational change takes a grip. They often speak of who has the most power and influence, or who is perceived to have the most power and influence and what needs to change or can be changed within short spaces of time. Focus groups and some service leads voiced that the service user should have an equal say to every other stakeholder (V, U, T, R, U, I, J, G, F). They also note the reality of this is unlikely in this specialty, as who is going to sit on committees as a user of sexual health services? They acknowledge this as an added dimension to getting service user views heard. 3 medical leads find this an uneasy transition. Others ‘think there should be more balance in the process of gaining views and acting upon them. Most think encompassing the views of all stakeholders, commissioners, providers, service users and prospective service users, or the community, should be balanced and should not be giving power to the loudest and most dominant.

Change Agents or Drivers of Change, Characters and Leaders Shifting the Balance of Power

Change agents or drivers of change, characters and leaders who were envisioned and determined comes through in talk from service leads and practitioners and it is the theme where significant change and modernisation has already taken place (E4, U, L, P, Q, N, G, E2, M). These individuals speak of believing in shifting the balance of power, or who didn’t see it as an issue who did what, as long as the outcome was accessible, user-friendly services provided by competent practitioners and with other

agencies. They were talking of a strategic view, they talk of putting their heads above the parapet and are prepared to be shot down and knocked back, but they are not prepared to give in. They talk of gathering the evidence and have a sense of what could be achieved. These interviews are from those holding senior posts and they identify that with enough power to be able to hold onto their position until they make break through. They are expressing that they are highly motivated and committed to breaking down barriers between service providers and users, to normalise them and make them more acceptable to the community and to health Trust boards, who they say also hold their own prejudices. They admit as service leads they are not always the most knowledgeable people, experts in sexual health, but maybe more objective and understand the wider picture. They talk of knowledge of systems and processes and an ability to question working systems, which allows them to take actions and be seen as risk-takers, within a context of professional knowledge; this is acknowledged here:

“The drive and the vision was one person, the director of the service; you need a champion to integrate services.” (Service lead, interview M)

A dynamic service lead, new to sexual health could see the foundational issues that as a marginalised service has not been addressed over the years and hence the blockage that is being faced now to modernise:

“Leadership and personality can let you down if they aren’t interested in staff development it just won’t happen and they won’t be able to recruit if there is lack of willingness and drive.”(Medical lead contraception, interview F)

The Obstruction Makes Non-Clinical Leads Consider Running Services without Medical Lead

All of the service leads talk of the need for strong leadership with new ideas and vision. They are well aware of the problems caused by entrenched medical views and the blockage on modernisation. One service lead is starting to consider whether a service could be modelled without being led by a physician:

“For future developments there are a variety of models proposed. Consultant led or small steps to nurse led, hub and spoke model using contraception and sexual health settings and building up.”
(Service lead, interview I)

Service Leads Want to Address Clashing Cultures and Obstruction

Service leads speak of characters or individuals blocking change and clashing cultures of professional groups that need untangling to shift attitudes and insight. Many talk of team away days to address this very issue and to begin to gain ground in this area before they can move forward to introduce change. They talk of needing fundamental changes to impact culture, behaviour and working systems (K, L, N). 5 service leads perceived themselves as change agents, knowing how systems worked, what to tweak to make it happen and what micro-processes and systems could add to the pace and type of change.

They knew it also took robust commitment and competence to achieve desired outcomes:

“The new lead is talking to services. But we are just providing clinics, working long sessions and not seeing the wood for the trees; there previously has been little forward planning. The service is provided in a highly medicalised way. It won’t change overnight. It needs a cultural change from all staff.” (Service lead, interview L)

There Was Also Some Talk of Having Good Working Relationships

One focus group from a service that had evolved into an integrated model over recent years has mainly nurse led service and is providing more holistic care, they have moved away from this highly medicalised model. This group of specialist nurses talk of providing clinical care but were seeking to meet all the needs of the client either at one visit or under one roof. They have developed good working relationships with

doctors and work autonomously; they speak of rarely needing to refer for medical support:

“The lead doctors value the input of the specialist nurses, we aren’t mavericks. We all have been here a long time now. Nurses tend to stay once they train up. They feel they are doing a valuable job. The lead doctors trust us, that’s what it comes down to really. They have confidence in us. There is a respectful relationship. That’s what makes the difference. But nurses have to be prepared to challenge, that goes alongside our own accountability, we are responsible for our own registration, the doctor is not responsible for that, we are accountable for our own practice. Everyone can make mistakes, doctors and nurses, we all work to clinical guidelines. The number of problems identified as too complex for us is minimal. But the advance will continue, I see nurses taking on more and more. We are offering so many things here, and young people in particular need more time from us. The nurse needs to continue to develop and not get bored. We no longer define what is a doctor’s job and what is a nurse’s job.” (Interview U, focus group specialist nurses, integrated service.)

Their talk was of achieving a paradigm shift. They are aware that their view and actual practice was quite a radical one compared to others across the nation and that this modernised service has a lot to offer more traditional services.

Looking Out From an Integrated Service with Dismay at the Service Offered Elsewhere

This same service voice amazement at the amount of poor access across the nation when they tried to just telephone other departments themselves; this is illustrated in this extract:

“You want to hear what the response is when you telephone most GUM clinics across the country, just “we are closed phone back”,

even London services. We are rare in that we are here 6 days a week and open 'til 8pm most evening, although obviously our lines are always busy and people can't always get through straight away."

(Interview U, focus group specialist nurses, integrated service.)

The Disempowered Service User

Another focus group, whose aim of meeting together is empowerment, was the African women with HIV and seeking asylum (Z). Ten of these service users are keen to talk of how it is for them when they access services and can be totally disempowered by the experience. The whole group discussed lack of education around HIV issues within the NHS and staff in non specialist departments and primary care not knowing how HIV is transmitted. Some voice understanding how there would be irrational fears of health workers and related this to how it was back home, in Africa. They have experience of not letting people know your status because of being shunned by the whole community, including your own children in Africa. Stories of insensitive care abounded. The women voice they would prefer to go to specialist departments for HIV and other doctors to come to that department, if they needed for instance gynaecology, rather than risk going out to them and face misunderstanding or ignorance regarding their condition. It becomes embarrassing and raises anxiety. The non specialists start to be blinded by the HIV diagnosis and putting all illness down to this. They said it is often a relief to tell your story to one doctor, but when you have to do it over and over again it becomes very upsetting. It is a poignant moment when a woman on my left said:

"They always ask, how did you get it?"

She spoke quietly to me only, saying:

"I was raped and forcibly circumcised, I have nothing to be ashamed of, it is not my fault." (Focus group Z, African women with HIV and asylum)

These women talk of the voluntary sector playing a large role in supporting them in this country. Some identified Tyneside as being a good place to be dispersed to. This is compared to other big cities where the support is said to be not so good. The consensus is that there was more emotional support, not just clinical services; also more help with children and childcare was here. They noted it is very intimidating going to a ward specialising in HIV at first, but it eventually becomes a safe and secure place, not having to explain everything each visit makes it easier.

This Is Not How Service Users Voice They Want Services

Obstruction, poor access and un-modernised service is presenting in all the interviews across the nation. This is in contrast to how the disempowered and marginalised groups who need the services voice how they want them, as user-friendly and accessible (Focus groups T, V, W, X, Y, Z).

4.6 The Commissioning and Provider Split in the NHS and Sexual Health Service Provision (Category 5)

This category has 35 concepts, demonstrating its importance within this evolving grounded theory. These concepts range from good commissioning makes a real difference to service providers, to disagreements between commissioners and providers. The influence and change is possible through this relationship working well and equally the opposite is voiced (See Appendix 3).

Modernisation Happens Dynamically if the Commissioner is on Board and Understands the Agenda

There is consensus from 19 service leads that there is a good working relationship if the commissioner understands the government agenda and works with the provider to determine ways to drive it. It is voiced that modernisation of services will then happen dynamically. They note that it does not always halt change if commissioners are not involved, but that the change agent is often in the middle of a battle to get what is needed to achieve it. They say that battles with consultants can seem

insurmountable when they do not have the support of commissioning. 3 leads do not even know who their commissioners are for sexual health and voice:

“Does the Department of Health actually know who these commissioners are?” (Service leads C, D, H)

A national lead (R) notes the investment in commissioning but says that if they have large portfolios placed upon them then the political nature of sexual health as a poor relation may well place it on the back burner.

This national lead for commissioning (R) talks of a vision and a drive that could completely transform the delivery and resourcing of sexual health services where the needs of the public are prioritised before those of the provider, if the local commissioners really understand the task at hand:

“But in terms of the longer vision that I have I genuinely believe that getting people involved in commissioning for patient need as opposed to service need, is absolutely crucial.” (Commissioner for DOH, interview R)

Effective Commissioning is the Answer to Obstruction

This same commissioner recognises all the obstruction and belligerence that goes on around clinicians and that it could actually be tackled through more support for them from a competent and effective commissioner. This would be someone with a vision of where they want to put resources and use power that is placed in them as a commissioner, but achieving it through working in partnership with all the stakeholders and considering all the barriers and boundaries; this is reflected in the following:

“The consultants are disappearing up their arses with business. What it requires is some serious stand back time and some opportunities for discussion around that. It requires competent commissioning to

take that forward, that is the key.” (Commissioner DOH, interview R)

Everyone Has a Part to Play in Commissioning

One commissioner (Q) notes that everyone has a part to play in the commissioning process. However, clinicians and service leads need support from commissioners and it was not always evident that they receive it. She identifies in 2006 some commissioners are not even including service leads in the development of the Local Delivery Plan (LDP), which will have the sexual health targets built within it, hence, she suggests how could they expect services to deliver on these targets within such a culture? This is demonstrated in what is said by the following medical lead:

“As the service lead for sexual health I have not been consulted about the LDP, I haven’t even seen it. We have the targets around teenage pregnancy, chlamydia and gonorrhoea reductions, we are mapping but we have no real levers. The merger of the PCTs introduces so much unknown that will influence the future direction, there are so many unanswered questions. The LDP is certainly not helping our cause at the moment, they don’t even acknowledge the 48 hour waiting time target for GUM. The teenage pregnancy target is not dropping fast enough.” (Medical lead for contraception, interview G)

Three service leads speak of good commissioning processes and people in place that made the difference in the quality of provision:

“We are fortunate that we have a very good commissioner, it makes a difference. Lots of districts don’t know their commissioners. Your voice is then heard at the board. You need that voice to get your pot of money. It’s not just about delivering services, but about lobbying, commissioning, leadership, this with good access to the integrated sexual health service makes the best model. The patients will be satisfied and we achieve our healthier nation. We need the whole

lot, we can't do things in isolation. But then we become a victim of our own success." (GUM physician, interview A)

"But we have been very fortunate that the health commissioner is on our side. That assists the process." (Service lead, interview O)

Commissioning Perceived as Mostly Positive Some See it as a Necessary Evil

The principle of this relationship is seen by 75% of service leads interviewed as a good one to address the changes needed. Others view it as a necessary evil to get what they need to have a good provision. Three commissioners themselves show concern over the concept of modernisation, interpreting it as possibly just a way of saying what the particular government of the day is wanting at the moment. They say interpretation by stakeholders of what that means in reality seemed to be left wide open for anyone to modify (P, Q, R).

Lack of Commissioning Strength Allows Reduced Access to Continue

Within one silo-centred service a medical lead for contraception (H) is keen for integration to proceed. Her funding is secure, but because of strong objections from a GUM consultant and with no commissioning strength behind her, then this dynamic strategy has just stood still. Any nurse led provision is not allowed to happen and patients are seen by appointment only, reducing access greatly to the community. This is said by a lead in an area of England that is mostly rural.

Commissioners Can Ignore Sexual Health as an Aspect of Their Portfolio

It is voiced by another service lead that commissioners are not always interested in sexual health:

"The commissioning lead needs to be more tuned in and have the authority and insight and translate it to the directors. The communication really isn't there." (Service lead, interview I)

Organisational Culture is Changing

It is expressed by 18 of the 19 service leads that organisational culture and values are moving and that it is difficult to keep pace of the changes and that adaptation of change is happening reluctantly in some areas. They note there will not always be agreement over how things should go forward and often this is backed up by cynicism; demonstrated here:

“The Local Delivery Plan has become a talking shop. Nothing concrete comes out of it. The public health teams are full of promises but are very disappointing.” (GUM physician, interview D)

Commissioners Should not Interfere With Management of a Service but do Need to Understand it

Senior clinical service leads are sometimes happy that commissioners did not become too involved in the managing of their services as long as they are looking after their interests well, illustrated in the following:

“The commissioners are separate and not too involved, which is how it should be. The patient led NHS is exactly how it should be. Commissioners are key to this. They are employees of the NHS on good salaries. They need to listen to the direction of others; they don’t necessarily have the insight or experience. But we need to help them by giving as much information as we can to equip them to do the job e.g. target hotspots. We have the knowledge where services will work and where they won’t work. People only think about the central service but we need to remember the local needs as well. We can help develop the model, the service providers; we shouldn’t just stand back and wait for commissioners to do it. They don’t necessarily have the insight or experience. Commissioners have their own agendas but they are usually very keen, receptive and enthusiastic. They have a more long-term view than the service

provider; they see the bigger picture and help to keep everyone onboard.” (Senior clinical lead contraception, interview E)

“But commissioners often don’t have the insight into the clinical work and have difficulty understanding. Commissioning is quite a key role and we do need to help equip and brief them. They have such large portfolios and sexual health probably isn’t priority.”

(Senior clinical lead contraception, interview F)

The Commissioners Need to Get to the Root of Problems

The power and authority imbued in the role of commissioner is taken seriously by one lead (K) who was successful in gaining £180,000 annually to develop an integrated model as a pilot site. She acknowledges that the service providers need to start to change their ways of working and to think differently to develop new ways of taking services forward; she knows this will not happen overnight but that she is determined there is no going back.

A relatively new service lead (L) was brought into post in another area she said because of a massive overspend by the sexual health services. She explores why it is difficult for commissioners to get to the root of such disparity unless they work closely with the providers:

“The funding stream for sexual health is unclear. Commissioners are concerned that there is lack of audit to justify increasing costs. There was a massive overspend and hence a change in management had to happen. Commissioners must get involved to help the process move forward.” (Service lead, interview L)

Commissioners Think They do not Need to Know Too Much About Sexual Health Services, They Need to Listen to Those Who Do.

Two commissioners talk of the sexual health aspect of the commissioner’s portfolio as not a specialty they would choose. They say difficulties around modernising services

and ingrained culture does not make for an easy role. However, they identify that commissioners do not need to be a specialist in sexual health themselves; they just need to listen to what the providers are saying and match it to the national agenda:

“The acid test of commissioning is where you allocate resources, actually stopping and starting services.” (Commissioner, interview P)

The three commissioners say achieving targets and performance outcomes are key areas where they expect results from the provider without themselves getting too involved in the design of how that happens:

“Commissioners can’t get embroiled in telling clinicians how to do their jobs, but you can expect them to achieve targets. How they deliver is up to them, but if they don’t deliver that’s different. I don’t think commissioners would design and plan services, they would appoint someone to do that.” (Commissioner, interview P)

Remaining distant to providers and not too involved is said by two commissioners to demonstrate there is no vested interest and that they are objective. Otherwise, they say there is more likely to be resistance to change. They note the commissioner needs to bring a centralised government agenda, or they risk being so steeped in services they couldn’t actually deliver the targets. Commissioners consider clinicians need to be more engaged with achieving targets and that their clinical hegemony makes it difficult for commissioners to challenge. They say that a commissioner without a clinical background may not be prepared to take the risk to do things differently to what the clinicians say will work. One commissioner (P) is asking, is it a service developed in the interest of clients, policy and performance, or is it just the ideal model in someone’s head and not tested against other criteria?

Does Accountability for Targets Lie With Commissioner or Provider?

However, from this commissioner there is concern that if targets are not achieved then the question will be asked does accountability lie with commissioning?

“The PCT judge our effectiveness as to “do you know what needs to be delivered” and whether you have an action plan. For example in teenage pregnancy I have done all I can to deliver. The fact that I haven’t reached the target doesn’t mean I have failed in the commissioning role. It’s down to many others, including the culture, society. I have discharged my responsibility, being careful not to stray into the process of managing.” (Commissioner, interview P)

Commissioning Key to Keeping Sexual Health on the Board Agenda

The three commissioners suggest there is a skill to keeping sexual health on the agenda of this Trust board without giving it priority over other targets that are on the public health agenda for Choosing Health. They voice that this role is imperative to sexual health services being healthy and rounded and really striving to achieve the balance between meeting the needs of the public and meeting government targets, maintaining high standards, but modernising and evolving; moving forward to see things differently and introducing change. They identify being grounded in the coal face issues, being prepared to be challenged, as well as to challenge, as an art for the commissioner with sexual health within their portfolio.

Quantity versus Quality

The constant focus on outcomes and targets is spoken about as a contentious area in all of the interviews with the 52 service leads, senior practitioners and commissioners. Mostly practitioners talk of being trained to give the highest quality service, the service leads and managers are talking of achieving both, whereas the commissioners are concentrating on quantitative aspects, statistics around attendances and time frames; demonstrated in the following extract:

“From a commissioning point of view the real master is performance management rather than quality, maybe putting you at loggerheads with the providers. But with this new environment of

performance management you have to ask can this model deliver on the targets?” (Commissioner, Interview P)

This commissioner notes that most of the government directives around sexual health have an implicit assumption that services such as GUM are delivered in the acute sector, by hospitals, as they mainly are in London districts. This is very challenging to commissioners who work within PCTs. He says targets are much easier to achieve in separate, silo-centred services, where everything is not being offered at each visit to the patient, where all their needs are not met in one visit; illustrated in this extract:

“The PCT has allowed quality care to develop. Staff would be worse off in a hospital, but targets would become more deliverable. But the PCT wants to be part of a gap between providing and commissioning. It is a luxury to develop a model without the performance outcomes aspects, the quality is not doubted.”
(Commissioner, interview P)

Commissioners can Ensure Participation and Gain a Better Response

A commissioner with a strategic health authority role (Q) talks of her position within the sexual health arena as an exciting place to be with so much change and possibility for improvement, with the politics, policies and pressures being just right for exploitation, to the advantage of sexual health. She felt that the commissioner somehow does not have a clear definition in role within PCTs and they just need to make sure everyone is informed to ensure a better response and more participation. Involvement within a public health focus, rather than just within commissioning she expresses as more appropriate to ensure understanding of the agenda and to be on-board with it. She thinks this will help speed up the whole process of bridging the gap between commissioning and providing and the board of the PCT. She feels there is a lot of enthusiasm around the specialty of sexual health, with people looking for solutions and new ideas, rarely seen in the NHS.

NHS Reorganisation is Responsible for Some Incompetent Commissioning

The cause of commissioners not getting to grips with the sexual health agenda, as well as not driving it how the government expects, is seen by a national lead for commissioning (R) as one of the hardest areas to change; the structural changes in the NHS. The re-organisation of the NHS is blamed for not keeping competent and capable people. She considers this reorganisation took new people and allocated tasks within a structure, added to a job title of sexual health lead; she expresses this is not good enough:

“Where there is incompetent commissioning and constant change in the NHS everyone is confused. Those providing services are confused. How many people I meet who don’t even know who their sexual health commissioners are. How many commissioners say “Well I have sexual health today but I may not tomorrow.” Also their jobs are just too big. We shouldn’t set people up to fail. Evidence speaks for itself, look at the epidemiology; this is not like other areas of health inequalities. We have serious communicable disease. We have serious unintended pregnancy. We have got to address it and if you don’t performance manage this it isn’t going to happen. We are going to be an embarrassment. Staff working against all the odds, constantly getting negated because their not a priority at local level, it is not acceptable. I have fought; we will see a real shift as we get the choosing health priority.” (Commissioner DOH, interview R)

Professional Development of Commissioners is also Needed

Another national lead for contraception (S) thinks the juxtaposition of commissioning and provider should work well if only the commissioners are invested in. She feels they work mechanically rather than strategically and the role is desperate for improvement with training and standard setting alongside experience, as often they are not equipped to carry out this very complex role.

There is a consensus across all the 52 interviews of employees of the NHS, as well as from some of the service users within focus groups that a workforce fit for purpose is integral to the whole concept of modernisation of the NHS. 64 concepts form this category scoping aspects such as physicians who are trained in disease management and not preventative medicine. This is alongside a lack of specialist staff and other national programmes taking away experienced staff. The shortages of trained staff, medical and nursing roles, are said by most to be reaching a crescendo (See Appendix 3).

