Brook, J., Salmon, D., Knight, R.-A. & Seal, J. (2015). Sexual Health Education: an evaluation of the Northumbria Integrated Sexual Health Education (NISHE) Workforce Development Package delivered by UWE, Bristol (Report No. ISBN: 9781860435256). Bristol: UWE.

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2015

Sexual Health Education: an evaluation of the Northumbria Integrated Sexual Health Education (NISHE) Workforce Development Package delivered by UWE, Bristol

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Acknowledgements

We are very grateful to a wide range of people who contributed their knowledge, time and attention to this evaluation. In particular, we would like to thank the Sexual Health students from the four cohorts over the period of 2013 to 2015 who completed the surveys and took part in focus groups and interviews.

This evaluation would not have been possible without the commitment of sexual health service managers across the South West region. Thanks also go to those services managers who agreed to take part in the study as we also recognise this meant giving up precious time in their busy lives. The advice and guidance of the Practice Education Facilitators, Hettie Lean, Sarah Davies, and Jane Cromarty has also been greatly appreciated. Without their help to contact participants, this evaluation would have been much more difficult.

We would also like to acknowledge the contribution of the steering group members: Clare Chivers (Deputy Director of Education and Quality Health Education South West); Ann Steele-Nicholson (Lead nurse for genitourinary medicine, contraception and sexual health, Bristol Sexual Health Centre). In addition a big thank you to our funders, Health Education South West; this support has resulted in a formal evaluation, which will contribute to wider national debates around sexual health and service development.

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ISBN **9781860435256**

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Introduction and policy context

Sexual health and wellbeing is a central focus of public health policy and service development in England (Department of Health (DH) 2013a, 2013b, Public Health England (PHE) 2015). Recognising that sexual ill-health impacts on all parts of society, the Framework for Sexual Health Improvement (DH 2013a) sets out a number of priorities to reduce inequalities and improve sexual health outcomes overall, whilst building an open and empowering culture ensuring everyone is able to make an informed choice about sex and relationships. However, sexual ill health is not distributed equally throughout the population. Established links exist between deprivation, sexually transmitted disease, teenage conception and abortion, with vulnerable groups such as teenagers, women, men who have sex with men and black and ethnic minority groups at higher risk, not only of sexual ill-health, but also from poorer access to services through stigma and discrimination (McDaid, Ross and Young 2012, Brook 2014, Hadley 2014, Snow et al 2015, PHE, 2015). In order to develop and improve services in the UK there is a focus on 'rapid access to confidential, open access, integrated sexual health services in a range of settings, accessible at a convenient time' (DH 2013a, P5).

Historically, services in the UK have been delivered either through Family Planning clinics for contraceptive services or Genito-Urinary (GUM) clinics for sexual health issues. Within the Integrated Sexual Health Services, NHS Service Specification emphasis is placed on the delivery of an integrated service, at a one stop shop, delivered by a single health professional (DH 2013b). The argument for integrated sexual health services is compelling, however, this move has significant implications for the sexual health workforce. In 2003, Kane and Wellings recognised the need for broader based training and speculated about the divide between the specialisms of GUM and family planning with regard to culture and structure. Over ten years later, Anderson (2014) acknowledged the progress made but conceded that without whole system commissioning, the divide is still evident. This is an approach reiterated by PHE (2015), advocating that commissioners, providers and wider stakeholders need to take collective responsibility for ensuring accessibility to services. The result is a public health specialism that is in a state of flux, with regional and in some cases local differences between service delivery models.

Within the South West, quality assurance work highlighted a number of nursing workforce developments that needed to be made in order to meet the demands of an integrated service, particularly given the increasing mandate for nurse led services (Steel Nicholson et al 2012). Similarly an analysis of sexual health education had identified a disparity of provision with multiple, modular courses focused on knowledge with no practical competence element, suggesting that the Standards for Sexual Health Education (Royal College of Nursing (RCN) 2004) were often not met (Mehigan, Moore and Hayes, 2010). In order to address these issues and equip sexual health nurses within the South West with the appropriate knowledge and skills to deliver an integrated sexual health service, the University of the West of England (UWE) entered a formal agreement with Northumbria University who had developed the Northumbria University Integrated Sexual Health Education (NISHE) workforce development package (McNall 2012). The NISHE workforce development model was devised as part of a whole system approach to integrated sexual health service delivery, focusing on practice development and person centred care.

UWE commenced delivery of two new sexual health modules in September 2013, using NISHE, an established Integrated Sexual Health Education model, which had previously only been successfully delivered in the North of England (McNall 2012). The model was adopted for two years by Health Education South West, which provided financial support for 100 sexual health students to complete the modules between 2013 and 2015.

The NISHE workforce development package consisted of:

- A competency framework
- An e-learning package
- An e-portfolio system and framework
- Module descriptors, booklets and content as exemplars for local validation
- Advice and guidance to support development of infrastructure and capacity for practice based blended learning and to deliver NISHE

The Sexual Health Education Programme delivered by UWE consisted of two modules; a Foundations of Sexual Health module (20 academic credits) (the Foundation module) and a Specialist Practice module (40 credits) (the Integrated module). Both modules were delivered at level 6, equivalent to the academic level of a third year of a Bachelor of Science degree. The modules were delivered by UWE through a contract agreement with Northumbria University. The foundation module was undertaken over five days, in the form of face-to-face lectures, seminars and problem based learning and included a written assessment related to practice. The 40 credit practice module was delivered through a blended learning approach incorporating an e-learning package and work based portfolio assessment; students worked through a range of themed practice issues to reach and maintain a significant number of clinical competencies within integrated sexual health, which are outlined within the NISHE competency framework document. Students were required to either undertake the Foundations of Sexual Health module prior to undertaking the Integrated Sexual Health module, or provide evidence of prior learning or experience equivalent to the learning outcomes of the Foundations of Sexual Health module. Local arrangements in the South West allowed students to take the Foundations of Sexual Health module as a standalone module.