A Shortage of Specialist Clinical Sexual Health Staff

The nurses and managers speak of professional development and the accreditation process as poorly understood even between doctors and nurses. It is said many universities nationally are not providing these sexual health modules (U, E5, L). This is identified as a cause by leads in areas where services have not moved forward significantly in recent years. Where three leads speak of good partnership work with the local university provider, nurses are accessing courses and showing more interest in moving over to this sexual health speciality (U, T, E5). They voice it will take two academic years, on top of a nurse registration and maybe other professional qualifications, such as midwifery or health visiting, to gain these new competencies. 11 practitioners and leads point out that nurses have done much of this development in personal time with no compensation, but have the motivation to move into the speciality (U, E4, E1, E2, E5, N). Four Doctors (A, B, C, D) think it is just a case of doing a two-day course as an introduction to GUM and a few days for contraception that would gain GPs the knowledge to specialise. They also say:

“The insight gained for some from courses the services provide mean we would rather refer clients on, as they we?? can appreciate the complexities of the work.” (General practitioner P, E3)

Practitioners Require a More Holistic View than Just a Clinical One

Three practitioners and the six in the nurse focus group express having a wider perspective than just a clinical view is what brings change in the thinking of staff (N, I, J, U). One says attitudes must be changed and shaped and not just knowledge gained; a factor that will shake the old foundations (E5). She identifies that moving away from a narrow clinical view without accommodating the sociological and psychological aspects to a client's life is never going to impact the health of the community. The sexual health modules that the nurses access (U) they talk of stretching them to think more broadly and strategically, as well as focusing on achieving competencies around providing a service saying:

“We see that health promotion and prevention work is vital to be built into our interventions with clients and that we must take every opportunity to make a difference.” (Focus group, integrated nurse U)

Needs Around Sexual Health Have Changed

The six focus groups of service users and marginalised groups and their workers, identify that needs around sexual health have changed, as lifestyles have changed and therefore the equipping of staff with skills and education should take this into account (Y, Z, X, W, V, T).

Commissioners, managers and other workers all voice they need equipping for their specialist roles around sexual health. It is said to be obvious where they lack these skills, where they had not given it enough importance to giving the time to gain the knowledge, skills and attitudes to contribute significantly to driving change. Even where they have been let down themselves by the bigger organisation, which had no expectations of them to need those skills, or to give the time to it, the nurse's voice:

“We are determined to access education to be equipped to do a good job.”
(Focus group, integrated nurse U)

Impacting the Medical Model with More Integrated Education

Interviews of five newer, younger clinicians show there is an enthusiasm for change and an acceptance that nurses are able to offer quality practitioner skills, this is not always perceived as a threat by them, but they acknowledge that older colleagues found this difficult to accept (A, H, E, F, O).

They remain loyal to colleagues but are aware some colleagues find change in the culture of service provision, particularly integration and nurse led service, as difficult and unnecessary; demonstrated in the following 3 extracts:

“If you are training these days in sexual health they should be integrated. The diploma in family planning now does include STI/HIV/partner notification, all elements of GUM. But it doesn’t seem to work the other way in that the GUM training doesn’t include contraception training. So the Faculty of Family Planning recognises the need but the GUM side doesn’t seem to.” (Senior clinical lead contraception, interview F)

“Nursing staff require and are encouraged to gain considerable practical and academic experience before going solo. On completion of this process they become knowledgeable and valuable, unfortunately in this service nursing staff will then not be using their skills gained for contraception.” (Health adviser GUM, interview E2)

“The present training and education obstructs integration.” (Medical lead contraception, interview H)

Contraception Services have Less National Focus and also have Gender Issues Within Them.

It was said “It’s the gobby birds that will make a difference.”
(DOH, commissioner, interview R)

Eight of the GUM and contraception leads talk of history playing a part in the development of both genito-urinary medicine and in contraception services as separate services, with the contraception service staffed by part-time females both doctors and nurses, fitting it around family commitments. They noted that the lead medic tends to remain part-time and because of their different background training to a GUM physician, although they will act as seniors will not make consultant grade. They identified that workforce development is needed to bring change right across these services and bridge the disparities and inequalities that effect how services are provided.

This gender issue is tentatively raised but acknowledged as an issue by service leads (A, E, F, G, H, J, R, S). A commissioner working nationally (R) notes contraception services have suffered disproportionately from the rest of the new NHS; this she put down to GPs prescribing at 1st level and so is not a particular focus for a government short of resources. She highlights that commissioners are ignorant of the complexity of women's reproductive health and so they have marginalised it and hence there have been no targets set for performance management. She feels that "shifting the balance of power" has failed as a policy. However, she comments that staff who work in it seem to be either brilliant, or their not interested in policy, or their just not engaged enough; demonstrated well in the following extract:

"Where I see the serious champions. It's the gobby birds that are going to stand up and be counted, the ones who will get things done, and that's the way it is. It's true. But it's the gobby birds who aren't liked! Yes, gender and inequalities, power structures, my point, you get a male consultant sucking in his cheeks and everyone listens, you get a gobby bird who takes the agenda forward for reproductive health and she is instantly put in theI keep saying she just has to shout. I mean what have you got to lose." (Commissioner, DOH, interview R)

A Workforce Fit For Purpose Produces Strong Leadership.

Five NHS interviewees thought a workforce that is fit for purpose will be producing more strong leadership characters, those that can seize the opportunities and bring necessary change that the public need to improve their health (E4, R, L, H, K).

Eight clinicians and the six specialist nurses and the 11 school health nurses within the multi- disciplinary focus group, all voice they are over burdened with clinical work with little time to think about services and other than fitting in patients. Those that identify they are more involved in management are saying they are often working over their paid hours to be able keep up with events. This clinical staff group with lead responsibilities said they have not had specific management training and are sometimes struggling to understand the political nature of large organisations and government agendas, on top of their daily workload. They identify that when they do become involved it is because there is a definite lack from management outside the service (A, B, C, D, E, F, G, H, O, T, U).

A Training Burden on Top of Increasing Workloads

Five clinical service leads and the six specialist nurses and a health adviser explored how most training is provided within clinical settings and the National Strategy for Sexual Health places this requirement on the specialist services. This is seen as a heavy burden as their workload is increasingly dramatically (A, B, C, E, F, H, U, E5). Demonstrated here:

“No-one is taking responsibility for providing extra resources for this training burden to allow a more balanced approach with the delivery of both education and patient work, ensuring the trainee and the patients get the best from the practitioners.”
(Contraception lead H)

School Health Service not Always Rising to the Challenge of Sexual Health

The school nursing service was spoken about by themselves and seven service leads. They note that it has a history of having some resistance to becoming involved in sexual health services in some districts, some of which is from the staff, but also from their management, from those who have not understood or become involved in sexual health aspects of the NHS and have not grasped the importance of the agenda or have marginalised it. Six of the GUM clinical service leads do not acknowledge school health as something they are involved in. The school health service workers who do get involved with sexual health see it as vital, at the fore-front of sexual health work with young people, with tremendous opportunities to both educate through personal and social health education and to advise and provide contraception. It is identified by them that workforce development in the NHS seems to miss this aspect of the link to improving the nation's sexual health. They say job descriptions do not always require that these nurses either have a sexual health qualification or are prepared to undergo post-basic training, unless there is a sexual health manager working closely with the management of these nurses. Where districts have been forward thinking and recognise the value of a robust school health service in preventing sexual ill-health then school nurses are saying they are highly motivated to improve the situation. Some said they are seeking the national healthy school awards and would ensure they have invested in sexual health priorities (E, F, I, J, K, L, Q, T). This was all demonstrated in the following:

“Some school health advisers are seen as champions. What they do should be formalised and accredited, whether that is through the RCN distance learning or through somewhere like the Sheffield Sexual Health Centre. There needs to be more investment in the school health advisers' role around the condom distribution scheme and sexual health generally. Some school health advisers do have personal values that they see in conflict with sexual health work, or it being too risky for themselves to get involved. They need more help, or even persuasion. They know they have to do it but there is reluctance often as well with some, especially with those not working with high schools. Healthy school awards accreditations

are the schools that really use the school health adviser role.”
(Service lead, interview J)

New Opportunities for Training and Education, Nurses Engaged Quickly

One dynamic commissioner (Q) is quick to acknowledge that developing an integrated model immediately provides training opportunities for those that wanted this development; she noted:

“It is the nurses that engage with this opportunity; nurse led service is a feature of their model, totally so in the outlying clinics. I can see that specialist service in the future will be giving up routine work to satellite services and to GPs while they concentrate on more complex conditions such as HIV and syphilis. This has implications for training and education. The aim for that service is to have dual trained staff, in both contraception and GUM, but finding workplace trainee placements to gain competencies and a university partner will prove difficult. Aiming for a one stop shop in the long term but in the short term just skilling up staff for the satellite sites will be where it should start.” (Commissioner, Q)

She sees this as different to the government agenda and as an example of how models develop around the skills of the people and the buildings that are both at hand to begin with. With their early model she predicts they will quickly achieve their 48 hour access target for GUM and a more holistic model for young people in the community clinics.

More Calls for a Cultural Shift

A commissioner working nationally (R) thinks the workforce for sexual health needs to be evaluated for what it is equipped to do; looking at their competencies and skills and looking at what is needed in the future. She suggests a cultural shift is needed in terms of how clinicians behave in relation to their specialisms, including GPs:

“I mean, it doesn’t take rocket science to work out if you come through the door with an STI or a possibility that you might have one, you need seriously quick, brilliant help. Especially when we are talking about communicable disease. So it requires some really well equipped nurses who are going to be able to address it, very good doctors who are going to be able to handle devolving responsibility to nurses and stepping in where and when they’re needed. The other thing is their courses, much broader stuff around access to contraception, and a range of contraceptive services, that meet the needs of those women coming through the door. So modernisation is used as if we what we are currently providing is old fashioned. It needs a huge cultural shift, to look more broadly at how to work together, what they do and who does what. There are lots of opportunities, but it requires people to be able to change their behaviour about the way they work.” (Commissioner national lead, interview R)

More Performance Management to Gain a Shift and Engage with the Vision

Another non clinical service lead (L) who has been brought into a PCT to deal with the lack of modernisation within sexual health services has a very a clear objective view. Her assessment is that there has been a lack of performance management which has led to unilateral working and little investment in staff development; the consequences of this is continued reduced access for the public to the services as senior staff go on in their old ways; illustrated in the following:

“We need to balance performance management through workforce development and this would lead to improved access for patients. It will take some new and multiple skills. With appropriate investment in nursing there will be good value for money. We need a workforce development strategy.” (Service lead, interview L)

Strategic Forward Planning Needed to Skill up Staff

This service lead who is beginning to introduce a new strategy for achieving better access to sexual health services notes that staff often are not equipped to take services into the 21st century and she devises a plan to bring change:

‘The strategy to breakthrough all this was to group services and to have a long term vision of integration. To stabilise separate teams first and then have a natural progression. Integration would then develop. We took advice. We used standards and systems and processes and applied good management principles, core principles. We tried to do too much at first. But we had to break it down into manageable parts, back to basics, examining what we already had. Why had the sexual health service got so poor. There was poor leadership and confusion about roles. There were people in roles that didn’t have the skills or competencies for. People had disengaged so much there was manipulation going on, medics trying to blind managers with science. Only some people were listened to and others were not. Processes weren’t in place to be able to introduce simple change. Even experienced staff don’t feel able to take forward anything, to introduce any change.’ (Service lead, interview L)

This person also speaks of inefficiencies within the NHS and how to address them without crisis management. She considers that the workforce needs to be engaged in a process of understanding the vision of the whole PCT and how they function as an organisation. She identified that the poor management and strategy ability of the senior clinicians needed addressing if they are to have authority within the decision making process. She identified a culture of blame and hostility created from the medics, because no other way is known to get what they want but to use their power. She viewed that an organisation that is fit for purpose to deliver a vision of integrated sexual health services, needs to facilitate the roles of management and clinical roles, complimenting and supporting each other.

A Workforce Fit For Purpose Requires Strong Leadership Who Are Risk-Takers and Have Vision.

Five service leads think a workforce that is fit for purpose should be producing more of these characters with a vision, those that can see the opportunities and bring necessary change that the public require to improve access and their health (E4, R, L, H, K). Again it is suggested there is a lack of direction:

“There is no definite direction for service provision, tends to be driven by people.” (Medical lead contraception, interview H)

More Investment in Staff Needed so They Can Raise Their Heads Above the Parapet and Think More Strategically

This is the same as on p 232 – is that right? 15 practitioners all voice they are overburdened with clinical work with little time to think about services other than fitting in patients. Those that did become more involved in management were often working over their paid hours to be able keep up with events. This clinical staff group with lead responsibilities mostly had not had specific management training and were sometimes struggling to understand the political nature of large organisations and government agendas, on top of their daily workload. It seemed mostly when they did become involved it was because there was a definite lack from management outside the service (A, B, C, D, E, F, G, H, O, U).

Nurses Need To Push the Old Boundaries

10 leads and practitioners talk of the driver of change as often a risk taker and for the vision to be fulfilled they would need to envision other risk takers (A, E, G, J, K, L, M, P, R, E1). This was particularly so where nurse led service had not been developed and nurses had worked within a medical model; illustrated by the following service lead:

“For nurses it’s about risk-taking, and how much of a risk taker they actually are will determine how much they will push the old boundaries.” (Service lead, interview M)

The university educator (E5) reflects how this has implications for the provider of training and education, particularly around the post graduate courses for sexual health that will equip nurses to become more autonomous.

The service lead of an integrated service (N), with 30 years nursing experience feels strongly that a lack of higher academic qualifications has not held her back from promotion or having opportunities to implement a vision. She does believe in developing nurses, but not necessarily with clinical education, but to empower them with leadership and management skills to give them more skills to think strategically; she expresses this in the following:

“It’s about your performance. It’s leadership, that’s what it is and leadership courses. Leadership in a changing environment, this had the biggest impression on me and it is the most dramatic course I have ever done. It gave me an insight into how people operate in teams and how they can destroy teams, understanding the dynamics and leading to integrating. You need to be visionary and take risks. You can’t be one without the other. You have to have passion and you have to care.” (Service lead, interview N)

Workforce Development has been Low on the Agenda of the NHS for Sexual Health

There is almost consensus from service leads, clinical and non-clinical, as they express sexual health as a career pathway for doctors and nurses and that most of the services that are modernising are doing so by investing in their education, particularly of nurses, providing support and sponsorship for pertinent courses. Six suggest those looking to bring change must forward plan, saying that it would take an academic year for each course and the shortage of specialist staff requires more investment in education. They think that workforce development and commissioning within the

strategic health authority need to take this issue on board. Specialist training for sexual health is not taken seriously by NHS workforce planning, professional bodies and even universities.

The education provider and the health adviser emphasise that a specialist area of work for partner notification has not always been invested in by some sexual health services across the UK by providing health adviser posts to carry out this public health responsibility. They note that now the latest NICE guidelines (DH, 2007) is advising that one to one interventions through the health adviser is a most lucrative health promoting opportunity and that GPs see this as an area they really do not want to get involved in (E2, E5). They point out that this is yet another area where workforce planning for the NHS had not been forward thinking as a shortage of these professionals is looming.

Politics Even in Universities Who Do Not Appreciate the Importance of Their Input

The education provider (E5) talks of developing pathways for specialist community public health nursing over 2006-07, as she has the vision that nurses need to be trained differently to meet the new public health agenda, and to meet the new registration requirements for health advisers. She says this is supported and driven by the Department of Health, but her own employing university and their internal politics blocked this development going ahead. She feels this is because her senior management lack understanding around the needs of the local workforce and new ways of working. She identifies a lack of systems thinking or interest within her own institution, a place that should have been driving the modernisation of nurse education. She articulated:

“Everyone in the process is losing out when decisions apparently are only made on cost or profit and an economic model and just maintaining traditional core nursing contracts of education.” (Education provider, E5)

Integrated Education was Refused Further Investment

This same provider of education (E5) notes that nurse led service has expanded dramatically in the region since her sexual health pathway had been validated in 2004 and developed around government targets, hence giving a foundation for nurse specialist development. However, other dynamic inter-professional training with teachers and school health advisers, and medics and nurses, which has all been evaluated highly in recent years, is now to stop; again this decision made only around financial reasoning.

It is Acknowledged the Department of Health have not Invested in Nurse Education

A strategic health authority commissioner with a whole region oversight for sexual health acknowledges the Department of Health has not been good at combining workforce planning and sexual health modernisation. She sees nursing as vital to the modernisation process in taking a lead role because of the more entrenched views from the medics. There is reliance on practitioners to take up post-graduate qualifications without there being any particular strategic drive to do so; the following illustrates these points:

“The capacity isn’t built into services to provide more training and education. We just aren’t good in the NHS at capacity planning. The university and workforce development confederation/education and training consortium need to be much more productive. There are lots of constraints around recruitment, even if you do have the funds, there are shortages of trained people, or those interested in working in the services. Nurse leadership is important in bringing change. As some of the more entrenched views are on the medical side of things. Without nurse involvement and taking a lead you won’t achieve the targets.” (Commissioner S.H.A., interview Q)

Clinical Staff May Not Be Included in Leading Services.

One nurse leader (N) who has invested many years of her career developing other nurses for autonomous roles talked of a management structure for a large modernised service that was being developed that did not include nurses. She was determined this should not be so and created a business case for an assistant directors' post with a person specification for a nurse. This determination proved worthwhile and it was accepted; she demonstrates this in the following:

“Nursing was being left behind. All I wanted was what I wanted for nursing. As long as a nurse sat on the management team. What we have achieved here in nursing would never have been achieved if I hadn't gone through that fight to get into that management team. I knew exactly what was happening; I needed to develop the nursing team. We were very consultant led; we had nine consultants across contraception and GUM.” (Service lead, interview O)

A lead commissioner for the nation (R) does not feel it is the place of the DOH to tell the professions how to address the training of the doctors and nurses of the future. Their role is to introduce expected standards. However, she questions whether the workforce is fit for purpose and whether indeed a two day course driven by GUM consultants will meet the needs of GPs. She comments that there should be more comprehensive and systematic training, consistent across the country.

Nurses are Equipping Doctors for their Role

A focus group of specialist nurses working within an integrated sexual health service express that they have become so highly skilled through accessing university courses alongside their experience and they are now equipping doctors for their job. They have concerns about the training of doctors, expressed in the following:

“Nurse led service has really enhanced this service provision and made it so accessible, reducing waiting times, we just couldn't manage without nurse practitioners now. We have to acknowledge

we do still need the medical leads for the specialist work, the more complex. As for the other doctors, well they ask us, the nurses, how to do things 'cause usually they aren't dual trained. We should stop employing them really. They don't add to the model or enhance the service for patients. We only need more experienced ones. The training of doctors should be addressed. The patients should get the same standard of care from everyone. It's a bit much if you get less of a service from a doctor than you will from the nurse. The routine work does not need a doctor, but then I suppose they have to gain skills as well. Total care management is what the patients get from us so everyone should be able to provide that service." (Focus group, specialist nurses, integrated model, interview U)

Service Users Identify Training Needs of GPs

GPs are noted by the gay men group (V) as very accessible from a geographical point of view. However, there is concern voiced over their lack of competency around sexual health and dealing with issues pertinent to gay men. They identify obvious training needs for primary care. They say that although the government agenda is to promote enhanced services in the community and practice based commissioning they are not confident that they will receive a good service if they use Primary Care:

"In the main, experiences of GUM are much more positive than at the GPs, we much prefer a specialist service where they know what they are doing. It's just too involved and complicated for GPs."
(Focus group V, gay-men)

Teenage mothers (W) also state they prefer to use their local GP service for sexual health needs but are not always sure they will get such a good service as they did at the contraception clinic. Having a choice of a female GP is also very important to them but they do not feel they could ask for this.

4.8 The New Public Health Agenda alongside the Inequalities in Health Agenda (Category 7)

This category forms a thread throughout the interviews, particularly of the service leads and the practitioners. There are 53 concepts drawn out that fit this category as well as some overlapping into other categories. These concepts scoped issues such as the socially disadvantaged and the vulnerable population form a large part of the workload. This is alongside raising more public awareness impacts on the time spent with service users, adding stress to the services, and the socially disadvantaged are less likely to travel to services.

More Resources or Can We Use What We Have Already to Bring Health Improvements?

Five service leads speak of using multi-agency work to introduce diversity and creative thinking, which has been an aspect of other prevention work for HIV for over a decade. Although they also acknowledge that the huge monetary investment in HIV prevention work never did reduce HIV or have a knock on effect of reducing teenage pregnancy or improve sexual health (G, I, J, U, Y). They all think the Choosing Health (DH, 2005) government document has given sexual health improvement the profile it required and that giving it the profile should bring with it the resources. However, these service leads identify that in the first year, although actually allocated to sexual health, it was not ring-fenced and therefore they did not receive it. This was a question area specifically asked of service leads. From the PCTs involved in this study only one, at that time, is gaining resources from it. They all cite that the money is used for other priorities in PCTs, who in the main are having financial crises. They talk of battles being fought with directors of finance who have little or no insight into sexual health priorities, they are voicing that their services are still not being taken seriously as an important health arena and still suffer from a marginalised approach. Service leads are looking elsewhere to have service developments taken forward and neighbourhood renewal funds often respond with funding (G, I, J).

Performance Management Surrounds the Public Health Agenda

Six service leads speak of performance management and how PCTs and local authorities perform will determine their star ratings and whether senior people stay in post. Performance monitoring is voiced as an anxiety as there has been little investment in IT systems within some of their areas and some services had only basic or none available (C, D, H, I, J, E2).

Most of the service leads are talking of rapid developments and that despite this the commissioners probably will not get what they want regarding targets for reduced sexually transmitted infections and teenage pregnancies. However, they are also voicing the welcome change that sexual health is high on the agenda for attracting resources. They speak hopefully about long term improvements as a result of more investment. (A, B, C, D, E, G, H, I, J, L, M, N, O, P, Q, E2). This is illustrated in the following extract:

“The future will see a new sexual health centre which will just improve things. This will mean more infections will be detected, in the short term; it will take 10yrs to turn it around. Sexual health will start to improve, but on paper, the statistics etc will look worse. Normalising sexual health services will really help to improve things. The children we are educating now will talk differently to their children. It will be gradual; it’s not a quick fix.” (Service lead, interview J)

Reducing Teenage Pregnancy Is a Tough Target

A question area around the teenage pregnancy target being realistic is mostly answered by service leads as this being a very difficult area, as there are so many aspects involved in this reduction. It is thought not to be just down to service providers providing services in an improved or different way. The strategic health authority commissioner (Q) speaks for most service leads when she notes the lost opportunities within education because as a nation we just do not seem to be able to normalise sexual health. She emphasises that there are just so many factors involved

around self-esteem and confidence and so many team players to contribute to this. She identifies there is still much to be addressed within the education system and that made it a tough target to achieve. She recognises when the rate goes up it is difficult to know why. She notes a teenage pregnancy could have kudos in one culture and a more negative connotation in another. Although it is not always seen as a bad outcome for some and it is important not to disadvantage the teen mum or the child. She articulates it really does require some radical thinking around the education system to motivate people into action around this issue. On reflection she thought maybe this is an unrealistic target, not taking into account some teenage pregnancy is planned and what right do we have to say otherwise when it is down to personal aspirations and informal choices.

Asking the Public

When exploring the issue of consultation and participation 13 leads perceive it as crucial to modelling a service that will meet the need of the service users and the community. They voice determination to develop creative ways to seek opinions from service users and from more vulnerable and marginalised groups such as young people, those often excluded from service planning(F, G, I, J, K, L, P, Q, R, T, Y, E3, E4). The following extracts demonstrate how this is carried out:

“It’s more difficult to access the more vulnerable young people’s views, like those out of the school system, we need a better feedback process for them.” (Service Lead, interview G)

“Service-user consultation is quite extensive with young people and gay men. User feedback is used in the action planning. The participation and evaluation scheme went through ethics and patient and public forum. The Trust generally is looking at the sexual health model of gaining users views for wider use. When new staff are taken on we have service users on interview panels. We encourage the public to complain if unhappy and it goes through the governance route. This is the patient led NHS and any changes to PCTs, or to services on the front-line will be very much from an

evidence base. Targets still have to be achieved and this is the best way to achieve them.” (Service lead, interview J)

A service lead from a very large city service (I) with huge recent investment and large areas of social deprivation within their communities is taking consultation seriously and employs workers to carry out this task. She says this process allows constant feedback into the prevention strategies, as well as informing the service providers about access issues and discovering other things that otherwise are hidden; demonstrated in the following:

“We have the social deprivation issues, low achievers. In the city teenage pregnancy isn’t necessarily seen as a bad thing by the young people themselves. How do you change that? That is a struggle for everyone. Is integration of sexual health services a major contributor to improving sexual health? Yes, with everyone working together, everyone’s contribution. But we also have huge consultation processes. This helps to shape and improve access as we work with marginalised groups. We have focus group helpers who come in each week and also a community access group and an inequalities team. We do focus groups, comments cards, user involvement. We have two workers who had worked in health promotion. He does community consultation, stakeholder views, focus groups, a huge amount of work. That is the interesting side to this integration, it is the hidden stuff, to measure it you need to read up what is being said when you read the reports. You realise there are so many not accessing services.” (Service lead, interview I)

This service lead explores how the service is trying hard to encompass views of those who do not use services. She talks of using participation as a bottom up approach and not just the surveying of service users. However, this was at odds with one clinical service lead who has a concern that the most vocal, or those with the least insight could have major influence on evolving service; this is illustrated in the following extract:

“The patients view can’t always be taken as factual as they don’t have the full picture and each client will have differing view. So although we encompass their views they should not be allowed to dominate as they are lacking some information.” (GUM physician, interview A)

An education provider (E5) expresses that the reason current models of service and practice are hard to challenge is because there is an absence of user discourse around these services and providers can go on in their own entrenched ways if they do encompass these views within planning services. She feels strongly that more effort is needed to seek, in creative ways, the views of users and possible future users of services.

It is Not like Other Areas of Health

A national lead for commissioning (R) is more realistic about getting views from the community on the subject of sexual health:

“The morality, you don’t get any of that in coronary heart disease or cancer. There are fundamental differences in sexual health. You know if you have cancer you can go and talk about it on Judy and Richard. If you’re 14 with gonorrhoea, you are so not going to take part in a patient forum; to talk about your experience of going down the clap clinic! People just want to get in and out anonymously. You can’t put sexual health in with other things. You don’t want to talk about your abortion, or who you had sex with and got syphilis or HIV; it’s a minefield of human interaction that doesn’t exist in other areas of health.” (Commissioner, interview R)

There Are Lessons to Be Learnt From The Past

This commissioner, very experienced within the sexual health field, talks of what has been learned over the years just listening to young gay men dying of AIDS a decade ago. She speaks of how extraordinary stories enlightened the clinicians. Also how it

took the voluntary sector to drive this consultation for those people, to listen to the voices of young gay men, the most affected group at that time. She emphasises there are terrifying lessons to learn and they are brought about by patient advocacy. She identifies the contemporary issue of African community with AIDS in the UK, bringing new problems and complexity and the even greater need for more advocacy and consultation.

Normalising Services and Promoting Sex as a Positive Aspect of Life Will Allow People to Take Better Care of Themselves.

14 of the 19 service leads emphasise the importance of user-friendliness and accessibility of services, not only with good locations, acceptable opening hours, but also with a perception within the community of being non-judgemental and confidential; and most of all that there is choice for all. These leads also note the weight placed on government targets is taking the eye off the quality of provision (A, C, D, E, F, G, J, I, N, Q, P, E2, E, E5). Providing choice and quality is emphasised and expressed in the following extracts:

“Good access is giving services where people want them, where they need them at the time they want them, in the way they want them. Some of course will never have all their needs met. We need different things for different people such as for those with disabilities and those who need interpreters.” (Medical lead contraception, interview G)

“Access isn’t necessarily about being open all the time. But other aspects would be patients understanding how to complain. Venues need to be pleasant and offering a range of services. People need to feel valued. The needs of the client should be met at the first appointment, or there should be a smooth transition or sign-posting to the appropriate service. It’s about the quality of the service and the experience of the service user.” (Service lead, interview J)

Lack of Consultation Can be Perceived as Services Not Needed

A service lead (I) from an area that has no screening service for infections, GUM, identifies the lack of the public voice as an aspect for Trust board then not taking the need seriously, it was easily a hidden need:

“There is no genito-urinary medicine service yet. People have to travel elsewhere. Hence the PCT is not paying for a service and the lack of a client voice to push for a service just isn’t there. There is some political resistance to having a service but it is hard to identify.” (Service lead, interview I)

Trying to Utilise the Media to the Service Advantage Does Not Always Work

Service leads also talk of publicising sexual health services as important to improve access, but that sexual health services often attract bad publicity from the media; although even if perceived as bad they note it still tends to raise the profile of services. One service lead speaks of experience of it feeding the fire of the negative anti-service providers within the Trust (I).

A national lead for contraception (S) explores the role of media campaigns to destigmatise and contribute to a more informed society and a move to perceive these services as normal. She expresses that sexual health should be a central aspect of people’s lives and not marginalised. She suggests even lobbying should be used to bring this change and using new and a variety of strategies, such as working with parents and skilling up young people to resist pressure. She notes the recent government campaign of delaying early sex as a positive thing but that it should be used alongside the old safer sex messages for those who choose to have sex. However, she is aware national campaigns are not necessarily the answer for every community where there are differing needs and cultures. A service lead (E2) thought too much was invested in campaigns when there was not match funding in services to cope with the increased demand as a result of the increased media attention.

Voluntary Sector Seen As Vital To Normalising Sexual Health

A focus group of gay men (V) identifies that the voluntary sector play a crucial role in promoting sexual health and preventing sexual ill-health, especially for vulnerable groups; they suggest they create a more normal approach, or culturally relevant approach to the subject. These say that these groups are often under-funded and that these areas of work are not acknowledged. Without this input the public health messages just will not reach those most at risk and in a way that is meaningful to them. Other focus groups catering for more marginalised members of society, youth offending (X), Sure-Start (W), HIV support (Z), all talk of providing individual support and an empowering approach to their work. They ensure sexual health issues are a regular agenda items but explore issues that are pertinent to the service user.

Normalise Sexual Health to Bring Rapid Change

A health adviser for GUM (E2) notes how different sexual health is as a political arena within public health, in fact not normalised. She identifies many of the infections that are managed by services are actually preventable and yet have huge implications for the health economy. She says:

“Stigma and barriers stop us normalising sexual health, it prevents people being empowered and comfortable to deal with the risks they take within their lifestyles. Sex sells anything these days and is used to portray a range of consumer goods as attractive. Society accepts sex but not all the consequences.” (Health adviser, GUM, interview E2.)

The education provider (E5) articulates that sex is rarely spoken about in positive terms in the health promotion context, it is always seen as a public health problem or as sexual ill-health. She feels there is a need for more emphasis on supporting parents in delivering sex positive messages in partnership with schools and health providers.

5.1 Introduction

This study was investigating if service provision for sexual health was to be made more accessible then it would contribute significantly to improved sexual health of the community. An integrated model of provision, a one stop shop, principally bringing together contraception and genito-urinary medicine with multi-skilled staff, was proposed as a way forward to improve this access. This was suggested as a more user-friendly model and more able to meet the needs of the service user in a more holistic or comprehensive way. This model fitted with the modernisation of the NHS and the sexual health services proposed in government policy (DH, 2000, 2001, 2002, 2004).

Asking questions around the modernisation processes produced the categories, themes and concepts (demonstrated in Appendix 3) resulting in a grounded theory with the core category of: there is deteriorating sexual health alongside an increasingly sexualised society.

A further six categories that fitted beneath it: (might be better to do these as bullet points? You've used bullets before and would make separate categories clearer? sexual health provision is a highly political field; power, obstruction and influence play a significant part in service provision and in reducing or improving access; the influence of the commissioner for sexual health provision is a key role for the modernisation of sexual health services; modelling sexual health services as an integrated provision can make a difference to improved access but is not always accepted as the way forward by the service providers; there is insufficient workforce fit for purpose for a modernised provision; the new public health agenda alongside the inequalities in health agenda and the issue of sexual health should be taken more seriously by the hospital trusts and PCTs before a difference can be demonstrated in the nation's sexual health.

This theory illustrates that there is acknowledged historically poor access to sexual health services that indeed do not always meet the needs of service users. Attempts to improve this situation are frequently thwarted by poor strategic planning and

obstruction by senior clinical staff, who fear loss of position or power. Where services aim to develop integrated service provision models this is from a strong ethos of having service users at the centre of care and that this is what the public want to improve access and quality of provision.

5.1.2 Government Policy Had Promised Major Reforms That Were Not Evident in the Findings

These findings demonstrate that the “top to toe modernisation of the NHS” stated within the NHS plan 2000 (DH) are not greatly evident within sexual health services over 2005 to 2006, when the fieldwork is carried out. The services have in most cases not been redesigned around the needs of patients, access has not been improved and the roles of nurses have not been extended to help these access issues, but in many cases blocked from doing so. The Modernisation Agency has actually had little effect on sexual health services. Service users have not felt the effect of the devolved power promised through policy so they could bear influence and service providers are not often centred on them. The imposed targets and increased performance management and monitoring by government on services also contradict the ethos underlying the policies of decentralising their control.

Another lever used to get resources to services, also trying to open them up to closer scrutiny, is The National Strategy for Sexual Health and HIV (DH, 2001). The findings suggest that the effects of this policy are beginning to be talked about in those services with less medical dominance, or in those with strong leadership and often where services have come together as an integrated model of provision, or where they are seeking to do so. Many services are still struggling with power issues which severely affect the access for the public.

The complexities of the NHS policies explored within the literature review intended a process of investment and reform. The core principles of them all are around quality and safety, effectiveness and sustainability, dignity and respect, shaping services around need, equality and non-discrimination, supporting and valuing staff, partnership working and seamless services and confidentiality and access to information. This process appears to be long and drawn out for sexual health services.

The focus of these policies does not seem to be incorrect; they say they are a result of listening to the public. However, the fitness for purpose of sexual health service provision is shown within the findings to not always be in place to achieve this reform. Indeed, these findings demonstrate the culture of sexual health services, which previously had gone unnoticed, is in need of long overdue reform.

The key issues, that matched my own experience from working within sexual health service provision, are around nurse led service and the obstruction of it, alongside a gender and power agenda of the GUM consultants. This disempowered workforce face similar subtle forces as the vulnerable disempowered service user. NHS staff with the task of facilitating empowerment of the public, are struggling with the very same issue. Stilted or frozen professional development opportunities for nurses results in reduced access to sexual health services for service users. The consequences of this can only be poorer sexual health within the community. This study demonstrates as the stranglehold is broken that a more holistic service, created around the needs of the service user, can be provided. This will contribute in the longer term to better sexual health for the community within a context of health promotion and a public health agenda. The breaking down of obstruction is demonstrated around the characters, or leaders, who are responsible for bringing change. They are the risk-takers and again, within this study, often women. Risk-taking is usually perceived as a negative connotation within sexual health services; however, this risk-taking brings great benefit to modernising services, as they are also motivators and empowered others.

In the process of developing these findings I found the frameworks of complexity theory and feminism provided theoretical models that supported them. I will explore these findings within this framework and refer back to the key aspects of the literature review and fit this with my insider, practitioner view.

5.1.3 Nurse Led Service Provision Resisted Despite a Crisis in Access

A significant finding which is also similar to my own workplace experience, is developed within the core category, as well as within the other six categories, which is the multiple references to nurse led services and the difficulties that surrounds this

issue. The findings demonstrate strongly that it is the nurses who frequently take up the baton to modernise services, despite often experiencing obstruction and belligerence from their medical colleagues. These nurses are not shadows of medicine but accountable for their own practice. They are often supported by a service lead, frequently a business manager, who is actually often, although not in all cases, female. It is in addition demonstrated that the blockage to service modernisation is most definitely male. Drawing from my own 16 years of experience within the speciality, there are some female physicians and occasionally male nurses, but they are few in number across the nation.

The literature, reviewed in chapter 2, established that it has been six to seven years previously, within the NHS Plan (2000) that the government advocated extending the nurse's role to allow more development of patient centred services. This Plan is a strategy to create better ways of working, to benefit all, service users and service providers. A key issue within this document is a will to reduce waiting times and yet in 2005 GUM waiting times are quite unacceptable. The HPA (2006) report of the state of the nation's poor sexual health still has to recommend rapid access to sexual health services as one solution. Redesign and modernisation was supposed to be driven by devolving power. This movement of power was to be taken up by staff groups other than medicine but also by the patient who should be at the centre of all collaboration and alliances. This should be a new consumer culture, or we should be moving towards this, and a much reduced paternalistic service provision. There is much to gain for medical individuals from new government policy in monetary terms through the consultants' contract and increases for General Practitioners would follow (Rivett, 2008). The exploration of power within the literature review explains how the history of medicine, the institution and the ethos of sexual health services as a military model, to contain infection, does not easily relinquish power but uses domination as governance (Lowy, 1993). Unless nursing takes hold of its autonomy and uses what it has been "empowered" with by the UKCC (1993), using its capacity and consent (Foucault, 1988, 1994) and also now given by higher authority through government policy, then modernisation can not happen. To avoid domination, power needs to be negotiated, avoiding this entrenchment of resistance. The literature demonstrates that theory around dominance of medicine and professional status has sensitised us to the need for change to bring about more equality. However, good leadership is required to

negotiate this move of power, alongside the tools given through policy, ensuring everyone is informed as occupational boundaries are gradually changed (Witz, 1992; Nettleton, 2006; Leathard, 2003; Freidson, 1970; Lukes, 1974; Klein, 2001; Harrison et al, 1992; Faubion, 1994).

The reality is shown in the findings of this study that in practice sexual health services are not responding readily to this driving change, that belligerence and blockage from mostly GUM consultants is widespread. The NHS Plan (DH, 2000) is having little effect on these services. These findings illustrate that it takes the further implementation of government targets and performance management in 2006 before some services take it seriously, decentralising power through government policy was not a reality for these services. The National Strategy for Sexual Health and HIV (DH, 2001) has linked poor sexual health with poverty and social exclusion and identified the need to raise standards within services and yet the fieldwork shows even this is not sufficient to motivate change from those who hold the power within the sexual health services and they are still dragging their heels.

5.1.4 The Inside Researcher Hears What is Not Said Publicly: Gender and Power Issues

This study demonstrates mostly nurses are waiting to just get on with the work. However, it takes their own motivation and commitment to drive any progress alongside the enthusiastic managers. I have not heard this said publicly or written about in health service journals. It is known amongst those who work in the field and evidenced within my work, only because I am an inside researcher. Much of what is disclosed by professionals would rarely be heard if those specific areas had not been probed by someone who understood what is being said directly or what is implied. There is a level of trust imbued in myself from these professionals, who in many cases are very keen to talk. Another key issue proven from this fieldwork is that there are indeed gender issues within the workforce of this speciality, if not generally still dominant within the NHS. This work identifies an aspect of the institutionalised NHS that Wanless had spoken about (2004). It also confirms the view of Bergman and Luckman (1991), that emergence and maintaining of social order can be identified

within institutionalism. Energies are freed up by just maintaining how things have been done, as they had been throughout the history of medical practice and not thinking about new challenges.

I found similar themes of power and disempowerment within this study between professionals and as well as for those seeking services. The Sigma reports of 2003 and 2004 exploring stigma and prejudice for those with HIV, gay or African, used Goffman's theory showing when power was to be maintained by the powerful then boundaries could be maintained. It is only when this principle is understood that it can be challenged. The strategy of modernising services and developing the nurse role seems to have been to insidiously remove power from some medics by equipping the nurses to carry out extended roles and begin to blur the boundaries. However, although the nurse has been given the power and autonomy through policy and has the capacity to take it she is not always perceived by the medics to have a right to use it. This demonstrates, as Foubian (1994) suggested, forms of authority within the medical model have never been tested before and boundaries moved so quickly to create this new institutional order. The medics need to be included in these changes of hierarchical relations and supported within the changes with negotiation to ensure less resistance. Power will be seen to be illegitimate if it has not been consented to and the power nurses take will become unstable and reversible (Hindess, 2001; Witz, 1992; Lukes, 1974). Those services with obstructive lead consultants are usually in areas with a history of un-involved, non-medical management, where departments are relatively marginalised and left to get on with things. Frequently they are still positioned within the acute hospital trusts, rather than in the community PCTs. Where attempts are made by management to bring change those strong medical consultant roles often block attempts, reinforcing role typification and legitimizing traditions. The findings show communication is not commonly open or transparent about the driving government agenda or why the medics find this difficult to apply. Different staff groups seem to work in opposition, either resisting giving up power or taking power; demonstrated in the following spoken by professionals within a silo-centred service.

“Change is resisted; professionals protecting what they see as their role, fear of what the change might mean for them. Availability of

suitable venues for a new service has been problematic, but also an excuse to carry on as we are.”

“There are professionals holding on to their own single specialisms. There is resistance to change, and others are just passive.”