This sexual health educational model claimed to be innovative in a number of ways, which included a comprehensive delivery of integrated sexual health education to nurses via practice based and blended learning approaches. In addition, Practice Educators supported the educational progress of students and mentors and developed high quality learning environments within a range of clinical settings. A crucial aspect to the success of this model was the 'signing off' of clinical competence through high quality clinical mentorship. To support the delivery of this module, the equivalent of two whole time sexual health practitioners were employed by UWE to work across the South West for the duration of the two-year delivery period. The broad aim of these posts was to develop capability and capacity within the sexual health workforce across the region, in order to establish an effective mentor infrastructure, which is integral to longer-term sexual health workforce development. The practice educators continued to undertake clinical contact with clients at nurse practitioner level alongside their role as clinical educators. The South West region covers a large geographical area and sexual health practitioners undertook the modules from counties that were a long distance from UWE. It was therefore important that the practice educators employed a wide range of new technologies to make support possible across

such a large geographical patch. The geographical characteristics of the region also had the potential to impact on the transferability of the educational package to the area, which had been initially developed to serve a smaller region in a different part of the country.

The overall ambition was to not only develop nurses who can practice to excellent clinical standards but also significantly increase the number of sexual health nurses within the workforce who are graduates, consistent with specialist practice, and who can practice across all areas of sexual health service provision as indicated by national health policy (DH 2013a).

Aim of the Study

This research sought to explore the transferability of this model from a relatively small geographical area in England to the South West region. It included the perspectives of students and clinical service managers.

The specific objectives were to:
Students

1. Explore the expectations of students from different educational backgrounds at the start of the modules and ascertain the extent to which these were met
2. Identify any challenges and barriers from a student's perspective in completing the programme
3. Assess the extent to which students, knowledge, attitudes and practice/competencies have been influenced by completing the modules
4. Assess the extent to which students' confidence to practice/preparedness/self-efficacy improved through participation in the modules and the subsequent impact on patient care

Stakeholders

5. Establish stakeholders views of the extent to which the educational delivery meets service demands in relation to integrated sexual health provision for patients

Methods

Overview of methodology

A mixed methods approach was used in order to facilitate a more comprehensive and detailed study. Although mixed methods research requires additional time due to the need to collect and analyse two different types of data (Creswell & Plano Clark, 2011) it has the distinct advantage of providing multiple perspectives (Greene, 2008) and adds value by increasing validity in the findings (Hurmerinta-Peltomaki and Nummela, 2006). Employing both quantitative and qualitative methods acknowledged the added value of in-depth perspectives and promoted understanding of the research questions. The initial data collection using questionnaires informed the secondary data collection via focus groups and interviews, a particular advantage of using mixed methods in research design (Hurmerinta-Peltomaki and Nummela, 2006).

Longitudinal survey data were collected initially by questionnaire, with some students also

participating in focus groups and some volunteering to participate in one to one telephone interviews over the eighteen-month study period. Service managers were also interviewed by telephone using a semi-structured approach. Quantitative analysis of questionnaire data was conducted using SPSS version 22 and analysis of qualitative data was conducted using thematic analysis (Braun and Clarke 2006).

Issues of trustworthiness of the data were considered and addressed in the design of the study. The triangulation of information from the focus groups, interviews and questionnaires demonstrated the credibility and dependability of the data. The qualitative data were also independently analysed by two of the research team (JS, JB) and themes compared and discussed to confirm validity. Both researchers were independent to the sexual health module delivery, which offered a level of objectivity to the process and encourage open responses from the participants. Reflexivity was essential at each stage of the research process and was incorporated in order to recognise and bring to the forefront any preconceptions and attitudes held by the researchers, "making transparent the values and beliefs we hold that almost certainly influence the research process" (Etherington, 2007, p 601).

Student Sample

All students who undertook the modules in sexual health were invited to take part in the study with information emailed in advance of the start date of their first module. In total 88 students were recruited to the study across four cohorts between the period of November 2013 and October 2015, which represents 99% of the target population (n=89). Inclusion criteria for the quantitative analysis included those students who provided pre and post module questionnaire responses for either the Foundations of Sexual Health module or the Integrated Sexual Health module or both modules. The achieved sample was ultimately 49 students, which is 56% of the original target population. Attrition occurred due to lack of response to requests to complete the follow up questionnaires. All 49 participants were registered general (adult) nurses, 48 were female and one was male. Seven of the participants already had a degree and 23 had a diploma in nursing. 30 of the 49 student participants had undertaken previous sexual health education. Of the 19 who had not, only one completed the Integrated Sexual Health module in isolation, 9 undertook only the foundation and 9 undertook both modules. There was very little difference between the demographics of the students undertaking the foundation module compared with those undertaking the integrated module as can been seen in Table 1.

Sample Demographics

Table 1: Student sample demographics

	Overall	Foundation	Integrated
Age (mean) **Standard deviation**	43 years **8.1**	42 years **6.7**	43 years **10.1**
Years since qualified as a nurse (mean) **Standard deviation**	17 years **8.5**	16 years **8.1**	17 years **9.2**
Years working in sexual health (mean) **Standard deviation**	6 years **6.6**	5 years **7.8**	6 years **6.2**

All students attending the seminar days at the university were invited to attend the focus groups, employing opportunistic sampling methods. In total 22 students attended two focus groups. In addition, students who returned the questionnaire on completion of the Integrated Sexual Health module were invited to indicate that they were willing to take part in a telephone interview by ticking a box on the questionnaire. These students were considered to be able to provide in-depth data on their experiences undertaking the modules and the implications for practice, although the researchers acknowledge the potential bias inherent in a volunteer sample in the context of an assessed educational programme. This was mitigated by the fact that the researchers were not connected to the module delivery and the students were reassured about the confidentiality of their responses, inviting openness and honesty. All students who indicated that they would participate in this stage of the study were contacted and interviewed. This self-selecting sample consisted of seven students, who worked in different settings across the South West of England, including GP surgeries, integrated sexual health clinics, contraception clinics and a minor injuries unit.

Student Data Collection: Questionnaires

Students attending the university to study sexual health could choose to undertake either of the two modules in isolation or to undertake both the Foundations in Sexual Health module followed by the Integrated Sexual Health module. Data were collected from three groups of students at up to three separate time points in the student journey. Questionnaires were given to the students on the first day of their modules, when they were attending a university teaching session and also emailed to the participants within one month of completing the modules. The participants are categorized in to three groups:

- Group 1 – Those that completed both the Foundations of Sexual Health Module and the Integrated Sexual health Module
- Group 2 – Those that completed only the Foundations of Sexual Health Module
- Group 3 – Those that completed the Integrated Sexual Health Module after providing evidence of previous study or experience equivalent to the Foundations of Sexual Health module learning outcomes

The number of students in the study undertaking each module on which complete data was collected is detailed in Table 2.