This is not a healthy theme heard from those who should also be facilitating empowerment of the public. Indeed, identifying why the UK has poorer sexual health than other Western European countries is encompassed within the literature review and within the Finnish study (Lottes and Konula, 2000). This study cites empowerment mechanisms as strong indicators for good sexual health. This is alongside most of the literature review for sexual health promotion. A shifting of power is shown to be a key for both providing more accessible services through nurse led provision, through opening up more of it, alongside more empowered marginalised groups. This should contribute to the improved sexual health of the nation. It is ironic that the Choosing Health agenda (DH, 2004) is marketing a fundamental shift in culture in how the NHS is relating to the patients as consumers at the centre of everything and yet it obviously still has these gender and power issues among NHS staff groups. Experts are being used as transmitters and enforcers of health messages to tell the public to take more personal responsibility and yet can be working within cultures which try to stifle personal and professional development.

Power and gender are key issues from this research that need to be addressed to be able to move towards a more user-friendly, accessible, model in the form of the integrated model of service provision for the UK. Integration appears to make a difference in the widest sense of a theme of access. This type of service is seen as more acceptable to the service user, by those staff who do work within such a model and also from the focus groups. Service users are asking for services that are able to listen to the clients, particularly those clients who are more vulnerable. An integrated service would maximise their opportunity in one visit, in one place; this is demonstrated in the following extracts from the professionals who worked within this model or were aiming to develop it:

“You need to engage the patient quickly.”

“Integrated sexual health must be the way forward.”

“It’s needed for all groups; it allows complex needs being met.
Especially for the hard to reach groups”

“People want all the services at one point. That’s how I would want it.”

“Physically integrating services results in better use of resources”

Integrated models were talked about as more inclusive, engaging more with the public and meeting all of their needs. There was talk of creating partnerships between patient and practitioner. It is seen by service leads as a way forward, to modernise and transform what is provided. It is also how the government suggest it must be within their policies. However, as Covey (1989) noted, the paradigm shift needed to arrive at that place will be limited by everyone’s perceptions and experience. The history of AIDS has demonstrated that innovation was used to create new coalitions and plurality of practice and sharing of responsibilities prior to treatment being introduced in the mid 1990s, when the medics had not had great involvement. This required working with uncertainty and political tensions, but also conceptualising differently. Modernisations for prevention and care around HIV brought great lessons to the NHS through this time and introduced an equality agenda, with anti-oppressive practice, not seen before, that the sexual health services could continue to learn from (Rosenbrock et al, 2000; Street, 1993; Berridge & Strong, 1993).

5.1.5 Keys to Breaking through Resistance to Modernisation

From the findings, less medically dominated services or those that did not have a high profile, those not so large or in the city, seem to move more quickly to new models of service provision. Overcoming and breaking through the resistance to modernisation is managed by some, and identified in the study, as those strong characters with good leadership skills. Those interviewed who fitted this mould are mostly women. They have developed understanding and insight into how to drive change; they are resilient.

They are also people who could identify where the barriers are and how to break through them. They have knowledge of systems and processes and are not overwhelmed by status or gender dominance. A key to their characters appears to be that they are risk takers. Wanting to move the boundaries rather than maintaining them, having the will to devolve power, encouraging people to reach their potential and providing support for everyone within the process. This is a bottom-up approach, not an externally driven dynamic telling people what to do. As Bevan (2006) suggested, change does not happen that way. This is an emergent self-fuelling approach, suggested within complexity theory (Byrne, 1998; 2005; Cilliers, 1998; Plsek, 2004; Goldoff & Jay, 2005). This is not the irony of government talk of devolving power and yet introducing strict monitoring and target setting, a possible cause of institutional paralysis identified by Ferlie (1993) where there is insufficient power handed over to reconfigure services. This is where effective leadership using a bottom-up approach is crucial. Ham's (2004) suggestion that the hierarchical relations of the 1990s would break down with a change of culture in the 21st century is proving correct but within sexual health this has been slower.

These leader characters have the authority to move things forward, but they no longer fit into Talcott Parsons' expert authority of the professional, where people obey commands because they believe they know something they do not (Latham, 2002). These professionals are, in the main, doing a management job, not motivated by status and reputation amongst peers and society, as Parson's suggested this would be the motivation for the medical profession. Some of these characters do have clinical backgrounds in nursing and some in medicine, but it is their leadership role that is driving their service. They are not claiming superior wisdom, just considering getting the job done a better way, as suggested by central government. They are not dominated by the medical consultant but utilise their own capacity and the consent given to them within their role (Foucault, 1988; Hindess, 2001). There is no heavy investment in status capital. NHS managers do not really have a socially constructed identity to live up to, but as Barker and Roberts (1993) noted, are exercising their power as responsible agents. They are able to make a difference to service modernisation by taking this stance. The following comment from a service lead illustrates this point well:

“There is no definite direction for service provision; it tends to be driven by people with vision.”

Interestingly this theme of risk-taking characters within services also matched the theme of risk-taking of the service users.

Leadership is often shown in the literature review as a key theme in government documentation to drive an agenda when a strategy was identified as not achieving and at risk of failing. This was particularly so around the reduction of teenage pregnancy and the Deep Dive report (DH, 2006). This report is appealing to those in management to bear more influence to drive it. It is also a crucial finding in the Bristol report on sexual health service provision for young people (2006).

5.1.6 Matching Themes of Service Providers and Service Users

There are coupled themes between the providers and users of services shown throughout the literature review. This is particularly so for marginalisation and stigma of the services alongside that of the vulnerable clients. This study suggests that the marginalisation of the sexual health services within hospital and Trust settings, throughout history, allowed the domination by the medical consultants, disempowerment of the nurses, the evolving silo-centredness of services and the lack of modernisation. For many areas this has resulted in reduced access for the service users and the inability to maximise a health intervention opportunity through providing an integrated service. Fear is a feature demonstrated by clinicians protecting territory, also seen in the service users as a result of stigmatisation and prejudice, particularly those with HIV, but also for other vulnerable people. Marginalisation for both the services and the service users is present because sexual health is not perceived as a normal issue, or aspect of health, for society. Normalisation could come as we move forward, accepting sexual health as an aspect of everyone's health and as a routine NHS service. However, the history of AIDS has demonstrated that as normalisation occurs there is a loss of status around being part of “exceptional” policy, this is alongside less innovation or willingness to be attracted to the different area of work (Rosenbrock et al, 2000; Berridge & Strong, 1993). Imposed targets do

bring attention and focus for a time until there is improved capacity and culture around these services.

Change is brought about in some places by risk-taking managers and mobilisation of the nurses, who in complexity terms were creative and allowed new possibilities to emerge (Byrne, 1998, 2005; Cilliers, 1998; Gatrell, 2003). Both individual and collective responses are needed to bring this change. Time and space and motivation are needed for each to acquire new skills to begin to adapt to the change and then realise they had choices. There are successful relationships and interactions which allow the unpredictable to emerge, as adaptation and self-organisation takes place. The stable, historical processes are being shaken to create what could be perceived as chaos. An empowerment process is taking place of previously disempowered nurses; it matches exactly how it should be for any young person, or a socially excluded young person, a teenage mother, a gay man, or an African woman with HIV and seeking asylum. Having the resources at hand is often what these vulnerable groups do not have. When investment is made to support them in culturally, socially and psychologically appropriate ways then change will take place and there will be less sexual ill-health. All of this is identified within Department of health reports on reducing health inequalities and creating a less NHS dependent culture (DH, 1999, 2001, 2002, 2003, 2004). Appropriate sexual health services should be key agents, not just providing clinical judgements, but reiterating good health messages and maximising the opportunity within their interventions. Those that talk in this way, the one stop shops, or those trying to achieve integrated sexual health services, are few and far between.

Complexity theory considers the question of who actually grants power (Plsek, 2004; McClure & Jay, 2005). This theory identifies that structure, or the organisation, can actually move the power and allow change to take place. This is seen when power is realised, or appropriately used, by a leader who is not disenfranchised by another dominating force, as demonstrated in the medical model. To create this cultural shift, in a way that allows services to relate better to patients, will take space and time. This study shows it will also need to challenge vested interest, of status and power. Again this causes chaos or instability until behaviour and attitudes change and others gain knowledge and skills. Clinical autonomy will remain unchanged without shared

beliefs and values alongside norms of behaviour (Davies et al, 2000). The internal market reforms attempts to manipulate what is visible such as commissioner and provider roles and changing professional responsibilities, but the more deep rooted elements remain unchanged without a change in culture (DH, 2001; Klein, 2001; Nettleton, 2006; Ham, 2004; Witz, 1992; Lukes, 1974; Schein, 1992, 2006). There are attractors and motivators for managers in the form of targets that could be achieved more easily if more of the workforce were managing patients and not just the doctors. There are attractors for the nurses in professionally developing and being skilled to provide total patient management, providing more job satisfaction. When the medics are engaged with the process the attractors for them are to give up the routine work and only manage more complex cases, making the role more interesting and more manageable. The evidence shows for some steeped in a medical model that it will take hammering, wedging and shocking (Miller, 1998) before they could catch the vision and for the unstable systems to move further and further away from their original condition (McClure & Jay, 2005; Stacey, 1993; Rosenhead 1998). This unstable phase, moving within modernised services, appears to be a battleground where all the government levers are used as the weapons, demonstrated in the following quotes from service leads:

“Change is difficult.”

“But the services are very different to how they were.”

“Nurses were just hand-maidens to doctors.”

“But nurses have been keen to get on and work on their own.”

“The changes have been more difficult for doctors. They after all, no longer have the hand-maidens.”

“No-one else will have an opinion and everyone will defer to them (doctors) which adds to the marginalisation of the service.”

“The targets have helped get us here.”

“This service is very evolving; it’s constant change, ongoing, no let up.”

“To get integration you need painful attention to detail and taking small steps, it all allows worthwhile progress.”

A realisation that change will happen, despite the medical resistance, is shown in some places to be a motivator to those stuck in the past. If the organisation recognises and shifts power then it happens more easily, it is even seen as almost a natural shift without loss of face by those who originally held the power. This is illustrated where the nurses gradually took on the roles and responsibilities previously held by the medics. It could be identified when this happens that new possibilities emerge and there is new vision within the chaos. Things then become more spontaneous and natural. People begin to feel valued in their roles and they become aware that they are giving better value to the service user. A new ethos emerges as domination diminishes (Foucault, 1994). This model of provision now becomes sustainable as it is an inclusive one, integral to each person, one that does not require long-term planning, it will continue to evolve, as it is encouraged to do so, in true complexity fashion. The following quotes from practitioners illustrate these principles of feeling valued, included and empowered within a modernising service:

“Nurse led service has really helped this service provision and made it so accessible, reducing waiting times, we just couldn’t manage without specialist nurses now.”

“The dual training of nurses in GUM and contraception is what allows this enhancing of the service we provide.”

“To move it forward we try to listen and talk. Treating everyone as an individual, as well as a team member.”

“We were all very keen and over-enthusiastic. Everyone had involvement in a steering group.”

Complexity theory notes in these circumstances the use of personal, political and economic power shifts; as would happen with the service users if they also had these resources. This theory identifies the small, incremental changes that will move the agenda forward, each change making real difference, all contributing to reducing unwanted pregnancies, STIs and a more sexually healthy community (Byrne, 1998, 2005; McClure, 2005; McClure & Jay, 2005).

5.1.7 Contradictions from and for the Government

Complexity theory although it identifies small changes as significant, identifies contradiction and compartmentalised thinking as not achieving the desired outcome. Silo-centredness for genito-urinary medicine will actually more easily achieve the government target of a 48 hour appointment, than within a service that seeks to meet all sexual health needs of a client within one appointment; for example adding on contraceptive requirements within one intervention. These targets, if not considered together, are also representing silo thinking. The whole sexual health agenda is not being presented nationally as a united effort. This again contradicts the government policy and ethos of having patients at the centre and providing more patient centred services suggested through providing more comprehensive services such as one stop shops. Individual schemes and strategies from the many targets are not gaining the best for the nation from the resources we have to work with. For example, Terence Higgins Trust (2004, 2006) and the government noted the targets for a 48 hour appointment within GUM was being achieved only through services game-playing, or fixing how an appointment was made or interpreted; although it did not specify the consultant's role within this game-playing they are mostly, at that time of 2005-2006, the people leading these services.

The integration of service models requires levels of trust given to the practitioner to decide the appropriateness of the intervention, whether to deal with all those patient needs in one appointment or to sign-post elsewhere or to another time. The empowered and skilled up practitioner should be trusted to make that decision and not be driven only by targets that have to be achieved. Commissioners play a role here where they are driven to consider numbers and targets, to quantify and to not consider

quality. Surely it is quality that the service user requires to really make a difference? After all, the teenage pregnancy target is at risk if contraception needs are not addressed. If the contraception service does not respond to screening and treating infections then the STI reduction target will be affected. There should be ability for specialist services to respond more quickly and appropriately to higher risk-taking behaviour. The integrated model will provide more people with higher level of skills in more places, within one intervention. Sexual health centres, one-stop shops will blur, the boundaries and help normalise this as just another health service.

Complexity theory recognises information is imperfect, fallible, and everyone holds onto different information, the perspectives need to come together to gain broader understanding (Rosenhead, 1998; Stacey 1993, 1996). This study demonstrates that partnerships need to be stronger within the organisation of sexual health services, with listening more to what each can offer to the service user. Listening to those coal-face workers, who are feeding back realities of what the service user needs or wants, is seen to be key to that partnership. There are many unheard voices within this field, identified here by what is said by service leads:

“I feel un-listened to and agendas are driven by those who don’t know much.”

“I haven’t been asked for my opinion on modernising services or about the LDP targets”

Plsek, 2004, notes collaboration is integral to complexity theory, this should apply to the service user too, especially the more vulnerable service user, who should be consulted to help shape services and improve access, but they too are frequently unheard, as identified in the following quote:

“‘Cause you’re young the nurses and doctors don’t always listen properly, they’re too busy asking their questions. You feel judged.”

Models of service are not the first thoughts of those service users within the focus groups, as Anderson et al had shown in their review of literature (2000); other life

issues usually take precedence over the researcher's agenda. For the African women this is their asylum issue and the Home Office; for the group of teenage mothers it is having second babies; for the excluded young people it is alcohol, drugs and benefits. It is the other life issues that impact sexual health by causing the marginalisation and need to be taken into account when planning and providing services. These do not always fit with the government agenda around public health and identify that healthcare is only one determinant, as noted by Townsend in 1982 and within North Tyneside by Barke and Turnbull, 1992 and Campbell, 1993.

5.1.8 The Sexual Health Institution can Block Access and Mutual Engagement

This study gives insight to how an institutionalised NHS can block access to service, particularly for the more vulnerable clients. It demonstrates how imbalance of power within and outside of services does not allow mutual engagement. It prevents relationship centred care that is open and informing, welcoming the service user, encouraging services at their disposal, as discussed by Sang (2004) and the fully engaged scenario promoted by Wanless (2004). North Tyneside as a spearhead Local Authority area of disadvantage maybe was able to engage more quickly with the needs of the community and develop earlier their model of an integrated sexual health service, as indicated by the focus group of specialist nurses. Where there is evidence of withheld financial allocations to services, often by not giving priority within Local Delivery Plans, this adds to the disabling of modernisation and another example of withholding power. This is identified as the economic aspect of complexity theory, which was also needed to achieve movement to a modernised service (Byrne, 1998; 2005; Cilliers, 1998).

The changing sexual behaviour noted in the NATSAL survey (2000) is supported within this study from what the practitioners say they are hearing. The concerns of these workers are raised, along with all the national evidence, that availability and acceptability of services must meet levels of patient satisfaction along with the higher demand for service. Most of the research reports I consider around sexual health have not delved into quality of service provision. The focus group of gay men and the evidence within the literature review both show gay men are reluctant to disclose their

status to their GP. For HIV positive women this is also the case. Fear again plays a role, which means missed opportunities for health interventions. Yet the government is still driving an agenda of second level sexual health services through the GP. Equally this study shows there is reluctance on the GP side to get involved. Walk-in and rapid access services are said to be the answer to reaching the population who do not normally access services, according to the Terence Higgins Trust (2004) and this matches the evidence of the integrated nurse group, noted from the patient work they are carrying out. It is unlikely that such a responsive service could be provided within a GP setting. Again this was at odds with what the government are driving and are not achieving over 2004-2007.

5.1.9 Continuing Contradictions within the Government Driven Agenda

There are obvious contradictions in the government inequalities agenda for the African group with HIV and seeking asylum. This group voice they sometimes just lack basic needs of decent housing and income, as well as safety when under threat of being removed by the Home Office. For them sexual health was not going to be a priority. Yet, the reports in the literature review show preventable deaths and morbidity are occurring for this population (HPA, 2006). This research shows stigma and judgement of others compounds all of this, whether real or just perceived by the person this denies power to them. Intolerance within their own community is stated by the African group, also within the literature review, to an HIV diagnosis. All of this paralyses self actualisation and personal liberation. The absent social structures for this group determine taking care of their health less likely.

The delaying early sex education message that the government is driving through young people workers is said to be the correct message by the teenage mothers group, although some of them are choosing to have second babies at 16 and 17 years old. The workers themselves in two focus groups note that we do not fully understand the behaviour of young people, especially where there is economic disadvantage and low aspirations, which matched all other evidence. Early intercourse is still said to be less likely to be consensual and the young mothers stressed the need for young men to

take more responsibility for sexual health and contraception, as voiced by practitioners:

“We know sexual activity is taking place at an earlier age.”

“Alcohol and regretted sex, exposure to abuse and assault are worrying trends.”

The government agenda of more support for young families and more support for parents to talk to young people about sex and relationships is also confirmed by the focus groups. There are contradictions around the teenage pregnancy agenda when used as a negative connotation and then adds to the sense of marginalisation for these young mothers, as stated by them in how they believe they are viewed by others. The work of Hirst (2006) established there is a sense of agency when there is a desire of a young woman to continue with the unplanned, but not unwanted, pregnancy. This is confirmed by the focus group and their aspirations around future family life.

5.1.10 Small Steps to Bigger Change

Complexity theory shows how tweaking the micro processes, making small changes, can have a butterfly effect over time and space. Creating the unpredictable will bring innovation and change (McClure, 2005; Plsek, 2004; Cilliers, 1998; Byrne, 1998; 2005; Stacey, 1993, 1996; Morcol & Goktug, 1996). The government seems on one hand to be aiming for this tweaking, but institutionalised behaviour will not produce change. The nurse focus group from a “one stop shop”, an integrated provision, was an example of the institutionalised NHS, giving up power to the disempowered and no longer reinforcing roles and traditions. It now provides more accessible services through this one stop sexual health centre and illustrates how it can begin to impact the sexual health of the community. It requires an understanding by all staff groups and negotiation to move forward, again legitimising power through consent, moving from obstruction to strong partnership working with the patient at the centre, an empowering culture. Improvements can be sustained under these circumstances and

solutions constantly redefined with this collaborative way of working (Nettleton, 2006; Ham, 2004; Faubion, 1994).

Government public health campaigns contribute to these reinforcing messages for the public, but are supposed to allow informed choices and the making of healthier choices. This again, allows time and space for these messages to become a reality so they may contribute to emergent change. If the experts, the doctors and nurses, socially determine how to stay healthy, without there being economic and political empowerment of individuals there will be no change (Nettleton, 2006; Ham, 2004). If the HIV status of the African woman has to stay secret the culture is not impacted and low tolerance will not bring change. The government targets are seen in the study to be helpful levers for services to get resources. However, if used only to quantify numbers attending and not to establish improved quality, then real change is not possible. Quality is more time consuming, seen in this study as one-stop interventions that will impact sexual health. Quality will not happen if just counting numbers through the door is the aim to achieve a target.