Table 2: Number of students in sample undertaking each module

Module	Number of students
Foundations in Sexual Health and Integrated Sexual Health	19
Foundations in Sexual Health only	19
Integrated Sexual Health only	11

Each questionnaire contained three sections: Section A included the biography of the participant, motivations for undertaking the programme and the five most important outcomes for them in undertaking the module. Section B included an Evidence Based Practice Self Efficacy (EBPSE) scale (Tucker, Olson and Frusti, 2009). Students were asked to rate their sense of self-efficacy (confidence) to carry out evidence based practice in sexual health nursing on a scale of 1% -100% with higher scores reflecting greater confidence for each of the 17 items. Within nursing there is evidence to suggest that increasing a student's self-efficacy improves acquisition of clinical skills

and practice behaviours (Manojlovich, 2005; Wagner, Bear and Sander, 2009; Kuiper, Murdock and Grant, 2010) and that accurate calibration of self-efficacy is one factor that can prevent adverse patient outcomes (Stump, Husman and Brem, 2012). This particular scale was chosen as a measure due to previous positive reliability and validity testing (Tucker, Olson and Frusti, 2009). It was also the scale most applicable to the current study. In Section C students were asked to rate their sense of self-efficacy when communicating in difficult situations, again by rating themselves on a scale of 1% - 100% against nine areas of communication practice (Tucker, Olson and Frusti, 2009). In addition, the students were asked seven free text questions inviting them to write in further depth about their ability to make changes in practice, the perceived impact of their learning on services users and challenges faced throughout the modules. Written consent was obtained prior to completing the questionnaires with attention brought to the student's right to withdraw at any time. The questionnaires are detailed in Appendix 1.

Student Data Collection: Focus Groups

Students attending a seminar day at the University were invited to participate in a focus group. Focus groups were chosen due to the potential for powerful interpretive insights (Kamberelis & Dimitriadas, 2005) and the added value offered by group dynamics. The focus groups were audio recorded and transcribed by an independent administrator. Each focus group lasted one hour and was facilitated by the researchers. Discussion was influenced by the study objectives and the findings from analysis of the qualitative questionnaire data. Although a focus group guide was used, the participants were free to explore any issues that they felt were relevant. Integral to the direction of the discussion was the student experience through the modules, whether they felt prepared to work within integrated sexual health and contraceptive services in practice and if they were able to influence or make changes in service delivery.

Following each focus group a diamond ranking activity was used to elicit ideas, prompt reflection and promote discussion (Clarke 2012). Diamond ranking is an innovative method of collating qualitative data that facilitates engagement and discussion of the main concepts. The purpose of the activity was to focus on the specific question, 'What impact has your learning had on service users?'. The students were asked to rank nine priorities identified by the researchers from the qualitative questionnaire data in order of importance using topic cards and a diamond pattern. The top of the diamond represents the most important priority identified by the students. Students were given permission to annotate the diamond with qualitative comments and explanations if they felt necessary. Diamond ranking builds on the principles of nominal group technique by attempting to gain consensus, facilitating all students to contribute and prioritise ideas democratically (Tague, 2004).

Student Data Collection: Semi Structured Interviews

Students were invited to participate in telephone interviews through an opt in approach. Qualitative interviews were chosen as a method of establishing common themes between the respondents and establishing a 'joint construction of meaning' (Gubrium & Holstein, 2002, P17). The interviews were conducted within one month of the students completing the modules and had the potential to offer an additional perspective about the impact their learning had on service delivery. The research team developed the semi structured interview guide with reference to the study objectives and the three key areas: module content, student experience and integrated service delivery. The interview guide was also influenced by the comments made in the free text sections of the questionnaires. The research team conducted the interviews, audio recorded and transcribed by an independent administrator. Consent was given by annotating the questionnaire

but also reiterated verbally at the beginning of each interview. The interviews lasted 20-30 minutes, depending on how much the participant had to say.

Service Managers Sample

Stakeholders' perspectives were an important element of the study. Service managers were identified as a group of practitioners who would be significantly involved with students, practice educators and service delivery and who could potentially offer a wider view of the impact of the sexual health modules in the practice environment. All known service managers for the organisations offering sexual health services and supporting students on these modules in the South West were contacted by email with details of the study and invited to participate. This purposive sampling resulted in responses from six service managers from the across the South West of England.

Manager Data Collection: Semi structured Interviews

The semi-structured interview guide was developed by the research team from the study objectives and from comments made by students in both the focus groups and their questionnaire responses. There was a particular focus on exploring views on the preparation of students for practice, particularly in an integrated sexual health model of service delivery. The service managers' perspectives were also sought on the impact the students had on service delivery or patient care and any challenges that they had encountered in terms of facilitating the student experience. The interviews lasted 20-30 minutes, were audio recorded and transcribed by an independent administrator. The interview guide can be seen in Appendix 2.

Data Analysis: Quantitative Data

Quantitative analysis of questionnaire data was conducted on baseline and follow-up data using SPSS version 22. For this report the self-efficacy data was combined into a single variable for the scale relating to the evidence base (the average of responses to 17 questions) and a single variable for the scale relating to communication (the average of responses to 9 questions). For groups 2 and 3, where data collection occurred at two points, Wilcoxon tests were used to compare baseline and follow-up data. For group 1, where data was collected at three points, Friedman's tests were conducted. As all were significant they were followed by Wilcoxon tests for each pair of data points. The significance level was set at $p<.005$ throughout.

Data Analysis: Qualitative Data

Thematic analysis was employed as a technique for analysing the qualitative data as it can be effective in providing a complex, rich and detailed account of the data. Braun and Clarke (2006) argue that thematic analysis is a method in its own right due to its flexibility and in particular, the compatibility of the process with a range of different paradigms. The interviews and focus groups were led by interview guides that reflected the study aims and were influenced by the themes identified from the questionnaire data, and consequently the analysis of the data was predominantly deductive and conducted at the semantic level. Braun and Clarke's (2006) six stage technique was used during the analysis, beginning with familiarization with the data (stage 1), generating initial codes (stage 2), searching for, reviewing and naming themes (stage 3, 4 and 5) and writing a report (stage 6).