5.1. 11 Veils of Secrecy, the Un-Stated Agendas, Starting to Shift

A cultural shift within the NHS that will allow seeing sexual health and HIV as real priority issues, even more impacting than cancer or cardiac disease, is identified in the field work. Taking sexual health seriously has been a long journey for this speciality. Commissioners, as leaders are seen in this study to be slow to catch on and support the services. Commissioners are responsible for raising the profile of services and ensuring an internal agenda not just an external one. There is a push approach available by using national standards and targets as levers; all given for their tool boxes, there is also plenty of evidence of sexual ill health. There was a pull approach available to them also, an irresistible, logical and emotional argument. For excellence to flourish cultural change was required. Barker and Roberts (1993), as did the fieldwork with service leads, note blinding with science, or throwing a veil of secrecy around knowledge and information, used as a ploy to retain advantage by the medics. The feminist sociologists identify that power is never neutral (Smith, 1987, 1990; Brunskell, 1998; Oakley, 1981; Malseed, 1987; Stanley & Wise, 1983; Cain, 1986;

Stacey 1996, 1993; Mies, 2003). However, within the NHS, as Brush (2003) also noted, it was accepted that male dominance was normal, neutral and universal. Covey (1989) notes a fundamental shift in thinking will not be instantaneous unless there is a crisis, as there is in sexual health services, as they are unable to cope with the demands and needs of the public. The service leads frequently refer to the paternalism and authority from doctors needing to change, the patient as a consumer of services is not yet a reality for most of these services. There is obvious heavy investment in status capital, the institutionalised authority of doctors legitimising their power over staff and patients. There is an uneasy journey for those who challenge this through government policy directives. Sharing knowledge and skills, rather than veils of secrecy used to exclude and withhold power, will enhance the role of everyone and make a vital contribution to modernisation plans (Latham, 2002; Nettleton, 2006; Lukes, 1974; DH, 2002). Inter-professional training and education was suggested as early as 1970 by Freidson as a way of addressing autonomy and dominance and providing opportunities to bring change. Service leads also identify that a workforce fit for purpose is needed as an emergent change; this will require organisational change. In some places resistance was to become malleable before movement happened. It is obvious from the findings that some services are not yet ready to move to modernisation, the work roles have not been planned for and staff are not yet equipped.

From those who support integrated service models a new emergent culture is seen. They seek transformation, but will continue to tolerate some discordant subcultures. There is evidence of shared beliefs and attitudes that have moved away from the medically dominated model. The culture is being managed, which then improves access to services. There is a change in shared beliefs, which are shifting and dynamic. The increasingly risk adverse culture of the NHS through clinical governance controls could easily avert this risk-taking of leaders that is taking some services down a modernisation track. Schein (1992, 2006) linked culture and leadership as fundamental in forming and changing organisations, usually many of the internal processes not understood to an outsider. Evidence from the fieldwork illustrates managing that culture would be one route to managing healthcare:

“GUM, it should be in the PCT, but the consultant went mad it was like a major earthquake.”

It’s a deeply ingrained culture.”

“There is obstruction around. GUM always feels threatened.”

Being an insider allows me to decipher aspects of that culture an outside researcher may not have discovered or identified as a cause to lack of modernisation. It is possible an outsider would have accepted what the consultants said i.e. that it was just about needing more finance in services and more doctor roles. On the other hand an outsider unused to such a paternalistic culture may have identified even more symptoms of it than I have exposed.

Commissioning is crucial to this change, bringing new drive and authority with performance management; alongside this they bring with them the bigger picture, not just the local service but how it fits with national priorities and the health of the nation. They are the ones who need to use the hammering, wedging and shocking, noted in complexity theory as tools for creativity and emergent possibilities and change (Miller, 1998). They need to drive the new health policy with the individual ethos, patients accountable for their own health and healthcare workers accountable for standards of provision. Agency is being encouraged but is not always possible within economic and structural constraints. Constant change in organisational structure brings frustration and confusion for everyone, including commissioners. Their own contracting relationship with providers adds complications to good collaboration. They require more investment and equipping for their own roles to support this health economy and the processes within it, but also they need more understanding of the function of services and the staff roles (Annadale, 1998; Nettleton, 2006; Klein, 2001; Ham, 2004).

5.1.12 Unique Findings That Justify the Approach

The evidence within this study is a result of a qualitative approach by an insider. It is shown to be rigorously analysed, as all the fieldwork evidence is referenced and

systematic within Appendix 3. To improve validity and relevance of the findings Mays & Pope (2000) and Silverman (2003) also state the importance of being sensitive to the ways the researcher and the research process shape the data, encompassing the role and influence played by prior assumptions and experience. I am acknowledging my effect on the research, which is also said to contribute to validity. However, as Northway suggested (2002), my perceptions are not always in agreement with those I interview and I could be viewed as both insider and outsider at the same time. I have things in common with those I researched, but also there are differences. What is actually significant to being viewed as an insider is the question I needed to ask myself throughout the process of investigation and analysis. The ease of access to the interviews was a factor, as was the common understanding of the sexual health agenda for services. The research audience will have a role to play in deciding the influence I have on the process and the findings, as I have disclosed my position within it (Bonner & Tolhurst, 2002; Serrant-Green, 2002). However, the insider approach did allow me access to expert voices and raised themes that would not be covered in more evaluative research.

As an inside researcher, as Champ (2002) noted, I suggest I have achieved debunking or demystifying some outdated views of the functioning of sexual health service provision and the reasons for lack of progress. This insider role does create opportunities to capture stories that otherwise would have been missed and prevented the re-contextualising by an outsider.

The asking of naïve questions, suggested by Serrant-Green (2002), unlikely from an insider, I did not find a drawback, but rather I could probe where an outsider would not have knowledge and then build upon it. With the focus groups of more vulnerable people their views are more diverse and I am perceived as a knowledgeable professional but possibly more as an outsider with more than usual understanding or insight.

My approach to this study demonstrates a non top-down, democratic and encompassing approach, which draws on intuition and insight to bridge the theory and practice gap that a quantitative method could not have achieved (Meyer, 2000).

My experience as a practitioner is drawn upon to understand the talk of professionals and of the service users, or vulnerable groups. This achieved a different slice of life than could have been gained by someone without that experience (Rennie et al, 1988). The methods chosen are able to establish validity and relevance. They are appropriate and sensitive to the questions being asked (Silverman, 2003; Strauss & Corbin, 1990; Glaser, 1978; Denzin, 1989; Guba & Lincoln, 1982).

Using both service users and service providers, a variety of sources, to triangulate evidence through individual interviews and focus groups has increased the comprehensiveness (Bryman, 2001; Silverman, 2003). This allows contrasting the findings as well as coupling of themes between them. It also gives credibility and reliability to the findings. The wide range of perspectives that were gathered also gives a sense of fair dealing; with no one group representing the truth (Silverman, 2003).

The question of generalisability of qualitative work is explored within the methodology and I suggest that although this study would indeed give a rich slice of life it also demonstrates usefulness for the NHS. Meyer (2000) notes that qualitative research methods, by drawing upon and encompassing the practitioner's experience, then also generate meaningful findings. The use of descriptive and contextual evidence, as suggested by Murphy et al (1998) allows illumination of the issues, which are built upon as the fieldwork progressed. I propose that the theory drawn from the concepts is indeed useful and meaningful and can be applied to the government agenda to achieve much needed change in services to improve the nations' sexual health. It also does appeal to the wider audience of the public and practitioners.

Usefulness and meaningfulness can be drawn from the grounded theory that has been developed from the findings. This theory can clearly draw recommendations and give insight to modernising sexual health services or indeed identify why services are not moving forward with a modernising agenda.

As Schofield (1993) suggests, the arduous and individual approach of a qualitative study, such as this one, would not allow replication, however, the findings may

stimulate further studies around the subject. Bryman's (2001) suggestion of authenticity as criteria of fairness that has assessed the views of others, I would say is inbuilt with the diversity of views brought into this work and as he suggests, will be a catalyst in the future to bring change.

The qualitative approach has fitted more with the feminist epistemology I work within. As Brunskell (1998) noted, this perspective is an influence for the subject chosen as well as the methods used. Smith (1987, 1990) and Oakley (1981) note, when speaking of the world from the standpoint of women, there can not be created an appearance of neutrality, concealing class, gender or profession. They rightly identify that the knowledge I create does not exist independent of the knower, or the part I play to generate it, this knowledge is not neutral. With this in mind I have made clear throughout this study what my role and standpoint is. From this view I have drawn out gender relations and report them as problematic. This is illustrated within the concepts of power of the male NHS consultants, the female dominated contraception service with less career progression and the obstruction of professional development of the nurses' role. These may not have been themes identified by another researcher with a different lens. Although I do not set out with the intention of exposing the gender imbalance, it does naturally emerge from the data.

I do also need to invest some of my own identity within the fieldwork as others wanted to draw from myself and my experience within the speciality. I found this reciprocity of talking about my own service provision to professionals, or giving information to the focus groups, which I was asked for, fitted with a less powerful position within the research. This is a position I am comfortable with, one that adds to congruence and authenticity and a feminist standpoint. The NHS Standards for Better Health (DH, 2004) and other policy has empowerment of staff and service users built into the agenda and can be compared, or measured, to the reality of the findings of this study. Sexual health services are found to be lacking in this aspect, with still some rhetoric as the empowerment ethos is frequently not yet a reality. This is fitting to be exposed within a feminist framework (McClure & Jay, 2005; Smith, 1987, 1990; Brunskell, 1998; Oakley, 1981; Malseed, 1987; Stanley & Wise, 1983; Cain, 1986; Stacey 1996, 1993; Mies, 2003).

5.1.13 Complexity and the Evidence

Complexity theory notes that evolving, dynamic change in the form of minor tweaking can not always predict what the effects will be (Byrne, 1998, 2005; McClure, 2005; Rosenhead, 1998; Cilliers, 1998; Plsek 2004; Goldoff & Jay, 2005; Stacey 1993, 1996). This study demonstrates this well where services are making changes to improve access and trying to modernise, despite resistance from the consultants. However, no government document is very direct about services becoming integrated or joined up to improve the opportunities for patients. They suggest it as a way forward only and the service leads find this frustrating, illustrated here:

“What does modernisation mean? A euphemism for delivering what the government want.”

“The Government refers to this model frequently but they don’t say how to do it.”

The policies are driving other changes needed in societal behaviours, reductions in teenage pregnancies and sexually transmitted infections. They imply improved access for service users must be sought but do not say how to do this. It is as if service leads have to discover a secret way through a maze, this was voiced strongly by those struggling to achieve an integrated model. The findings exposes it is those services, either integrated or wanting to be integrated, that are showing sensitivity to client need, which brings change. It is the services that respond to the service user voice and are now equipping the staff with skills, to meet that need in one place at one time. The context and time will influence the type of service the client will receive. This tweaking has resulted in some services having a completely different model of provision than was historically provided.

The interviews illustrate others wanting to be in that place of a new age service and insidiously beginning to introduce small changes, not quite knowing how it will turn out, but realising things need to change to make services more acceptable.

Complexity theory explains this strategy as a good thing. It presents long-term planning as unnecessary if other processes are in place, such as the vision and motivation (Plsek, 2004). New possibilities will emerge through the disorder or surprise, developing through adaptation and self-organisation. This change may happen despite obstruction, even if more slowly, poised between order and chaos, constantly evolving and adapting. A few variables interacting to produce results, maybe a good leader and some motivated nurses, or some money for a new building allowing an opportunity to bring together services.

This will be moving from a historical, orderly, predicable, separate and silo-centred service provision, to a sense of disorder and a reforming process of modernising and integrating. This will be until a new form of order is found, one that is never static, but will continue to evolve.

If this model is open to the environment, both on the inside and outside, through agency, economics, technology, politics and societal influences, then it will move to a new form of order. This non linear dynamic system emerges also from natural phenomenon, such as enthusiasm, skill, motivation, resilience, empowerment, challenge, collaboration and partnerships, alongside resources, that could be enhanced by the political climate, internal or external (Byrne, 1998, 2005; Cilliers, 1998).

Although natural the state is not accidental or extrinsic. Nurses need to be trained; it takes time to develop skill and experience. A health Trust may be fortunate to have individuals who have professionally developed without direction from their employers as a starting point, but they will need to sustain this development by further planning to encompass more like it within the system. A workforce fit for purpose for the sexual health speciality is seen in the findings to have had little forward planning. Those who have progressed earlier have recognised the natural phenomena needed for a new form of order and have been purposeful. This is despite the fact they can not predict how it will turn out and are constantly fighting against the resistance that is predicting failure. The stigma and marginalisation of services has not produced many characters ready for a fight, as there is so much to be done, within and outside of services.

5.1.14 Interdependent Entities and Complex Mechanisms at Work

No one, single, entity can bring that change, but it is variables that are interdependent. These are unobservable, complex mechanisms and consequences that are at work. These new integrated service processes have pre-existing variables and are becoming systematically organised (Byrne, 1998, 2005). They are more robust than those with silo-centred thinking. Their position, as Byrne suggested, is moving away from their original condition. This state presents concerns for those who want predictability, as it hovers between stable and unstable. The integrating service will not know if they can train up, or recruit, sufficient multi-skilled staff to achieve this new model, they will need to start with one or two and take risks to develop further. They will not be able to predict if they can meet the demands of service users or the government targets, they will just have to rely on quality indicators, such as patient satisfaction surveys, to see if they are reaching the parts others are failing to reach. It will be long-term health consequences that will be impacted, with only some short term gains. They will gain confidence by interdependence on other services that are going down the track of integration, learning from their discoveries.

5.1.15 Each Integrated Service Will Look Different

Those services that develop integration at different times in different places will evolve with different outcomes. This is seen in the evidence where some services are encompassing different elements within their models. Rosenhead (1998) notes those with similar starting points but with slight differences will cause quite different trajectories, this is the butterfly effect. The pattern of trajectories or strange attractors is the dynamic, evolving and preferred state for a modernising service. If the system is left in an undisturbed state, they will be seen as stable attractors. This is a stagnant state that will not achieve modernisation. These services are complex adaptive systems, which even require probing and the introduction of movement if they begin to stagnate (Plsek, 2004; Stacey, 1996).

5.1.16 The Process and Not the Goals are Emphasised in Complexity Theory

As I give context to these service models, gained from the evidence of the study, it is exactly how Byrne (1998) suggests this theory should be used. Intuitively inducting, bringing together the variables as I explored. I have been able to demonstrate that I knew what I was looking for, as the insightful insider, or attempting to group elements together forming systems, into complex adaptive systems. Using the quantitative data of sexual health epidemiology and this qualitative study, considering interactions of information, collective and individual views, was the context. From this I was able to define basic frameworks of models of provision. I am able to show if certain conditions are in place such as an equipped and motivated workforce, with a visionary leader and the right political climate to address sexual ill-health then the most accessible service will evolve. As Byrne suggests, this study as an integrated account, constructed around a complexity framework, has given an excellent opportunity to describe changes in sexual health service provision. Maybe it could even shape change, as he also suggests. However, he notes the dilemma I will be faced with of trying to reason with expert knowers, who have not engaged with what I am describing, and those on the outside.

Complexity theory has indeed been engaged and different. This perspective should allow more understanding of sexual health service provision and present rich information. It demonstrates well how the past is co-responsible for present behaviour, for example within the category of obstruction and power. It is shown how there is competition for resources, as services are not given what they are promised through public health policy of Choosing health (DH, 2004). This interaction between power and competition, alongside levels of cooperation, as Cilliers (1998) suggests, is needed to allow a constant flow of energy to evolve and to survive as a complex entity. Even the silo-centred services release energy when there is finance to be gained or when it was not given. This study does illustrate that an end to equilibrium is needed, seen within the silo-centred services. It is the process that is emphasised, not the goals, with individual elements, such as individual staff members, or service users being ignorant of the behaviour of the whole system in which they are embedded. These individuals can neither control the system, nor comprehend it. It is only the interactions that are significant, which will be non-linear (Miller, 1998;

Byrne, 1998, 2005; McClure, 2005; Rosenhead, 1998; Cilliers, 1998; Plsek 2004; Goldoff & Jay; 2005, Stacey 1993, 1996; Morcol & Goktug, 1996).

5.1.17 Connectivity Leading to Networks of Integrated Services that Impact Communities

The next step could be seen as networks of integrated services coming together with more evolving, dynamic change ideas. These will eventually not just impact local communities but whole regions. An insightful commissioner within my study sees functioning networks as the only way forward. Cilliers (1998) emphasises that individual systems with connectivity will gain more significance. His suggestion that complexity theory embeds all human knowledge, including the marginalised voice, into social networks, gives a place for what was previously identified as unscientific. These findings then become significant as they compete for a place within the system where there is also co-operation. Each element will not have significance in isolation but only through an asymmetrical relationship within the network. Networks of services coming together to share experiences will enhance progress of modernisation of sexual health services. Such networks will need to invest in sharing of power, with a shared vision and a will to share creative ideas. Allowing one partner to dominate would not permit the network to flourish with creativity; it would become stilted and silo-centred, nothing would emerge, no surprise or disorder, no richness.

Drawing on Gatrell's (2005) application of complexity theory to the health and inequalities debate (DH, 2004) and the possibilities of applying it to health geography could be applied to these findings. Modernised sexual health services, provided as an integrated model, as part of networks, could send out trajectories. These could achieve powerful attractors or motivators from the government, such as more investment, to become even more sustainable as individual elements and as connected networks. This would encourage other service providers to consider the integrated service model and having even more positive impact on the nation's sexual health.

Miller (1998) notes the merit in this theory for addressing resistance in behaviour of medics towards encompassing preventative work. This will only succeed with

connectedness, conversation and cooperation, as the feminists McClure and Jays (2005) suggest. That is where dialogue is open-ended and understanding only ever partial, valuing the contribution of the other perspective. It will be poised between order and chaos, emergence standing in direct opposition to reductionism. Not an easy place for those who have been trained and practiced within a strong medical model. Those governing NHS organisations will also not easily accept the risk and uncertainty that goes with this system; this is alongside relinquishing their control. A complexity and feminist perspective both would consider that self-government and instability will allow improved functioning. This allows the values of diversity and democracy to flourish and could bring everyone into the decision-making processes. The previous mechanistic, patriarchal worldview dominating over sexual health services will be seriously challenged, as the complexity of nature is not allowed to be limited by linear dynamics. The world of sexual health provision would change to one that possesses agency, becomes spontaneous, resourceful and self-generating.

5.1.18 Cultural Change is Achieved With an Integrated Model

The cultural change that is necessary to achieve the complex theory outcomes is seen from the findings to be possible with the integrated service model. It gives framework to the management practice, but it will need to allow diversity and recognise that long-term planning and contingency is not exactly how the universe operates. As Rosenhead (1998) notes, it all becomes turned on its head and illusionary. The environment is actually unpredictable and open to serendipity. Managers will need to seek the edge of chaos to release potential and energy. With instability new possibilities will emerge; even changed behaviour. Resurrecting the service from corporate death will require welcoming disorder and instability as partners. Maybe, as Stacey (1996) suggests, this transformation of an organisation, requires extraordinary management and not ordinary management that requires control at the centre. Some of these managers are there in my evidence, those that had achieved integrated services or those determined that was the way forward. This complexity framework will give permission to extend boundaries and persuade others towards this view. Persuading others will be achieved by champions emerging, who come forward talking of the benefits of this changed culture. Small steps can be achieved within this

framework that will allow significant change to emerge, which Stacey (1996) suggested could even be revolutionary.

5.1.19 Central Control is not Necessary

Complexity theory applied to management is not creating dependency on a vision statement or central control (Morcol, 1996). From my own findings it can be seen that a dominating, central control has caused dysfunction across the nation in the way sexual health services have been provided within silos. There is evidence of a workforce that was paralysed and service users who had poor access, alongside deteriorating sexual health of the nation. Restricted expression for service leads and practitioners is obvious in the way information is eagerly shared. I am an insider, one of them and this is a confidential interview, guaranteeing anonymity.

As professional expertise becomes more widespread amongst a wider workforce and is not just in the hands of the medics, there should be more opportunities to work at the edge of chaos to allow new discoveries within dynamic practice. Self-organisation and spontaneity will lead to new possibilities, as it does within the natural world. It will certainly lead to survival, where the central planning of the silo-centred services has failed. I suggest these findings do demonstrate emergence as a product of coupled, context dependent interactions, non-linear in nature. It is difficult to account for the behaviour of the overall system by examining individual behaviour, for it is the interactions, the organisation and the interdependence of elements, both internal and external, which explains complexity theory within sexual health service provision.

5.1.20 Bringing Real Change and Normalising Through Chaos

To become accepted within an organisation such as the NHS, chaos would need to be defined or explained not as malfunction, but as temporal behaviour representing a variety of possibilities and as adapting to changing circumstances. Alongside an unknowable future and inability to plan, these will be difficult concepts for the NHS as an organisation which needs to give reassurance to stakeholders that it is indeed in

control and knows where it is going. However, as Goldoff and Jay (2005) note, complexity theory is providing a variety of possibilities and adaptation to changing circumstances. This allows the question to be asked, what is needed for modernising services? This should not be viewed as problems to be solved but merely as aspects of the process by which the living system is adapting and renewing itself, through self-organisation. It would bring with it a new order, one that is confident as it relaxes control and prediction. The professional perspectives will also change and evolve within this new culture, alongside the organisational and political change. The politics of sexual health would be inevitably impacted, the obstruction removed. The unilateral working and closed way of working would flounder. The history of AIDS identifies that as this condition became normalised, following an exception phase and then the introduction of treatment in the mid 1990s, there was less attention given to it with some loss of innovation and willingness to be involved. This could be compared to complexity theory or chaos where innovation and period of high activity is encouraged to meet demand, with adaptation to the changing circumstances until they reach a plateau of normal, or self-organisation (Rosenbrock, et al, 2000; Berridge & Strong, 1993; Ferlie, 1993).