Ethics

The study was informed by guidance cited in the British Educational Research Associations Ethical Guidelines for Educational research (2011). Ethical issues throughout the research included: voluntary informed consent, the right to withdraw, confidentiality and issues related with good research conduct set out in the guidance. Ethical approval was obtained from the UWE Bristol Research Ethics University and Faculty Committee prior to the research start dates. In accordance with ethical principles all the data collected were anonymised and research numbers allocated to protect the identity of those who took part.

Results

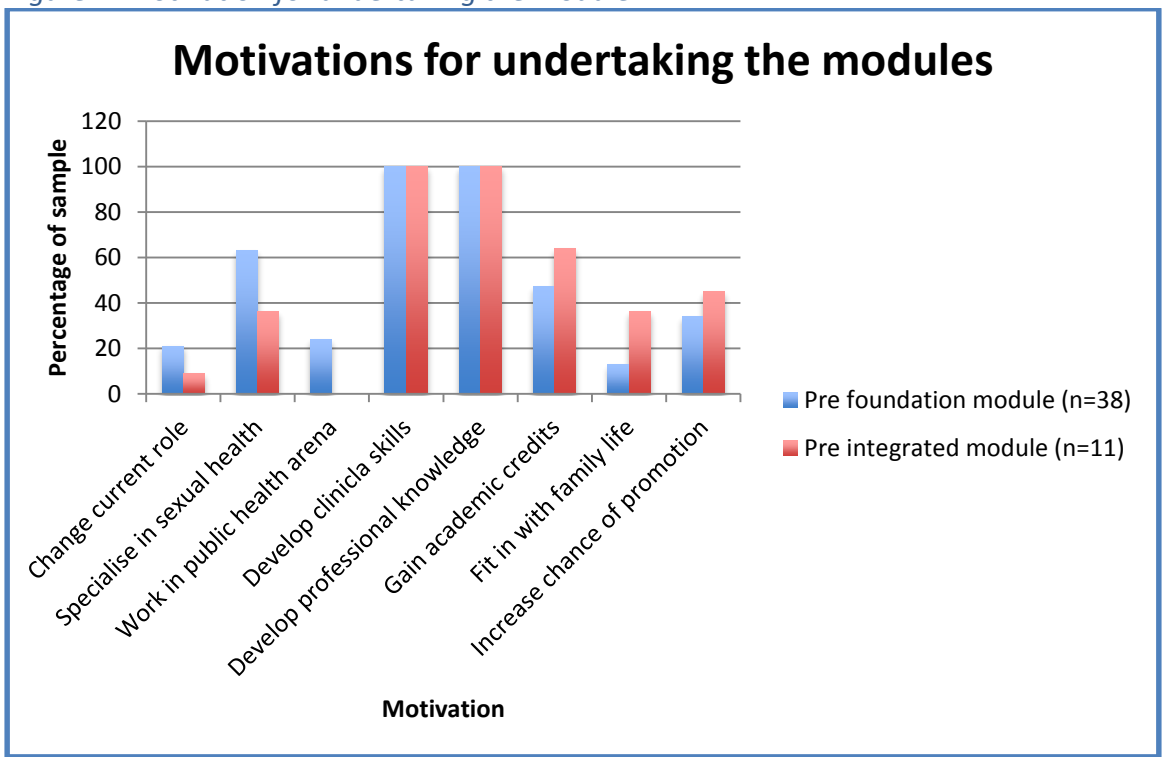
Student Perspectives

Analysis of quantitative data

Motivations for undertaking the modules

Participants were asked to indicate their motivations to undertake the module by placing a tick next to the statements that applied to them. In both the pre foundation and pre integrated questionnaires the students indicated that developing clinical skills and professional knowledge in the area of sexual health were the strongest motivators. Gaining academic credits, additional qualifications and wanting to specialise in this area were also strong motivators for students to undertake the modules. Figure 1 illustrates the student responses regarding motivation.

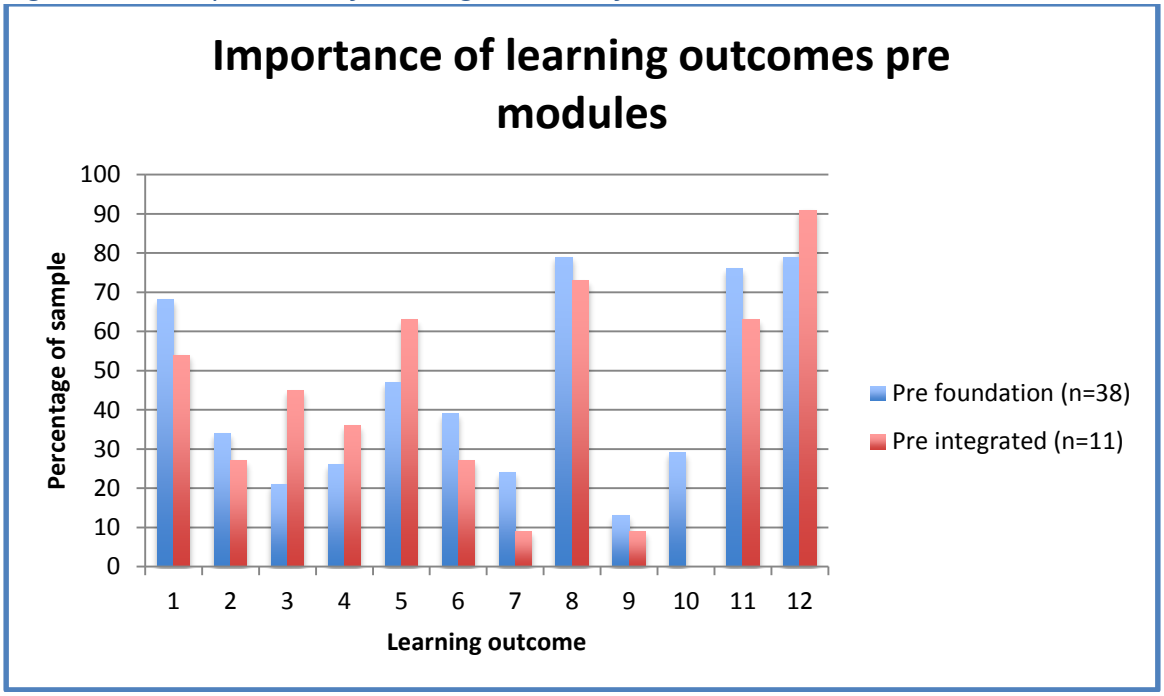
Figure 1: motivation for undertaking the module



Learning outcomes

The students were also asked to indicate the most important learning outcomes for them in completing the modules. Figure 2 shows the percentage of students who felt that each particular outcome was important to them. Demonstrating clinical competence, implementing evidence-base interventions and improving practice from an evidence-based perspective were identified as important by the highest percentage of students undertaking both the foundation and integrated modules.