Instead of apathy and stagnation among teams there will be encouragement, empowerment and sharing of power. A culture of blame and hostility will be removed and fear of change will no longer be a feature. Gender inequalities will be impacted and domination by one workgroup will disappear. The marginalised voices will be heard and actually listened for. There will then truly be a shifting of the balance of power. There will be balance in all ways, more natural harmony in systems, moving towards normalising sexual health as a service within the NHS and as an aspect of each person.

Modernisation will then not just be a term for what the present government wants, but actually what is needed to bring real change to the health inequalities agenda of this nation. Commissioners will take their role seriously and find sexual health services an exciting arena; they will have a grasp of the bigger picture and have more interest in quality rather than quantity. Performance outcomes will become unnecessary as adaptation and self-organisation brings excellence. They will have difficulty keeping

up with the? pace of change as they will see others driving it, those who continue to be enthusiastic and creative with empowerment.

5.1.21 Improved Access, Improved Sexual Health, Continuing to Normalise

Integrated services could all look different, taking a variety of forms, as different champions with diversity of skills, but of a higher level, move forward quickly. Seamless care for the service user would become the normal provision, with maximum health gain in one intervention. No longer would they have to move between services and to be seen by practitioners with different levels of skills. They would be in one safe environment, evolved to meet their needs. There would be no missed opportunities.

Small steps and small changes will be constant as the barriers are removed. Increased educational opportunities would be available to staff and knowledge would not be used by some as a wedge to prevent change. There would be improved access to sexual health services for the public, which would be user friendly in every way. Organisations or services would no longer be closed with unilateral working. Issues would no longer be hidden; marginalisation and stigma would be exposed and unaccepted by individuals, the service providers, and the network of service providers, the larger organisations and the nation. Inequalities in society equated with poor sexual health would begin to change. The major contributors would promote the improved access and normalising and acceptance of sexual health as an agenda that needs taking care of; individually and collectively it would have an impact. Everything due to micro processes that influence change, the pace of change being determined by the culture.

5.1.22 These Services Can either Get Better or Die

A paradigm shift could be brought about by application and understanding of complexity science, using it as a framework for dynamic change. It requires, however, visionary, creative, risk-takers; those who are passionate to improve sexual health

services and the sexual health of the nation; those who do not want power but are keen to give it to others. The evidence from my study shows there are already such people driving this agenda; they just require a helping hand instead of constantly struggling against the tide of change. As Byrne (2005) suggests, the services can either get better or die.

Issues of power, dominance and autonomy that have been shown to cause obstruction to the modernising agenda and a change from this paternalistic way of providing services to a new understanding that policy demand the NHS consider the patient now as a consumer, I have implied there is a way forward. The government policy is there to help, but as a centralised top down approach is not always accepted. Decentralised controls being suggested within them but a reality of targets and monitoring determines it is seen as more rhetoric. A change in culture is more likely impacted from within, a bottom-up approach, inclusive, sharing knowledge and skills and networking with other outward looking departments. Incremental change that evolves over time and with an expectation it will continue to evolve and not become static, but will meet changing needs of the consumer and become more accessible to them.

5.2 The Process of Finding Out and the Usefulness of the Findings to Transform Sexual Health Services and Improve Access

5.2.1 Sexual Health Services a Complex Social System, Sensitive to Time, Events, Beliefs and Feedback Loops

Following this analysis of sexual health service provision I would agree with the perspective of Tsoukas (2005) that epistemology, or how we view knowledge, how we obtain it and justify it, as being no longer just the prerogative of philosophers and social scientists, but as an area that organisations, such as the NHS, should be involved with. They are themselves creators of new knowledge and users and makers of knowledge that is frequently brought into the public arena, not just for discussion but for application. Most of this knowledge has serious implications for contemporary British society.

How that knowledge is constructed needs to be looked at within and from outside to justify their claims. This brings me back to Byrne (2005) who identified that complexity theory would affect a methodological approach to a study and hence my insider stance, challenging some outside and inside perspectives. This study was investigating complex forms of knowing, according to Tsoukas (2005), the results of which could surprise observers, the whole behaviour of the complex system under investigation can not be explained by each constituent part alone. My own research process itself was an example of a complex social system that has been sensitive to time, events, beliefs and feedback loops, part of an open-world ontology, in a process of becoming, that was capable of becoming something quite different.

5.2.2 Influencing Practice and Policy through Process and Continual Change

I did not know what the outcome would be as the study progressed, it was unpredictable. I took risks by chancing interviews with national leads in the speciality and placing them alongside talk from service leads and vulnerable groups. An unlikely mix for a study, but I was using my organisational knowledge and was connected with my mode of knowing. From the interactions of talk emerged simple concepts and themes, evolving into categories that became complex structures that had not previously been demonstrated in other studies on sexual health provision. The experience I had as a practitioner had made me aware that access was restricted to services and also that service users had unmet needs. However, I did not have the breadth of understanding to why this was until the interviews were completed and the analysis set within the framework of complexity and feminist theory and the literature review.

The qualitative descriptions captured organisational phenomena. The theory that emerges does justice to the historical context, interdependent and interacting agents, as well as the occurrence of chance issues and events. It has provided an alternative language to re-describe organisations in a non-reductionist or mechanical way. It shows events can not be forecasted and will indeed throw in disarray the strategic planning of the NHS and the vision statement of organisations. If adopting this theory then the implication for services, or the NHS, is a need to move away from this

preoccupation with a reductionist, clinical approach. The solutions are to be found in the sharing of power, the empowering of those who have little to contribute to the inclusion agenda and reduce inequalities. The consumer of services should be at the centre and seen as the main stakeholder. Professional dominance causing institutional paralysis is to be challenged to achieve improved access and more comprehensive services. Legitimate power that has been consented to and collaborated about can be given to other staff groups and services. The government policy suggests new roles and renegotiating boundaries of power also used as levers to achieve this. From a complexity theory view the inclusion of internally driven processes would then become more important than the outcomes and continual change would become the order of the day.

5.2.3 Transformation could Evolve if Organisational Patterns of Thinking, Behaviour and Values are Impacted

Those in authority could encourage the chasing of new possibilities and new experiences. They would be searching for whole systems transformation, rather than just structural change with service redesign. Within a complex system, such as an integrated sexual health service, transformation would only evolve where there has also been success in impacting patterns of thinking, behaviour and values, as also suggested by the literature referenced on power and autonomy and socialisation of the professions. Encouraging good communication, that also challenges any unchanged patterns, would be vital. Such patterns would also include levels of trust, which would need to be built over time as new roles and responsibilities evolve.

The five keys ways of addressing complex organisations to bring this transformational change in a whole systems way, according to Plsek (2004) is the opposite to what I found as a reality within the silo-centred services, however, they are the aspiration of those who have already moved, or were moving towards an integrated model of provision. He noted power should only be exercised constructively and decision-making be rapid. However, blockage and resistance was the theme from services that were structured around authoritative positions, a hierarchical structure with the

medical consultant not releasing power, whereas a whole systems transformation requires quick decision-making by those with the most knowledge about an issue.

Plsek also identified relationships should be connected and healthy, relationships that encourage creativity, and commitment, again not hierarchical, this way of connecting will release energy and innovation; relationships between professionals were demonstrated within this study as frequently stilted and paralysed.

How power is used is crucial to this transformational change. What I heard in the talk of informants inferred only some held this power and it was indeed used for self-interest and preservation of tradition and outmoded ways. A transformational management or leadership style does not need all the detail but would use their power for collective purposes in constructive ways. This style encourages small creative changes to evolve, all of which are important to the process. This would also include the voices of service users and those who do not use services. If management were transformational these opinions would be sought and their voices would be integral to the modernisation process. All consultation responses with the public would be acknowledged and responded to; there would be a sharing of power. Public engagement and involvement would become embedded within the processes as a way of working, making a valuable contribution, strengthening the quality of decision-making and levels of accountability. This would allow realistic, common sense solutions to emerge. This requires a transformed, changed culture.

Education in practice, the professional development of nurses in particular, was resisted, seen as threatening to the status quo. The transformed service provider has in place a system that allows curiosity; they are eager to learn new things about themselves and are allowed to take risks to find out.

Conflict was evident throughout the silo focused service provisions. This was causing a negative and destructive response within teams. Within a transformed team difference would be embraced and that would lead to new discoveries and new thinking.

5.2.4 Complexity Theory Sees the Value in Every Individual; the Micro Patterns

Plsek (2004) uses complexity systems theory to see the value in every individual, their every connection and every affiliation, allowing emotional aspects of individuals affecting who they are and what they do. Gender, race, sexual orientation, should all be embraced and brought to the table of transformation. Those who are gay, those who are teenage mums, those who are young offenders, those who are African and seeking asylum, those with HIV, anyone who has, or is, marginalised will be valued, listened to and responded to. From the service provision, the most junior, least experienced should have a place and value. These are the micro patterns that bring a rich complexity and really will affect the outcomes, maybe even achieving the government targets, as new patterns emerge. Broader patterns of meaning will emerge within organisations, or service provisions, as everyone's attitudes and beliefs have a role. As Plsek predicts, if the five pattern areas of energetic relationships, rapid decision-making, constructive use of power, management of conflict and learning embraced, all addressed with honesty, there should be natural and frequent change. According to complexity theory, new patterns will then emerge based on this foundation and hence unpredictable consequences. Each service provider will develop a new culture that is unique to them. It will have its own shared meaning and ways to behave, created unconsciously. It won't appear logical or consistent to those who have not worked within such a system, but then it is a non-linear system.

5.2.5 A Dance of Complex Systems; We Can Not Understand Every Cause and Effect

To those that showed they were already embracing this cultural transformation it was proselytised as the only way forward, there was no going back to how it was. As Byrne (1998) says, complexity science is a frame of reference for understanding why things are happening the way they are and how things could evolve differently. This is a dance of complex systems and there is no way we can understand every cause and effect. I am very aware of my own biography within this study as May (2002) notes we should be. I have contributed to the evolving of an integrated sexual health service within North Tyneside and my standpoint is quite different to someone who has not

been part of that evolving complex system. How I interpret the evidence from the study and the part I have played in it are a fundamental aspect of the process alongside the 363 concepts generated from the interviews.

Much of the Government policy around health that I have explored within the literature review was promoting the five foundational principles that Plsek (2004) talks about. That is the sharing of power and the encouragement of professional development within a context of consultation and participation of the public within services. However, it can be seen from the evidence, sexual health services are not often engaged with these principles, despite over a decade of drivers to consider them. This complexity framework has allowed an exploration of why this is and also given a means to move it forward. The poor access and blockage to user friendly services is not going to contribute to improving the nation's health.

5.2.6 A Challenge to Reductionist Explanations that has the Capacity to Bring Influence to the Local Context

Complexity theory is challenging the traditional, reductionist approaches to explanation and prediction and explores a range of possibilities. Processes become non-hierarchical. This theory is rejecting variables that are fixed in time and space, but makes sense of a plethora of conditions and gives rise to a complex range of outcomes. This was evident within the teenage mothers' focus group; they were planning second pregnancies, still in their teenage years. This went against all of the government policy that was promoting adolescent conception as a bad thing, for these women this was not the case. They actually had stable relationships and homes and were choosing to have siblings for their baby, just as most families do later on in life. Causality and association are challenged. Nurse practitioners were in some places encouraged to professionally develop, knowing what they were capable of and what was feasible from local knowledge, from professional journals and their links nationally. Nothing was fixed in time or space. Agency was playing a strong role; the motivation of the individual would determine an emergent system. With this theory we are encouraged to think more holistically and consider much wider possibilities. It challenges many of the policy directives. It asks you to consider believing in the

possible, rather than the reality of the present. Knowledge is local and contextual, so no matter what the policy makers propose, if it does not fit or work locally it will not be applied. This was demonstrated in the views of service leads, practitioners and from the service user or vulnerable group. It confirms the base line of complexity theory, that there is no universal law within a complex world (Cilliers, 1998; Byrne, 1998, 2004). Processes are able to flow in all directions, in a non-linear form, releasing energy and recognising agency, interacting, with unknown possibilities or outcomes. Government policy has been shown to encourage agency, particularly the Choosing Health agenda (DH, 2004); the complexity theory demonstrates that other things are required to support this agency such as the economic and educational opportunities.

The suggestion that more accessible services will impact the sexual health of the community is illustrated from the findings as applicable or possible.

It is seen through the model of an integrated service as most acceptable to service users. However, a few small changes in the culture of service provision can also have an effect on improving access and will consequently contribute to improved sexual health of a community. However, those services still resisting integration have many cultural issues to address that will make transformation slower, hence, reduced overall effects on improved health outcomes for the community.

We can not, from the evidence I have given, reduce life issues such as an STI, or teenage pregnancy, or HIV to single causes; cause and effect does not apply in complexity. There are interactions at many levels. What we are working with in sexual health services is not single conditions, problems or diseases, but a manifestation of social complexity, the emergent properties of that complexity are real, also with a range of probable outcomes. These outcomes can be impacted by the service that is received, if at all accessible. This brings me back to accepting the initial question asked of this research study, could more accessible sexual health services impact the sexual health of the local community? Redesigning the model of service provision alone will not bring change for the service user, the service provider or the policy makers. Transformation, real and fundamental change for all, will require that structures, processes and patterns are impacted. New programmes and re-organisation

alone will not achieve this. It will require challenges at many levels for this to be achieved; as was seen in the evidence of those working toward this change. However, they did also demonstrate a complexity principle that a few local changes can have a big effect, things moved forward despite constant tension. The leader, or character that was determined to bring change, probably a complex adaptive leader, was one part that affected many parts and particularly addressed the power imbalances.

5.2.7 There are Many Aspects Within Present Services that Will Need This Constant Challenge to Achieve Transformed Services.

Considering these principles of complexity theory, which I have explored as a frame of reference for my findings, they have clearly demonstrated why sexual health services have evolved differently across the nation. I take this a step further to suggest how things could be changed to improve the sexual health outcomes of service users using these complexity principles. This is illustrated in the following chart:

How It Is Now In NHS Services	Transformed Services
Professional autonomy.	Care is customised to meet patient need and values, moving from paternalism to consumerism. Power is shared.
Professional control or paternalism.	The patient is the centre of control, the key stakeholder.
Knowledge and information is withheld.	Knowledge is appropriately shared and more free flowing.
Decision making determined by training of practitioner.	Decision making is all evidence based and guided by best practice.
Individual responsibility to “doing no harm”.	Safety becomes systems property.
Secrecy.	There is transparency in processes.
The present system reacts to need .	Needs are anticipated.
Hierarchical roles of practitioners override everything.	Cooperation amongst practitioners is a priority, collaboration with patient at the

	centre.
Strategy and planning integral to the system.	Good enough specifications, not too much detail, things will evolve.
Same thinking, reductionist explanations.	Thinking differently, creatively.
The system is static, orderly.	Change is expected, constant and evolving, action by one part affects all other parts. Change is non-linear.
Laggards are more prevalent.	Early adopters of change become the norm.
Tradition rules.	Change becomes naturally attractive, attractors become obvious.
Closed system. Equilibrium (and possible death).	Open system, interacting with the environment. Requires a flow of innovation and energy to keep it vibrant and evolving. Results in self-organisation. Sexual health services move towards normalisation.
Reductionist, historical, medical model determines that it controls all elements of the system. Resists adaptation.	A single element is ignorant of the behaviour of the whole complex system. Relies on relationships and connections. But macroscopic change results from microscopic interventions (for which there are a large number).
Scientific, must be correct (impoverishing approach).	Rich in information from interactions and connections and collaboration.
Exclusive medical model determines all solutions.	More inclusive of new ideas from all stake-holders, bringing new solutions. Agency is encouraged. Bottom-up approach.
The most powerful receive the resources.	There will be competition for limited resources. All stakeholders have a chance of new resources.
The system is fragile, functions with	The system is robust as it is distributed

central control, in isolation, with few connections, and pursues constant stability.	over many elements and will balance itself through self-organisation and local controls. It will poise itself at the point of criticality, between stability/rigid order and chaos. Encouraging creativity.
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Figure 10. Applying Complexity theory principles to illustrate how it is in sexual health services now and how it is for a transformed service

5.2.8 Implications for Policy and Practice

The complexity theory has offered a pragmatic view of why things are the way they are but has also offered a way forward. It has given me understanding to why the one stop shop service provision could offer solutions to the services nationally that have not been able to meet the needs of the public. I can see that this model is more robust, not relying on central control, but on the skills of each practitioner and leader, alongside the connectivity with all stakeholders, technology, economics, politics and societal change. It is constantly looking for new ways and new solutions. It is vibrant and using energy to emerge into new states that adapt to meet changing need. It organises itself toward the critical point. It becomes user friendly and accessible, with a healthy work place ethos. It is a transformational model, which could offer transformation to the nations’ poor sexual health issues. The literature on professionals and power also demonstrates that the internal market reforms within the government policy will not achieve modernisation of sexual health services without negotiation and legitimising power for nurses and putting the service user at the centre of all change and as the key stakeholder. Investing in effective leadership to assist a change in culture was also shown to be crucial to these processes. Top down government directives can be perceived as externally driven rather than more internal pull approaches of collaboration and resisted through obstruction and belligerence.

5.2.9 My Effect on this Study

This study did draw heavily on my own experience but I attempted not to take advantage of my position as an insider, or to over-identify with any of the participants. It was useful to know where and when to gather data. It helped in many instances to establish acceptance and rapport and create more trusting situations quickly. The influence I had on what was said and on the process, I would suggest, was a positive one; being careful not to be too close and yet enabling the participant by them knowing I understood what they were talking about, without them having to give unnecessary detail or history. I felt it was my insightfulness of the culture of the world of sexual health that made a significant contribution to the fieldwork processes. I would be perceived as a researcher that was part of the social group under study, which maybe did allow a more natural acceptance and talk that flowed more easily. It also, as Bonner and Tolhurst (2002) suggested, promoted the telling and the judging of truth. I would propose that it has the potential to contribute new insight to the body of knowledge because of this. I did save time having to understand the culture and I do feel I was researching the real world; this study will have the capacity to produce pragmatic consequences. The subtle differences I was able to identify, because of the role I had, did bring out rich data. Being part of this culture made me very aware of assumptions I could make and that I could miss familiar patterns of practice and behaviour. This was alongside having an ability to hear sensitive issues that outsiders would not hear or be able to decipher.

However, drawing on my listening skills as a trained counsellor, and doing as May (2002) noted, to separate emotion and reason, I do not think I missed things that were just too familiar and I was able to produce rigorous research. However, another researcher would certainly do it differently. I did not sense any of this was at odds with a feminist perspective, as I invested sound core conditions of confidentiality, trust and warmth, valuing each participant's contribution. Alongside this was my offer and openness to the feminist principle of reciprocity. As I noted previously, where it was wanted, I was able to offer information about my own service and how it had evolved. Some service leads asked I return and do presentations to their staff teams and contribute to their own evolving processes. For the service user or focus groups, at the end of my research work, they often drew on my knowledge of what services

could provide for them or other issues around sexual health. All of this allowed me to give something back, rather than just taking from the research field. Having an interest and an ability to engage with their agenda, rather than sticking rigidly with mine, fitted with the feminist standpoint. I particularly found this to be the case with the focus groups. Not imposing too strongly the research questions, trying to keep some boundaries but recognising what was important to them. It consequently added to the richness of the findings that otherwise would not have been discovered. Hearing what was important to all of those groups is what services need to hear and take note of. As in true complexity style, this spontaneity added to the disorder (Byrne, 2005). This strategy allowed me to really enter some lived experience, revealing richness with real context that created connectedness that will allow more to be built upon and evolve in the future (Miles & Huberman, 1994; Plsek, 2004).

Gaining informed consent from every respondent was crucial to embedding trust to the process. Also feeding back what was heard and guaranteeing anonymity added to this trust.

I was very aware I was in a privileged position and I often had access to people, places and groups because of the position I hold within the organisation. However, because of this position and through this research study, I am also hoping to contribute to transformation of an existing structure, as McClure (2005) suggests, in new and fresh ways.

6.1 What this Exploration has achieved

Within this exploration of modernisation processes for sexual health services complexity and feminist approaches allowed me to explore differently the meaning of what was said and encompass it within the social processes that were taking place through time. It also allowed me to consider why some services were able to modernise and yet others were stuck in a mire of resistance. The exploration of power and the professions and the impact of government policy on sexual health services also demonstrated that externally driven directives can be used as levers but are frequently resisted. A change in culture is required to allow modernisation processes to evolve and a reduction in dominance by the medical profession; these are more likely to be responded to with a more collaborative and local approach. Incentives for everyone require being clearly stated.