Figure 2: The importance of learning outcomes for the students



Key to Learning Outcomes
1. To be able to demonstrate knowledge and understanding of sexual health
2. To gain knowledge and understanding of current strategic and local priorities for practice
3. To become more aware of the factors that can potentially impact on an individual's sexual health and wellbeing
4. To be able to evaluate the impact of personal attitudes and beliefs regarding human sexuality and behaviour on the individual and his or her care
5. To be able to evaluate my interpersonal skills so that I can effectively assess, deliver and respond to sexual health needs
6. To be able to critically analyse myself and the clinical environment
7. To be able to appraise ethical and legal factors which influence sexual health practice issues
8. To be able to develop, implement and improve practice from an evidence based perspective

9. To be able to appraise frameworks for client assessment to address sexual health and well being
10. To be able to critically analyse assessment data to identify priorities and plan care in partnership with the client
11. To be able to integrate evidence based interventions to reduce risk of unintended pregnancy and sexually transmitted infections
12. To be able to demonstrate clinical competence in assessing, planning and managing holistic care for clients with sexual health need.

Following completion of the modules the students were asked to express their agreement with whether the learning outcomes, outlined above, had been met. The results can be seen in Table 2.

Table 3: Students' opinion on whether the 12 learning outcomes had been met

	Post foundation			Post integrated		
Outcome	**Agree (% of participants)**	**Neutral (% of participants)**	**Disagree (% of participants)**	**Agree (% of participants)**	**Neutral (% of participants)**	**Disagree (% of participants)**
1	93	7	0	89	5	5
2	97	3	0	79	16	5
3	93	7	0	88	5	3
4	97	3	0	89	5	5
5	93	7	0	88	3	5
6	100	0	0	87	8	5
7	97	3	0	79	16	5
8	97	3	0	97	0	3
9	90	10	0	60	34	5
10	93	7	0	74	21	5
11	97	3	0	84	13	3
12	93	7	0	71	24	5

Self-Efficacy

Students were asked to indicate their self-efficacy in relation to practising using the evidence base and in terms of communicating in difficult situations. As described above, a single variable was derived for each self-efficacy scale.

0 10 20 30 40 50 60 70 80 90 100

Not confident Moderately confident Confident

Evidence base

For group 1, there was a significant increase in self-efficacy relating to the evidence base from 55% at the pre-foundation stage to 71% at post-foundation testing (z=-2.580, p=.010). There was a further significant increase to 85% at the post-integrated testing time (z=-3.576, p=.000).

Group 2 showed a significant increase from 53% pre-foundation to 74% post-foundation (z=-3.463, p=.001), and group 3 showed a significant increase from 66% pre-integrated to 84% post-integrated (z=-2.045, p=.041).

Communication

For group 1, there was a significant increase in self-efficacy relating to communication from 68% at the pre-foundation stage to 77% post-foundation (z=-2.557, p=.011). There was a further significant increase to 90% after the integrated course (z=-2.984, p=.003).

Group 2 showed a significant increase from 66% pre-foundation to 81% post-foundation (z=-2.965, p=.003), and group 3 showed a significant increase from 80% pre-integrated to 91% post-integrated (z=-2.192, p=.028).

Analysis of qualitative data

The participants were given a questionnaire to complete prior to the start of their sexual health education journey. All 49 participants completed pre and post questionnaires and in addition 19 completed an interim questionnaire. The qualitative responses were analysed using thematic analysis, although the responses were influenced to a large extent by the structured nature of the questions asked.

Looking forward: student anticipation and expectation

Motivation

Students were asked if they would like to make any additional comments about their motivation for coming on the course. The responses centred on the theme of improvement but were divided between personal and client centred benefit. From a personal perspective, participants identified improving their theoretical knowledge, improved competence, confidence, practical skills and general expertise as important motivations, especially in the face of integrated service delivery. There was a sense that being able to practice more safely, drawing on a newly discovered evidence base, would extend their role and increase the job satisfaction of the practitioner. Academic accreditation was specified, with students wanting to use this module as credit towards a specialist practice qualification in order to extend their role and potentially improve their career prospects. For most respondents, the modules were not regarded as an end in itself, more a stepping-stone leading to professional development.

> Extension rather than change in current role. Previously interested in public / sexual health and feel primary care and my role could encompass a lot more than it does. (Student 008)

> To complete the specialist practitioner degree. To enable me to practice more comprehensively for the benefit of the patients I see, as I have had no previous

> contraceptive training. I would like to help promote the integration of our two services. (Student 032)

The motivations were not all introspective; the participants expressed a strong desire to improve services, both through the questioning of service delivery methods that had become established through custom and practice and by being able to offer more choice to clients.

> To question and establish useable ideas to improve services and efficient use of resources in an area of nursing that is run a lot by historical practice and service design. (Student 001)

> I feel current provision is poor and I am looking to improve it. (Student 056)

> With integration with contraceptive services on the horizon I feel it is vital to equip myself with the skills and knowledge necessary to be of professional value. (Student 068)

Anticipated Challenges

The questionnaire gave the participants the opportunity to explore their apprehensions about the modules and offer solutions that might be useful to overcome the challenges to undertaking the modules. The anticipated challenges focused largely on the theme of time: time to manage work, time to manage the family and time to manage academic study. Students were also concerned about their academic ability, especially if they had not worked in the sexual health sector or were returning to study. There were some concerns about the workplace and how this would facilitate learning, in terms of gaining access to the necessary experiences or how the team would accommodate the requirements of a student, particularly pertinent for one respondent who had previously been a senior team member.

> Time management issues. Work/life balance. Steep learning curve to absorb all new contraceptive information, complete assessment and work full time! (Student 032)

> Time restraints in gaining placement time in contraceptive clinic due to staffing issues in current working environment (Student 068)

Looking Back: Reflection on the impact of the learning

At the end of the integrated module all the students completed a post questionnaire and seven students also agreed to a semi-structured telephone interview to explore some of the themes in greater depth. In addition two focus groups were held with students. Focus group one had five participants and focus group two had 17 participants. The following section represents data from the questionnaires, focus groups and interviews.

Student experience – managing time

The challenges to undertaking the modules were explored in the post questionnaires and continued to include time as a dominant factor, indicating that this is a very real issue for students. In the focus groups the students acknowledged the amount of time that study for the course was taking, not only as part of their clinical day but also as part of their home lives. Several protested

that the requirements of the integrated module were very difficult to fit in to the nine-month module span. The time pressure became all the more acute when the technology was not working or the students needed questions answering. Given that opportunity for study was often carved out of busy lives, it was clear that such barriers to learning became very frustrating. Several respondents indicated that they were only able to complete the modules by using their own time and annual leave to attend specialist clinics in order to develop competency and maintain momentum with the e-learning package. Given that the NISHE workforce development package is a whole systems approach, there seem to have been differing levels of commitment to supporting learning in the workplace, perhaps in part due to the degree of change that was occurring in sexual health services in the South West at the time of data collection. There was a sense of anxiety expressed by the group brought about by the pressures to achieve in the timeframe and trying to negotiate the complexities of the practical placements.

> For me I found time a particular challenge. Although completing the course in a supportive environment I had to find extra hours on top of my contracted ones to attend the clinics, and to complete all the theory. Having a family at home also restricted the time I had available. (Student 016)

> The workload on pebble pad was huge and I almost gave up a few times, there was so much that I stopped enjoying the material that I was reading. Trying to find time at work to do the implant training was difficult. I also found sorting out my placement difficult and stressful. (Student 010)

> If you're stuck it all takes time when you do get that support that it all takes time to come back to you and you miss that little window of opportunity on that day that particular time in which to be able to do that work. (Focus Group 2, participant 15)

One student described the challenge of coordinating opportunities to be with her mentor, juggling annual leave and the demands of her current paid employment, which had left her with an insurmountable task.

> This again has made me having to squeeze all of my experience hours into few sessions because with me I am in league with my mentor having annual leave. Other situations in the clinic I am currently working are not being able to release me. (Focus Group 2, participant 11)

Student experience – Mode of Course Delivery

The students were divided in their appreciation of the e-learning package as a mode of delivery. There was acknowledgement that the package offered great depth of detail, with all the information available 'at your fingertips' (Focus Group, Participant 3) and one student commented that she had really enjoyed the e-learning and particularly prized the flexibility of the approach. Conversely, others felt that the technology involved in the delivery system made accessing it difficult and limited the potential flexibility as it was not easy to use. There was a strong feeling that the electronic systems could have been more up to date and the package delivered in a more interesting way. The students commented about broken links to documents and web pages, out dated references, the need to have many windows open at any one time and the clunky and simplistic nature of PebblePad.

> So I really didn't find that easy. Just on a kind of user friendly basis… by the end of it I was just not really ever approaching it in a particularly good frame of mind because I was just irritated with it. (Student 008)

> I did find the academic work challenging. The package was at times uninspiring, it asks the same questions repeatedly. (Student 065)

Some students, who lived a large distance from UWE, felt that the e-learning was a real advantage as it limited the need to travel. In fact one student felt that she would have been unable to undertake the programme if more attendance had been required at university. Others felt that learning in isolation offered less value they may have gained from learning with other students in a classroom situation. This in turn decreased motivation and, although e-learning offered flexibility and choice about when and where to study, this was outweighed for some by the lack of shared learning and contact with other students. Several commented that they enjoyed the seminar days at the university and would have liked to have more of these, especially around the more 'difficult' subjects such as domestic abuse where they perceived that discussion and exploration of case study or exchange of experience and views would add value to the learning.

> Overall I found it quite sort of a bit isolating as a studying experience. I've not done a lot of on-line courses before and I think I got something out of it but I don't think it necessarily helped my particular style of learning you know I think I really missed having that interaction with other people that you're studying with or with tutors. (Student 017)

> For me I don't find online learning suits me at all…I enjoy coming to these here maybe at the learning events sitting with other people on the course and you know hearing other people's experiences. (Focus Group 1, participant 2)

The model of using Practice Education Facilitators (PEFs) to support learning in practice was well received. The PEFs were described as very helpful, responsive and willing to find out answers to question if they couldn't respond straight away. However, more clinical input from the PEFs would have been appreciated, in addition to local mentor support. Students commented that it was sometimes easier to organise PEFs to supervise clinical work as mentors were busy delivering the service and carving out protected time was difficult. This was made more acute by the pace of change that often characterised the workplace in the face of moves towards integrated service delivery. Students were unanimous in praise for the extent of their knowledge and the way the PEF role enhanced their practice experience.

> I found my practice educator was very, very helpful and she always got back really quickly and yes I felt very supported by her through it. She always answered my questions or if she didn't have the answers she would go and find out from somewhere else and would get back to me. (Student 010)

> Well people at the coal face are hard pressed for time and short staffed so more resources in this area would help…I was sent home from [name of base] such was the shortage which was exactly the right thing for the nurse to do but not good for me in getting clinical experience. (Student 037)

Student Experience – Content of Course

The students felt that the content was sufficiently detailed to enhance their knowledge of sexual health and allow them to make links between theory and practice. Some felt that the detail was too great and it was easy to get 'bogged down' (Focus Group 1, Participant 2) and one student commented that the volume of content was overwhelming and too much for a practitioner who was new to both contraception and sexual health. Several students would have liked a greater degree of flexibility to choose the depth at which to explore the subjects. If an area of practice was more relevant to their role they were keen to study it in greater depth but if it was a clinical skill that they were unlikely ever to use in their practice they would have liked the opportunity to opt out of the need to learn the theory and demonstrate competence. This was specifically raised in connection with contraceptive implants.