This unique exploration was achieved through inductive thinking and the use of grounded theory for the analysis, drawing on the abstract and putting it within a framework of the feminist complexity theory. I was using concepts from the talk of interviews and focus groups to build up into categories that nested under the main category of deteriorating sexual health within an increasingly sexualised society sexual health, beneath which lay sexual health as a highly political field, within and outside of the NHS, to form a substantial theory. The study went on to show that modernisation in the form of an integrated sexual health provision, such as a one stop shop, would address the many aspects of unmet need for the public. Obstruction and resistance, from a mainly genito-urinary medicine physician direction, was a strong theme to resisting modernisation. Robust commissioning, or commissioners, alongside good leadership, was perceived from this study, to be vital to overcoming entrenched views. This led to a category which identified the workforce was not actually always fit for purpose and there had been little forward planning on the part of the NHS to prepare for the high demands that would be placed upon sexual health services. The new public health agenda from the Choosing Health drive since 2004 (DH) is attempting to address the issue of people taking more personal responsibility for their own health. However, this study showed there was still much work to be

done as health inequalities in society are still a major issue within the UK and it will require much more than just turning the tables on the public and expecting them to be responsible for their own health.

The findings demonstrate that sexual health services must be user friendly and accessible for everyone, normalised in every way, they should represent just another aspect of who we are and be just another NHS service. This could then make a real difference and contribute to improving the sexual health of the nation.

The mountain of government policies that are pertinent to sexual health such as the MedFASH standards for sexual health services (2005) was thought would have the key to transforming services. Complexity theory illustrates that this throwing of government directives is a push approach. There is more power in the pull approach of proposing change as an irresistible, logical and as an emotional argument. This bottom-up approach is an emergent self-fuelling one and success will depend on good planning and strategy. This is a tool that would challenge our NHS ways of organising and leading. It would involve moving away from top down improvements and moving more towards frontline staff intervening with evidence based actions. Future advances will require staff teams united around specific aims that even exceed outside goals. It will entail competent leadership with a vision that will keep everyone involved.

This study could be accused of an over-use of frameworks and approaches. However, I feel I have justified each one as necessary and I would not have achieved a substantive theory that was robust enough to defend itself against critics without using the view I have taken. The evolved theory is a unique one but it is relevant and does not impose preconceived ideas on the data. Each category fits and relates directly to the data, but they can also be modified and adapted. The complexity framework has brought fresh understanding and new insight and it is able to scope its position i.e. within the NHS, within society, within the life of each individual. Although it is a unique slant there is generalisability to sexual health services across the nation. The insider view allowed me to uncover things that have not been acknowledged previously and are a real blockage to progress for these services and the access they give to the public.

There were many previously unheard voices, or voices without enough recognition, within this study. The principles of complexity theory and the inclusiveness of the marginalised voices are vital to the process of modernisation. Change has been difficult for everyone in this study, whether it be to modernise a service, or to try and stop the process, or whether it is addressing one's own risk-taking behaviour, or coming to terms with an incurable diagnosis such as HIV. There is an obvious need for support for everyone within the system, to accept the need for the change and to move forward with it.

The coupling of themes seen in many instances between the professionals and the services users was particularly evident around disempowered nurses and marginalised services users and service providers. A culture of blame and hostility within some services was also evident as sitting parallel with some of the marginalised groups such as asylum seekers and teenage mothers. All of which contributes to dysfunction and ultimately to the poor sexual health of the nation. The voices of these groups often represented disempowerment. The culture of the silo-centred services was not an inclusive one, not one used to sharing power by involving or engaging with the outsider.

To have a new lens, one that releases power to the most able and appropriate to meet the need of the service user, requires new vision and more innovation to release potential in individuals and within services as a whole. The micro-processes need attention, the smallest adjustment will have great impact to evolve into a whole systems approach. The less high profile and medically dominated services had demonstrated in the study that they had progressed with small steps producing major changes and services that were more acceptable to the service users. These were less formal places, open in evenings, with drop-in facilities, usually staffed by nurses and offering a holistic patient management. They were less likely to send service users away with their needs unmet, sign posting to other places at other times.

Nurses were definitely earlier adopters of change with little signs of any professional protectionism around their role, they just wanted to ensure needs were met and they engaged enthusiastically with education. However, they have been relied upon to take up the gauntlet and to make a significant contribution to the modernisation process

without the strategic drive of the government to make other changes within medical education.

There were some service leads who were champions, those who drive change, prepared to take a few risks to seek the edge of chaos, in an attempt to see innovation thrive. These were the leaders with processes that are transparent and the needs of the service anticipated, they encourage the cooperation of everyone. Change is attractive to them and if it does not happen they move things or introduce new things to make it happen. Their service constantly evolves and is never static. Relationships and connections are relied upon to add energy to their open system, which becomes robust as it is spread across many elements and self organises itself. Not all of the elements, either those within a service, or a whole service, totally understand the whole system but their individual contribution makes a real difference.

6.2 A Way Forward for Policy and Practice to Improve Service Provision

The sexual health service providers need acknowledging for the intensive input they give, in whatever form. Government targets have most certainly brought some resources and lots of attention to the failing sexual health services; even if the targets are not achieved they have been a lever to moving forward. These targets have forced services and the government to think differently. However, the government messages are often mixed and confusing, for both the public and the service providers. An example would be developing campaigns such as delaying early sexual activity in young people alongside national screening of young people for chlamydia.

Recommendations

There are many pragmatic issues drawn from this research that if rooted within the NHS could make a significant impact on sexual health service provision.

1) There Should be a Nationwide Evaluation of the National Sexual Health and HIV Strategy (DH, 2001) to Consider What Else is Required.

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Recommendations

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1) There Should be a Nationwide Evaluation of the National Sexual Health and HIV Strategy (DH, 2001) to Consider What Else is Required.

There should be some reversing of plans or change in thinking from the government, acknowledging some things have not worked and are not producing the desirable outcomes. The GPs acting as second level sexual health provider services is an example of this. Just creating NHS policies and expecting them to be applied, is demonstrated in this study, to often not have an impact on patient management. The abstract and high level concepts of public policy have not always brought reform. Service providers should be included and contribute to the vision of what best suits the service users. These findings alongside the Health Development Agency (2002) notes there should be more scoping of the views and concerns of practitioners and service providers. There should also be a national focus considering the acceptability and availability of services and levels of client satisfaction with the sexual health services on offer. The literature review illustrated a gap in this area of research.

2) Develop Sexual Health Networks

The Government should consider the use of sexual health networks to support the modernisation process in a way that would impact entrenched, silo thinking and encompass the views of all, including public engagement on these issues. Collaboration and connectedness with all stakeholders has been the talk of the NHS for a decade but in some areas this appears to be only facilitated by those with the most power. These networks could present the evidence for change and give support to those leading change.

Such networks would strengthen the voice of sexual health as a speciality within the NHS. The highly political nature of this speciality would then have an opportunity to come more into the open alongside other health issues in a more normal way, possibly disempowering those with the silo-centred mentalities that create the obstruction to improving access.

3) Integrate Professional Training and Development

There should be more investment in education of the professionals. This education should help them to think differently, more holistically and more broadly and not just clinically. A less medically dominated model of care could be achieved if there was

inter-professional training and less silo-centred training, maybe even doctors, nurses and others agencies training together. This should be alongside more investment in the training of managers or leaders which would assist in moving services forward more quickly and equip them to deal with obstruction or silo thinking. The equipping of commissioners to drive this service provision, to ensure it meets the needs of service users and engages with government strategies is also a vital aspect of the fit for purpose workforce.

4) A Toolkit for Integrating Sexual Health Services

The enquiry around providing services in an integrated way was accepted by most of the participants as the way to improve access for the public to sexual health services and would contribute to the nation's improved sexual health. The findings also considered this model to improve the quality of provision, addressing both practice and policy issues. This integrated model would allow complex and simple need to be met opportunistically, it is a model perceived to anticipate need rather than simply respond to it. This way of providing services is more holistic management and one that allows promotion of good sexual health. Silo-centred services were not perceived as user friendly, either to the service user or for the staff team. They could possibly have some impact on targets in the short-term, but long term gain for sustainable risk-taking behaviour change, with less teenage pregnancy and STIs, was less likely to be impacted through silo provisions.

The lack of direction for integrating services was a frequent complaint from the service leads. The government should offer more support to those trying to achieve this model, otherwise it is like a tabletop without legs; the legs give the ongoing support. The levers have been provided to bring change, but there is little instruction about how to get on with it. The findings demonstrate the obstruction that is faced and this should be more readily exposed for the good of the nation's health. Those who have achieved success in overcoming it should be encouraged to share their strategies, rather than these issues remain hidden, as was found in this study. The belligerence could be moved more easily if everyone was onboard and change was perceived as meaningful and non-threatening. Moving from a tribal world to more universal principles implies a loss of identity and culture and it will not happen unless people

believe in the vision, or at least see the point of it. Commissioners should be equipped for their role and take hold of the opportunities they have been given to adopt transformation principles and drive the priorities of the local people.

Improving access to health care and modernising sexual health services will involve not just investment in the infrastructure but creating models that require a different way of working, different ways of conceptualising, alongside models that challenge the health service culture and the power and control that has always been part of maintaining a medically focused provision. Different levels of integration that are inclusive of other agencies such as youth and education service or voluntary sector, providing wider approaches need more exploration.

5) Government Driving a Normalising Culture for Sexual Health within and Outside of the NHS.

Taking care of one's sexual health requires a normal place to go to; it should be an everyday event, just as you would go to the dentist. However, the ingrained culture of a medical model has been shown in the findings to require a paradigm shift to accept even nurse led service and a less medically dominated provision. A normalising culture also needs to be a government driver as the way forward for everyone to feel more comfortable and to accept these services.

Ensuring all major reports from hospital trusts, PCTs, public health directors and strategic health authorities, do not miss out sexual health but acknowledge this as an aspect of health, would assist this process. They should not be reporting separately on this issue. It could be core business of each health trust. This would greatly contribute to the normalising of these services as they then become accountable and encompassed into normal service planning.

The world of the modern organisation is complex, filled with challenges and opportunities. To survive and prosper it desires the full engagement of its members to think creatively. It will be a two-pronged approach to achieve success. There will be the authority of the state within the policy that leaves little room for organisations to squirm out of facing up to their responsibilities in applying the sexual health agenda.

This alone allows more effectiveness of the leader of services to act with authority and if they are strategic thinkers they will include the views of all stakeholders and interpret this into a model of provision that contributes significantly to improving health. I would suggest there will be obstructions, both implicit and explicit to achieving this outcome either quickly or at all. There is required a change in culture, underwritten rules that determine how people behave. Cultural change needs to be driven alongside any structural reorganisation reform to allow excellence to flourish. Service redesign alone will not achieve this.

Normalising also requires there is no longer poor access to information or services for service users. It requires driving the Choosing Health (DH, 2004) agenda of empowerment. Sexual health will be promoted with no discrimination around gender, race, religion, class or sexual orientation. It is also of course, a whole society approach that is really needed.

6) Quantifying Quality Interventions

Quality services require real investment with less emphasis on achieving targets and commissioner's obsession with performance outcomes in quantities. The practitioner should be trusted to make professional decisions and not be driven only by targets to be achieved. Surely it is quality that the service user requires to really make a difference? Time should be given to service users to not just treat conditions but to explore staying safe and wider issues that impact sexual health. A health promoting opportunity should be taken at every intervention by the healthcare worker. This study and consultation and engagement with the public demonstrates this is what they require, more opportunities to talk about their own agendas, about things that are important influences on their sexual health. Service level agreements that call for accounting for health promotion interventions within these settings, instead of just clinical work and numbers of people going through services, would underline the importance of it and the impact it could have. Clinicians perceive they are employed to give a core clinical service, that perception could be changed to encompass more public health principles.

6.2 Applying the Simple Principles of Complexity Theory to Achieve “A Normal Service”, Modelled Around the Service User

The NHS services are now working within a performance management and governance structure, which may impact unilateral working, but which could also restrict this poising itself at the point of criticality, between stability or rigid order and chaos, if it was not understood fully. The government wants modernised, transformed services but do not say how these will look. They keep themselves clear from the wrath of consultants by suggesting integrated services for sexual health is a preferred way forward, but merely suggest this should be considered. This evidence has shown many services are struggling because of this lack of direction. Introducing complexity science principles to the process of their development, I would suggest, would give a structure that allows incremental change for everyone's benefit. This change would embrace normalising sexual health, which would achieve more than financial investment ever could, but would be transformational. This minefield of human interaction that service providers face every day if in one place, under one roof, not an STI clinic, but a sexual health centre, could just be accepted and not judged as happening to others and not ourselves.

This theory challenges a traditional reductionist approach to explanation and prediction. It offers a complex system that is non-hierarchical, nested, intersecting and interacting; one that flows in all directions, recognising agency. It is an explanation that rejects single variables that are fixed in time and space. It offers a solution to silo-centred, un-accessible services that do not contribute greatly to improving the nation's sexual health and to those who want to modernise and need a helping hand to do so.

It suggests organisational change is needed, but also addresses the need for social change. A wider perspective has been captured within this study and demonstrates much rhetoric is in place rather than reality for the modernisation processes, particularly around the government suggesting decentralisation and yet imposing tight performance management. This study also illustrates that the service user experience is more important than performance outcomes.

6.3 Further Work Needed

This study has focused on modernised or transformed service provision as a means to contributing to the nations' improved sexual health. This is a limited view and there are much wider and significant contributions to be made from public health education and society as a whole. The marginalisation of sexual health services within the NHS was a key issue within this study and should be a national focus for research. Despite the resources, targets and raised profile, any improvements in services will not be sustained without a change in culture within the NHS and society. Getting to the roots of this problem is crucial to attempt to normalise services. Engaging with service user views and with those who do not use services will give more understanding. Patient and public participation and the expert patient programme for sexual health services are unlikely to occur. There is some engagement around HIV and services, however, as this study identifies, people will rarely go public about their sexual health issues. Quality of service provision and what the public want requires a national research driver.

This research is ultimately for the benefit of the service user and the findings hopefully can be used as a catalyst to bring some change and achieve more natural balance within sexual health services. To really impact the sexual health of communities they should not be marginalised, silo-centred or political, but equipped to manage and support this increasingly sexualised society. Many of the levers for change are in the hands of frontline NHS staff and attention should be given to the detail and processes that create an impression that the central organisation cares, both for the service users and the service providers.

Improving the sexual health of the population will require ongoing resources and more partnership working that creates services that then meet the needs of the service users. Complexity theory illustrated small, incremental changes within an encouraging environment for creativity will lead to transformed services, more equipped to deal with the social complexity of sexual health. It will also, however, require a shift in how services are perceived by the public and health professionals.

Taking onboard the recommendations from these findings would drive inclusive transformed services where agency is encouraged. Systems would become robust, open to new ideas with good enough specifications to allow things to evolve. It would become an open system, vibrant and interacting with the environment around it. Constant change would become attractive. Relationships and connections would become relied upon, leading to huge changes and rich information from the interactions. The processes would be transparent and open and there would be sharing of knowledge. The sexual health service user would be at the centre of everything, their needs and values anticipated.

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Appendix 1

SERVICE LEADS INFORMATION SHEET

RESEARCH exploring how sexual health services are provided.

Invitation to participate

You are being invited to take part in a research study. Before you decide whether to take part or not, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask if there is anything that is not clear or if you would like more information. For further information or if you have any queries about the study please **contact Helen McIlveen tel: 0191**

or e-mail helen.mcilveen@..... co.uk, fax 0191

What is the purpose of this study?

The number of people acquiring sexually transmitted infections in England is increasing and the number of teenage pregnancies is high in comparison to the rest of Western Europe. In response the UK Department of Health have developed the first National Strategy for Sexual Health and HIV 2001. The Strategy conveys an urgent need to explore different ways in which sexual health services are provided.

Some service leads are considering modernisation around integrating services, bringing together both contraception and genito-urinary medicine (GUM), and maybe other aspects of service. This integration model can take on many forms i.e. under one building or as multi-trained practitioners working in community settings. Others have decided this is not the way forward. This study aims to look in depth at the rationale for your service model. Or indeed why you may be obstructed from achieving the model evaluated as best for your service users.

Alongside interviews with service leads there will be focus group work with people who may have cause to use services for sexual health.

The fieldwork for this study will be running over year 2005 -2006 and written up in 2007.

Why have I been chosen?

You have been identified as a lead for service provision, initially either from your response to a call of interest via the e-network for sexual health leads, or you have been approached by the researcher.

Do I have to agree to be interviewed?

It is up to you to decide whether or not to be interviewed. If you decide to take part you will be asked to keep this information sheet for future reference and to sign a consent form (enclosed). If you do not wish to participate, you can either contact me within 7 days to withdraw, or inform me when I telephone you in 7 days. You are free to withdraw from the study at any time and without giving a reason.

What will happen if I decide to take part?

a) You will receive a telephone call from myself (Helen McIlveen) to confirm that you have decided to take part in the study. You will be asked if you have changed your mind, have any questions or need more time to decide. If you still wish to take part, then we will arrange a suitable time and date to conduct the interview.

b) I will need to receive a signed copy of the consent form (enclosed) before the interview is conducted. You can mail or fax it to. The consent form asks if you have read the information, agree to take part, agree to have your interview tape-recorded and agree to have direct quotes from your interview used in publications.

c) The interview will take around 60 to 90 minutes and will consist of some broad questions. I will be seeking your views on the extent to which you feel sexual health services are being modernised, or why they are not, and the reasons behind how they are modelled.

d) After the interview, the researcher will transcribe your interview (if tape-recorded) and store this on a computer system. No identifying details will be recorded or noted on the tape or transcript. Tapes, hard copies of text and software will be kept in a locked filing cabinet of the researcher's workplace. No-one other than the researcher will have access to them. Tapes will be allocated a unique identifier and anonymised.

What are the possible disadvantages and risks of taking part?

It is hoped the subject matter to be discussed has a minimal risk to you. However, should you require any support after the interview please contact the researcher who if unable to reassure you will arrange with your permission a suitable avenue of support.

What are the possible benefits of taking part?

The aim of this evaluation is to inform policy and practice with regards to the effective delivery of sexual health services. Therefore, it is hoped this research will benefit all users of these services, as well as benefits for the providers. There are no immediate direct benefits to the individual research participants, although some people find it helpful to have the opportunity to talk about and reflect on their ideas, thoughts and experiences.

The researcher is very experienced in this service area and could reciprocate at another opportunity with you or staff team to explore in more detail such aspects as nurse-led services or provide some training or education around the speciality.

Will my taking part in the study be kept confidential?

The information you give will be kept strictly confidential. Audio tapes will only be labelled with a unique identifier. The transcripts will be stored securely. Your name will not be recorded anywhere. This ensures there is no way for anyone to know the answers you provided. Quotes may be used in papers and reports but will not be accompanied by any identifying information. We are asking you for your permission to use direct quotes from your interview in the consent form. If you would like to see any material where we use direct quotes from you, this can be arranged with the researcher.

What will happen to the results of the interview?

The results will be written up into a PhD thesis. There may be reports published as papers in health or sociology journals. The study results will be used to help improve health services. Notification of any publications will be sent to the participating services.

Who is organising and funding the research?

The researcher involved in this study has been supported by her employer, North Tyneside PCT, but not funded to carry out this work. The University of Durham, dept of Sociology and Social Policy are supervising this work.

What if I have any concerns?

If you have any concerns or questions about this study or the way it has been carried out, you can either contact the researcher Helen McIlveen, or you may contact your local hospital or PCT complaints department. The research and development manager will be aware that this research is taking place. Please keep this information sheet and a copy of your consent form for future reference purposes.

Thank you for taking the time to read this.

FOCUS GROUP INFORMATION SHEET

RESEARCH looking at how SEXUAL HEALTH SERVICES are provided.

Invitation to participate

You are being invited to take part in a research study. Before you decide whether to take part or not, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask if there is anything that is not clear or if you would like more information. For further information or if you have any queries about the study please **contact Helen McIlveen tel: 0191**

or e-mail: helen.mcilveen@.....nhs.uk fax 0191

What is the purpose of this study?

The number of people acquiring sexually transmitted infections in England is increasing and the number of teenage pregnancies is high in comparison to the rest of Western Europe. In response the UK Department of Health have developed the first National Strategy for Sexual Health and HIV 2001. The Strategy asks service providers to urgently explore different ways in which sexual health services are provided.