> The course content has been very positive and very appropriate and useful and for my role it's all completely relevant the only issue I think was at the beginning there is an understanding that there would be some opt-out options that would be specific to your job role potentially. (Focus Group 2, participant 12)

> I do think the contents really good I think the online tasks stuff is excellent the online textbook. I think it's brilliant it covers everything in real detail and even if you are experienced I wish everybody in my unit would do it. (Focus Group 1, participant 4)

The content covered not only individual care but also population wide perspectives and this again drew controversy; on the one hand students were very concerned with how to treat the individual patient but others appreciated awareness of national strategies and adopted a public health perspective.

> I don't really care what the levels of herpes elsewhere in the UK is because it doesn't matter if I've got somebody in front of me who has got herpes I'm gonna treat it do you see what I mean? (Student 008)

Student Experience – Logistics

Students discussed the fact that the practical organisation of their placements and opportunities to experience the areas of practice in which they needed to demonstrate competence was sometimes a challenge and always impacted on their ability to learn. If there was more than one student in a particular base then sharing the mentor required forward planning and setting aside the time to learn when a service needed to be delivered also required careful time allocation. Different models were described, ranging from honorary contracts to secondments, with varying degrees of success in combating bureaucracy and sourcing opportunities to learn. There was a strong feeling of frustration about these logistical challenges amongst the students, especially as they felt the additional pressure to achieve competence within the time frame of the module.

> I was seconded from one service to another so I didn't have to set up any kind of placements that was already in agreement and I found that really, really good. (Focus Group 2, participant 21)

> I could observe but to meet those competencies you then have to go and get honorary contracts somewhere else and that again time pressure and everything else is difficult because in general practice you don't see the specialised parts of the competencies core for you to achieve yet on the course you're told that you need to learn it to your level of area of work so you have to achieve a competence that is higher than you would actually use in your working practice. (Focus Group 2, participant 22)

However, where students felt supported by colleagues, worked in a proactive environment and were able to organise the clinical experience that they needed, their enjoyment of the learning was enhanced. There was some sense that accessing suitable practice experience was the responsibility of the student to initiate.

> You know be a bit creative I think and a bit dogmatic. (Student 040)

Easing the journey

The students largely felt that making improvements was beyond their locus of control and limited their suggestions of how the course could be improved to changing the structure of the modules. Suggestions included dedicated built in study time, a less demanding workload or more time to complete the modules, an increase in the number of face-to-face study days beyond the seminar days at university and the group sessions in practice, and more support with setting up placements prior to the start of the modules. In addition, several students reiterated their preference for only learning skills that they would then go on to use in their role. Although regular updates were provided, some mentors were unable to attend due to work commitments or distance to travel. Participants were keen that mentors should be encouraged to attend annual updates specifically for their role supporting these modules so that they could, in turn, support the students more effectively.

> Getting a placement organised right at the beginning of the course. When you work in a GP practice there is no way you can get your competencies achieved there. Organising the placement was definitely one of the most stressful and time-consuming parts of it. (Student 007)

> There should have been more time spent explaining what was expected on PebblePad, there should have been an extra seminar for this and to feedback properly on how we were doing mid-course as a group. Examples of how to do it would have been helpful. There should have been a proper session on implant insertion and removal. (Student 010)

> Frequent updates for practice based mentors. It was only after she attended the training day she fully understood her role and things became clearer for both of us. (Student 069)

The students offered a range of opinions about their experience of completing the modules. Inevitably, there are extremes of view, with some students finding the modules challenging and some finding them beneficial. However, the responses about the impact the learning has had on service delivery and patient experience indicate that the outcome, if not the process, was overwhelmingly positive.

> Loved it, loved the learning, and the speciality and totally value the opportunity to learn something completely new that will enhance my previous experience at this point in my career. (Student 001)
>
> It was the most difficult course I have done so far, far more difficult than my nursing practitioner degree. (Student 010)
>
> I found it excellent – it constantly guided us back to the fundamental guidelines that we must all work with – i.e. BASHH and FSRH – I felt my resultant knowledge was sound and grounded in current evidence. (Student 040)
>
> Whilst I'm aware that there is a need to standardise sexual health training, the module wasn't quite what I expected in comparison to previous on-line courses run by Open University/University of Warwick - their packages are slick, intuitive, current and made you want to use them, I have been left bitterly disappointed and lost interest. Study day at University was brilliant, informative and learnt masses from the speakers. (Student 067)

Changing Practice and the Impact on Service Users

At the end of the modules the participants were asked how their practice had changed and what impact this would have on service users. There was a strong response, particularly in the interviews, indicating that the new knowledge provided a solid platform from which to deliver sexual health services and understand the need for service improvement. The majority of respondents felt that increased knowledge and confidence legitimised their ability to question practice and suggest changes to embedded but not necessarily best practice. They appreciated the opportunity to step back and look objectively at service delivery, identify areas for improvement and also barriers to change. Comments indicated that the modules had given the students a greater awareness of the evidence base, of the wider influences on sexual health and, for one student in particular, an awareness of her own personal values and beliefs and how these impacted on the service that she delivered.

> I have seen all the pitfalls and the difficulties and the challenges for staff and all the rest of it so that aside and in terms of practice well it's given me the whole knowledge that I've needed to actually be a sexual health nurse. (Student 040)
>
> I have a better understanding of what is meant by an integrated service and how providing such a service improves overall experience and outcome for the client. I have been able to demonstrate areas for improvement within my current chlamydia screening role but equally barriers that impact on implementing change. (Student 016)
>
> The module has expanded my knowledge and understanding of both individual and organisational factors which can impact on sexual and reproductive health, I feel it has made me a more rounded professional that is better able to meet patient needs. (Student 083)

> I'm seeing proper sexual health history now and all that side of it and I'm probably much more open and you know asking people so I think … we are always looking and seeing how we can improve it so yes it is good. (Student 010)

Several students identified that they were now able to provide a 'better service'. This was attributed to both their personal skills, such as being able to facilitate more open conversations with clients to encourage disclosure, but also because their increased knowledge allowed them to offer a more holistic and integrated service to clients, which included more in-depth and thorough consultations, improved diagnosis and earlier treatment intervention; client experience was enhanced because the practitioner could offer a broader and higher quality of care. In addition students felt that their ability to offer a 'one stop shop' would in turn reduce waiting times, increase access to services for patients and provide a more seamless service.