Some service leads are considering modernisation around bringing together both contraception and genito-urinary medicine (GUM), and maybe other aspects of service. This integration model can take on many forms i.e. under one building or as multi-trained practitioners working in community settings. Others have decided this is not the way forward. This study aims to look in depth at the reasons for service models.

There will be other interviews with service leads. You could contribute to the study by being part of a focus group as I am interested to hear the views of people who may have either used these services or may want to in the future.

The fieldwork for this study will be running over year 2005 -2006 and written up over 2007.

Why have I been chosen?

Your community project has been identified as one that may have service users with an interest in sexual health because of issues that affect their lives. Or you are simply a healthy volunteer and good sexual health services are important to you to be able to maintain your health.

Your project coordinator / manager will have had discussions with the researcher to ensure it is appropriate work to do with this project. They will have placed a poster on the notice-board to generate interest in it.

Do I have to agree to be part of the focus group?

It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to keep this information sheet for future reference and to sign a consent form (enclosed). If you do not wish to participate you can contact the project manager within 7 days. I will telephone them in 7 days, to establish the interest in taking part in this study. You are free to withdraw from the study at any time and without giving a reason.

What will happen if I decide to take part?

a) A date will be set with the project manager that is convenient to everyone. You will be asked if you have changed your mind, have any questions or need more time to decide before the group work begins.

b) I will need to receive a signed copy of the consent form (enclosed) before the group work commences. The consent form asks if you have read the information, agree to take part, agree to have the focus group tape-recorded and agree to have direct quotes from this used in publications.

c) The focus group will take around 60 to 90 minutes and will consist of some broad questions about your views on how sexual health services should be provided.

d) We will begin by setting some ground rules agreed by the whole group. However, we will ask that you do not disclose personal information. If you do hear personal information disclosed we ask that you respect that person by not taking that information outside of the group.

e) The researcher is a very experienced healthcare worker in sexual health, with a nursing and counselling background. You may wish to ask questions regarding aspects of sexual health. The group can choose to ask these as we go along or you may wish to invite me back to do this as individuals or as a group. I will also bring written information, useful brochures etc about sexual health that may be taken away or kept at the project.

d) After the group work, the researcher will transcribe (if tape-recorded) and store this on a confidential NHS computer system. No identifying details will be recorded or noted on the tape or transcript. The transcripts/notes will be analysed only by Helen Mcilveen. Tapes, hard copies of text and software will be kept in a locked filing cabinet of the researcher's workplace. No-one other than the researcher will have access to them. The transcriber will not be able to link the interviews to a name and tapes will be allocated a unique identifier.

What are the possible disadvantages and risks of taking part?

It is hoped the subject matter to be discussed has a minimal risk to you. However, this can prove to be a sensitive area of discussion for some people. I am not asking for any personal information. But should you require any support afterwards please speak to the researcher. Or telephone her on 0191, or her colleagues for health advising for sexual health on 0191, If unable to reassure you we will arrange, with your permission, a suitable avenue of support.

What are the possible benefits of taking part?

The aim of this study is to inform policy and practice with regards the effective delivery of sexual health services. Therefore, it is hoped this will benefit all users of these services. There are no immediate direct benefits to the individual research participants; although, some people find it helpful to have the opportunity to talk about and reflect on their ideas, thoughts and experiences.

There will be no financial gain, but any expenses will be reimbursed for travel. Snacks and soft drinks will be provided. A health stand will be set up with a range of useful brochures for sexual health.

Will my taking part in the study be kept confidential?

The information you give will be kept strictly confidential. Audio tapes will only be labelled with a unique identifier. The transcripts will be stored securely. Your name will not be recorded anywhere. This ensures there is no way for anyone to know the answers you provided. Quotes may be used in papers and reports but will not be accompanied by any identifying information. We are asking you for your permission to use direct quotes from your focus group in the consent form. If you would like to see any material where we use direct quotes from you, this can be arranged with the researcher.

What will happen to the results of the interview?

The results will be written up into a PhD study. There may be reports published as papers in health or sociology journals. The study results will be used to help improve health services and to inform government policy. Notification of any publications will be sent to the participating services.

Who is organising and funding the research?

The researcher involved in this study has been supported by her employer, North Tyneside PCT, but not funded to carry out this work. The University of Durham, dept of Sociology and Social Policy are supervising this work.

What if I have any concerns?

If you have any concerns or questions about this study or the way it has been carried out, you can either contact the researcher Helen McIlveen, or you may contact your local hospital or PCT complaints department. The research and development manager will be aware that this research is taking place. Please keep this information sheet and a copy of your consent form for future reference purposes.

Thank you for taking the time to read this.

Appendix 2

Helen Mcilveen M.A, BSc. (Hons), R.G.N., D.N
(Address)

CONSENT FORM – interview / focus group participant
Research into sexual health service provision.

I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

I agree to take part in the above study

I agree to have the interview / focus group audio-taped.

I understand that information given will be made anonymous. Direct quotes from my interview may be used in reports and papers but that my name will not appear anywhere except on this consent form, which will be kept in a locked cabinet separate from the interview tape and transcript.

I agree to have direct quotes from my interview, attributed to this interview / focus group only.

_____ Name of interviewee	_____ Signature	_____ Date
_____ Name of Person taking consent (if different from researcher)	_____ Signature	_____ Date
_____ Researcher	_____ Signature	_____ Date

Appendix **INTERVIEWS AND FOCUS GROUPS**

Lead physician genito-urinary medicine	
Lead physician genito-urinary medicine	
Lead physician genito-urinary medicine	
Lead physician genito-urinary medicine	(4)
Lead medic contraception services	
Lead medic contraception services	
Lead medic contraception services	
Lead medic contraception services	(4)
Lead manager	
Lead manager	
Lead manager	
Lead manager	
Lead manager	
Lead manager	(6)
Lead nurse integrated sexual health service	
Health service commissioner	(1)
Health service commissioner	(2)
D.O.H. lead for sexual health	
F.P.A. lead	
Focus group multi disciplinary workers for young people	(22)
Focus group nurses integrated sexual health practitioners	(6)
Focus group gay men	(12)

Appendix 3	Analysis of interviews	Theoretical sampling
Focus group Teenage mothers	(6)	
Focus group youth offending team	(6)	
Focus group youth workers	(2)	
Focus group African women HIV positive	(10)	

E.1. Electronic interview lead nurse genito urinary medicine

E.2. Electronic interview health adviser genito-urinary medicine

E.3. Electronic interview general practitioner

E.4. Electronic interview lead nurse / manager genito-urinary medicine

E.5 Electronic interview university education provider

20 single interviews, 7 focus groups, 5 electronic surveys, 89 voices

Core category 1.		DETERIORATING SEXUAL HEALTH ALONGSIDE INCREASINGLY SEXUALISED SOCIETY																													
Interviews	A	E	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	E1	E2	E3	E4
concepts		5																													
Unrelenting numbers in clinics	x	X	x	x	x	x	x	x	x		x	x	x	x	x	x	x	x	x	x	x	X				x		x	x		X
Increasing year on year																															
Increasing risks taken with sexual health	x	X	x	x	x	x	x	x	x	x	x					x	x	x	x	x	x	X	x					x	x	x	x
Practitioners see more younger clients having sex	x	X	x	x	x	x	x	x		x	x	x	x			x	x	x	x	x	x	X		x				x	x	x	
Practitioners see less stable relationships, more sexual partners	x	X	x	x	x	x	x	x			x					x		x	x	x	x	X	x					x	x	x	
Practitioners managing more unwanted pregnancies		X				x	x	X								x		x	x	x	x	X		x					x	x	
Need more input from school health for young people		X		x	x	x	x	X		x	x			x	x	x	x	x	x	x	x	X		x					x		x
Can't rely on service providers only to improve nations health	x	X	x	x	x	x	x	X		x	x	x	x			x	x	x	x	x	x	X							x		x
Changing demography such as asylum brings new challenges	x		x	x	x	x		X		x						x	x	x	x			X							x		x
Local authority have a vital role in sexual health prevention						x	x	x		x	x					x	x	x		x	x	X			x				x		x
Sexual health services aren't being normalised		X		x			x		x			x	x				x	x	x	x	x		x	x					x		x
More stis prevalence higher	x	X	x	x	x	x	x	x	x	x	x	x				x	x	x	x	x	x	X	x					x	x		x
Youth service and voluntary sector play a strong role in education and prevention							x	x	x	x	x					x	x	x	x	x	x		x	x	x				x		x
HIV funding for prevention work over the years formed a foundation								x	x	x	x								x			X	x								x
More HIV work needs attention in specialist service												x							x				x								x
Routine work should be passed to 2 nd level services											x	x						x		x	x		x								x

[illegible]

DETERIORATING SEXUAL HEALTH ALONGSIDE INCREASINGLY SEXUALISED SOCIETY

[illegible]

[illegible]

[illegible]

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SEXUAL HEALTH AS A POLITICAL FIELD

Core category 3.		MODELING SERVICES AS AN INTEGRATED SEXUAL HEALTH SERVICE																													
Interviews	E	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	E1	E2	E3	E4
concepts	5																														
104. Same clients in contraception and GUM		X		x		x	x	X		x	x	x	x			x	x	x	x	x	x	x		x			x		x	x	x
Same targets in each service		X		x	x	x	x	X		x	x	x	x	x	x	x		x	x	x	x	x							x	x	x
Better use of resources	X	X		x		x	x	X	x	x	x	x	x	x	x	x	x	x	x	x		x	x						x	x	x
Integrated service offers more confidentiality in waiting area	X																						x	x					x	x	
Easier to integrate in A smaller service	X	X		x		x	x	X		x	x	x	x	x	x			x	x			x							x	x	
National strategy is not driving integration																												x			
National Strategy is a driver for this model	X	X		x		x	x	X	x	x	x	x	x	x	x	x	x	x	x	x		x							x	x	x
The evidence is there already to integrate as best for client	X	X		x		x	x	X	x	x	x	x	x	x	x	x		x	x	x		x	x	x	x				x		x
No right model of integration	X	X		x		x	x	X	x	x	x	x	x	x	x	x	x	x	x	x		x	x					x	x		x
Model open to personal ethos of the person driving	X	X		x		x	x	X	x	x	x	x	x	x	x	x	x	x	x			x							x		x
The strategic view gets lost as pressure to perform increases	X	X		x		x	x	X	x				x				x	x	x	x		x						x	x		
No guidance how to integrate	X	X		x			x	X	x	x	x	x	x	x	x	x		x	x			x						x	x	x	x
Opinions of those who have never worked in the service over-ride those who do	X	X		x			x	X	x	x												x									
Takes a personality to drive this model with the vision	X	X		x		x	x	X	x	x	x	x	x	x	x	x		x	x	x		x							x		x
Modelling not top priority among the pressures in workload	X	X		x		x	x		x									x	x	x	x	x							x		
Integration offering choice and improved access	X	X		x		x	x	X	x	x	x	x	x	x	x	x		x	x	x		x		x	x				x		x
Integration brings constant change, evolving services	X	X		x		x	x	X	x	x	x	x	x	x	x	x	x	x	x			x							x		x
Good access must include wider	X	x		x		x	x	X		x	x	x	x			x	x	x	x	x		x	x	x	x				x		x

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Nurse led have been relied on in the past and will be the way forward	X	X		x		x				x	x	x				x	x	x	x	x	x	x						x		x	x	
Seamless service is what the service user wants	X	X					x	x		x	x	x	x	x		x	x	x	x	x	x	x	x				x		x	x	x	
Levels of integration with school health, HPU,		X					x			x	x					x				x		x									x	
Drop-in service preferred by service users but not to wait for long time	X	X								x						x				x	x	x					x				x	
Rural services need integration for service user							x				x	x								x												
School health advisers help improve access		X					x	x			x	x					x		x	x	x	x	x								x	
Silo services protect boundaries		X					x	x	x		x	x	x	x	x		x		x		x							x	x		x	
Training implications for integration	X	X					x	x	x		x	x	x			x			x		x	x							x	x	x	
A steering group of senior personnel to develop integrated model											x	x	x			x					x										x	
Ingrained Culture resists integration	X			x						x	x	x	x	x	x		x	x	x										x		x	
Microprocess changes needed													x	x	x	x	x	x	x	x	x	x							x		x	
Does integration detract from primary care providing services and takes away choice	X															x			x	x												
Without a framework you can feel successful without it being tested or challenged.																x			x													
Integration is not always right for highly specialist services				x															x			x										
Integration provides more people skilled in more places	X	X									x	x							x	x		x						x	x	x		x
Integration means the consultants				x							x	x	x						x	x		x	x						x	x		x

Core category	3.	MODELING SERVICES AS AN INTEGRATED SEXUAL HEALTH SERVICE
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Core category 4.		POWER, OBSTRUCTION AND INFLUENCE																													
Interviews	E	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	E1	E2	E3	E4
concepts	5																														
historical	X	X		x	x	x	x	X	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x				x	x		x
Hospital v. community services	X	X		x	x	x		X	x			x		x	x		x	x	x	x	x		x								
No open discussion	X	X			x	x		X	x					x	x					x									x		
Many assumptions made	X	X		x	x	x	x	X	x				x	x	x		x		x	x		x	x		x			x			x
Some Not wanting change, too long in the tooth	X	X		x		x	x	X	x	x		x	x	x	x	x	x	x	x	x			x					x	x		x
Underlying fear of change, unspoken	X	X		x		x	x	X	x			x	x	x	x	x	x	x	x	x								x	x		x
Fear of loss of position , loss of power	X	X		x	x	x	x	X	x		x	x	x	x	x	x	x		x	x	x	x						x	x		x
Obstruction by medics starting to change	X	X		x	x	x	x		x		x	x	x	x	x	x	x	x	x	x		x						x	x		x
Medical model strong within service providers	X	x		x	x	x	x	X	x	x	x	x	x	x	x	x	x	x	x	x			x					x	x	x	x
New technology less need for specialists	X	x		x		x	x			x				x	x				x			x						x			x
Specialist areas of HIV and Syphilis will need specialist input	X	x		x	x		x		x			x	x						x									x	x		x
Service lead asked to contribute to LDP	X	x		x	x	x	x			x	x	x	x	x	x		x	x	x										x		x
Reluctant to let nurses have total patient management	X			x					x				x	x	x	x			x		x										x
Its simple medicine GUM and contraception	X	x		x		x		X		x		x	x			x			x	x	x	x								x	x
Difficult working environment when there is lack of trust between organisations	X				x			X	x	x			x	x	x				x	x		x						x			x
Blocking through not opening up access with drop in service is a tactic used by consultants	X	x	x	x	x		x	X	x		x		x	x	x	x					x							x	x		x
Nurses good at total patient	X	x			x		x	X	x	x	x		x	x	x	x	x	x	x	x	x	x						x	x	x	x

Category 5.		The Commissioner / Provider Split in the NHS																													
Interviews concepts	E 5	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	E1	E2	E3	E4
Good commissioning makes a real difference to service providers	x	x		x	x	x	X	X	x	x	x	x	x	x	x	x	x	x	x	x		x	x					x		x	x
The commissioner doesn't have the whole picture but has the power to bring change		x		x	x	x	X	X			x		x			x	x	x	x	x											
Portfolio of commissioner too unmanageable		x					X	X									x	x	x	x											
Coal face workers do not always know their commissioner	x	x		x	x		X	X		x				x	x	x	x	x	x	x	x	x									
Commissioners not always agreeing with providers		x	x	x	x		X	X		x			x			x	x	x	x	x											
Providers think they know best	x	x	x	x	x		X	X	x				x			x	x	x	x	x		x	x								
Commissioners have the bigger picture that providers don't have						x	X				x		x			x	x	x	x	x											
Providers need to let commissioners get on introducing change						x						x	x		x	x	x	x	x	x		x									
DOH not driving commissioners to get on with sexual health work	x							X		x			x			x	x	x	x	x											
Huge possibilities for influence and change not always utilised						x		x		x	x	x		x		x	x	x	x	x		x							x		x
Commissioners don't always have the insight into clinical services	x							x								x	x	x	x	x		x									
No strategic approach often locally in place							X	x		x	x		x	x				x	x	x											
Choosing health money not used for sexual health		x	x	x	x	x	X	x			x			x			x	x	x	x		x									
Funding available for integration but no commissioning drive to make it happen								x					x						x	x											
Commissioner provider split can		x	x	x		x	x	x		x				x			x	x	x	x											

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The Commissioner / Provider Split in the NHS

Category 6.

Analysis of Interviews

Theoretical sampling

A WORKFORCE FIT FOR PURPOSE

Category 6.		A WORKFORCE FIT FOR PURPOSE																														
Interviews	E	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	E1	E2	E3	E4	
concepts	5																															
Good leadership required to bring modernisation	X	x		x	x	x	x	X	x	x	x	x	x	x	x	x	x	x	x	x	x	x						x	x		x	
Physicians not trained in preventative medicine	X	x		x		x	x	X	x		x		x							x			x						x		x	
Disease orientated medical training	X	x		x	x	x	x				x		x			x				x			x					x	x		x	
Gender issues between the two specialties practitioners	X	x		x		x	x	X	x	x	x		x	x	x	x			x	x		x								x	x	
Staff working under increasing pressure to increase performance	X	x		x		x	x	X		x	x		x			x	x	x	x	x	x	x						x	x		x	
Lack of specialist trained staff	X	x		x	x	x	x	X	x	x	x	x	x			x		x	x									x	x	x	x	
National Chlamydia programme taking away most experienced nurses and health advisers	X	x		x		x	x	X			x		x				x	x	x	x		x						x	x		x	
Sexual health services Its simple medicine in the main	X	x		x	x	x		X		x	x	x				x			x	x		x						x		x	x	
Willingness to have nurse led service	X	x			x	x	x	X	x	x	x	x		x	x	x	x	x	x	x	x	x						x	x	x	x	
Medical students need more community training perspective	X					x	x	X	x							x			x	x		x						x			x	
Separate specialist training for GUM and contraception medics needs amalgamating	X	x				x	x	X	x		x		x			x		x	x	x		x							x	x	x	
Government not forward planned for workforce development To meet increasing need	X					x	x	X	x	x	x		x	x	x	x	x	x	x	x	x	x						x	x	x	x	
Fear that there will be few specialist staff in the future to provide gold standard training						x	x	X								x		x	x			x						x	x			
Gender issues have been strong factor between senior clinicians in the two specialties		x				x	x	X	x	x									x	x		x										
Disparity between specialties.	X	x				x	x	X	x					x	x			x	x	x		x						x			x	

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Category 7.		THE NEW PUBLIC HEALTH AGENDA ALONGSIDE INEQUALITIES IN HEALTH AGENDA																													
Interviews concepts	E	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	E1	E2	E3	E4
	5																														
Social disadvantaged clients and the vulnerable form a large part of the workload of services	X	x		x	x	x	x			x	x		x			x	x	x	x	x	x	X	x	x	x	x	x	x	X	X	X
Prevention work needs to be integrated into service provision	X	x		x		x	x	x	x	x	x					x	x		x	x	x	X	x	x	x	x	x		X		X
medical professionals not trained in prevention issues	X	x		x		x	x	x	x	x	x			x	x	x				x			x	x				x	X	X	X
More targeted prevention work should be priority for Gov	X	x		x		x	x	x	x	x	x					x	x			x	x	X	x	x	x				X		X
Raising awareness for the public impacts on service provision	X	x	x	x	x	x	x	x	x	x	x		x	x	x	x	x		x	x	x	X						x	X		X
Providing choice for service users important	X	x				x	x			x	x		x	x	x	x	x		x	x	x	x	x	x	x	x	x	x	X	X	X
User friendly services vital	X					x	x		x	x	x	x	x	x	x	x	x		x	x	x	x	x	x	x	x	x	x	X		X
Keeping an eye on targets for public health takes time away from services	X					x	x	x	x				x							x		x									
The socially disadvantage less likely to travel far to services	X					x	x		x	x	x	x				x	x	x		x	x	x	x	x	x	x	x	x	X		X
Integrated one stop shop meets need of socially disadvantaged	X					x	x	x	x	x	x	x	x	x	x	x	x		x	x		x	x	X	x	x	x			X	X
Public consultation seen as important	X	x		x		x	x			x	x	x	x			x	x		x	x	x	x	x	X	x	x	x		X	X	X
Outcomes of public consultation should be acted upon	X																						x	X			x			X	X
Consultation findings encompassed in service developments						x	x	x		x	x	x				x	x				x	x	x								X
Lack of a public voice around STI services	X					x				x							x	x	x	x			x	X							X

THE NEW PUBLIC HEALTH AGENDA ALONGSIDE INEQUALITIES IN HEALTH AGENDA

89 voices