> It will provide a holistic and hopefully seamless service in the future, once the service itself is equipped to offer integrated sexual healthcare. (Student 003)

> Service users have already said they would like an integrated service, they don't need to access other services plus a bonus not to have to see someone else. (Student 018)

> I will be able to advise and deal with a wider range of sexual health issues in one consultation and know that I am providing evidence-based practice for service users. Better quality and patient experience. (Student 032)

Integrated service delivery and leadership

The students were asked about their experiences of integrated sexual health services. These were varied, with some students working in fully integrated services, some co-located and others entirely separate. There was a unanimous belief expressed that integration was a positive step, reinforced by the learning on the modules, but also recognition of the challenges to achieving this, both at individual and structural level. In addition, structural forces such as the way services were commissioned, dissection of services due to unsuccessful bids and managing clinics in isolated geographical areas presented further challenges to maintaining the momentum of change.

Students who were working in non-integrated services expressed frustration at knowing about best practice but feeling they had no influence over the direction of travel. The hierarchical nature of the service and the impact of financial considerations and commissioning structures were seen to override the best interests of clinical staff and patients in services that were not integrated. Central to supporting change was effective leadership and leaders who were committed to integrated services. Although the sexual health modules equipped the students to understand the political landscape, they did not feel it equipped them to influence change and did not see themselves as clinical leaders in their field of practice.

> We have to wait for those in charge to make those sorts of decisions. (Focus Group 2, participant 11)

> It frustrates the hell out of me now because I know what we should be able to do and it makes me quite a frustrated practitioner because I can't do...there is too much politics

> and there's too many issues for me to be able to do what I want to do so it does make it quite a fragmented time, quite frustrating. (Focus Group 2, participant 14)

> You get the feeling that there is a lot going on behind the scenes that we are not told about and it would just be nice if we were kept in the loop about it we're not even asked questions about how we feel because most of us have got really good ideas about how an integrated service should and could be run but nobody really asks us our opinion. (Focus Group 2, participant 11)

However, there was a sense that students were so committed to the integrated agenda that they would find their own ways of subverting the system so that they could offer patients a holistic service; patients received both sexual health and contraception advice treatment despite the challenges.

> I guess people are developing their own ways of integrating and delivering the whole lot in one go. (Student 001)

> I probably practice an integration model whereby I provide the services but not necessarily all at the same time if that makes sense. So they get an integrated service but it's not necessarily in the same consult at the same time. (Student 008)

One student held a leadership role whilst undertaking the programme and highlighted the fact that individual practitioners in the field could be slow to change if current working patterns suited them or they enjoyed their speciality. Another lamented the loss of several very experienced staff members who did not want to work across both specialities, commenting that their absence left a deficit of specialist expertise in the workforce.

> I feel there is quite a lot of service resistance to it as well… I am involved in designing and developing services and trying to recruit staff who are interested in working in an integrated service is quite difficult at times because you get people who just want to do contraception and people just want to do sexual health so I think it's quite difficult. (Focus Group 1, participant 1)

> Well I mean mostly skill mix I have to say it's been one of our biggest [challenges] we have lost you know quite a few old timers and that's quite sad in a way because they have you know such a wealth of experience but no not everyone is happy to you know to take on the whole role. (Student 040)

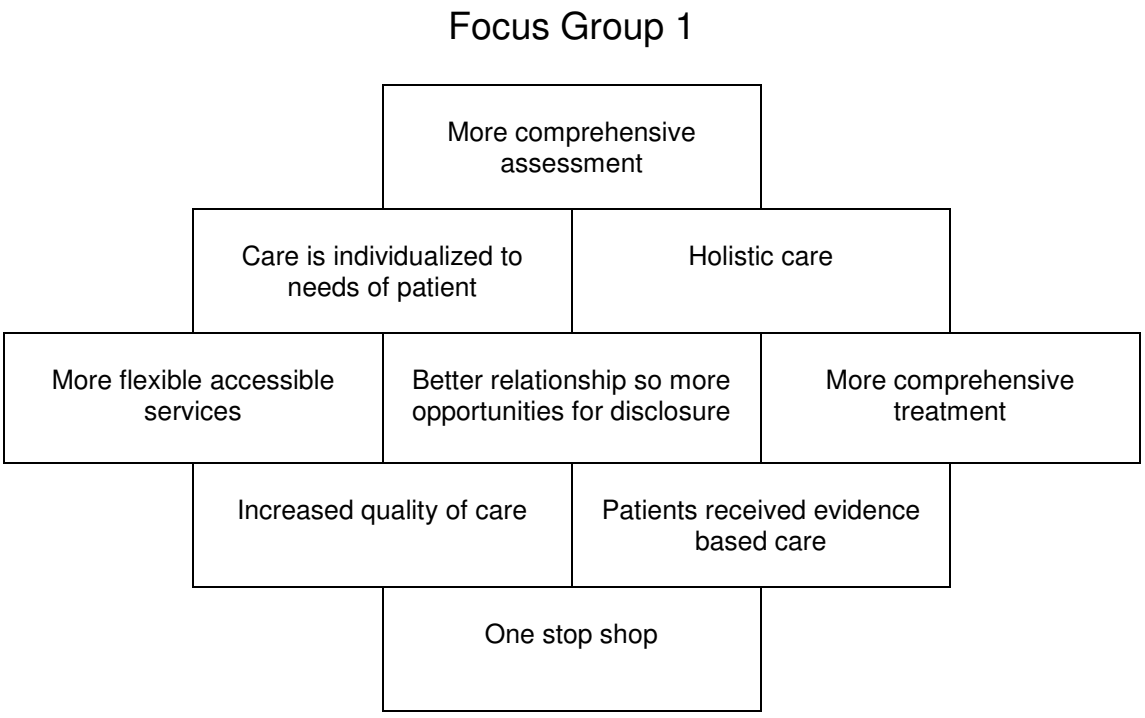
Diamond Ranking Activity

At the end of the focus groups, students were asked to participate in a diamond ranking activity to discuss the specific question, "What impact has your learning had on service users?" Five students participated in the first diamond ranking activity and in the second activity the 17 students were divided into two groups – group A and group B. The researchers had previously identified nine broad impacts that learning may have on service users from the answers on the questionnaires. The nine impacts were: more comprehensive assessment, more comprehensive treatment, a one stop shop, service users receive evidence based clinical care, improved signposting and communication between agencies, better relationships so more opportunities of

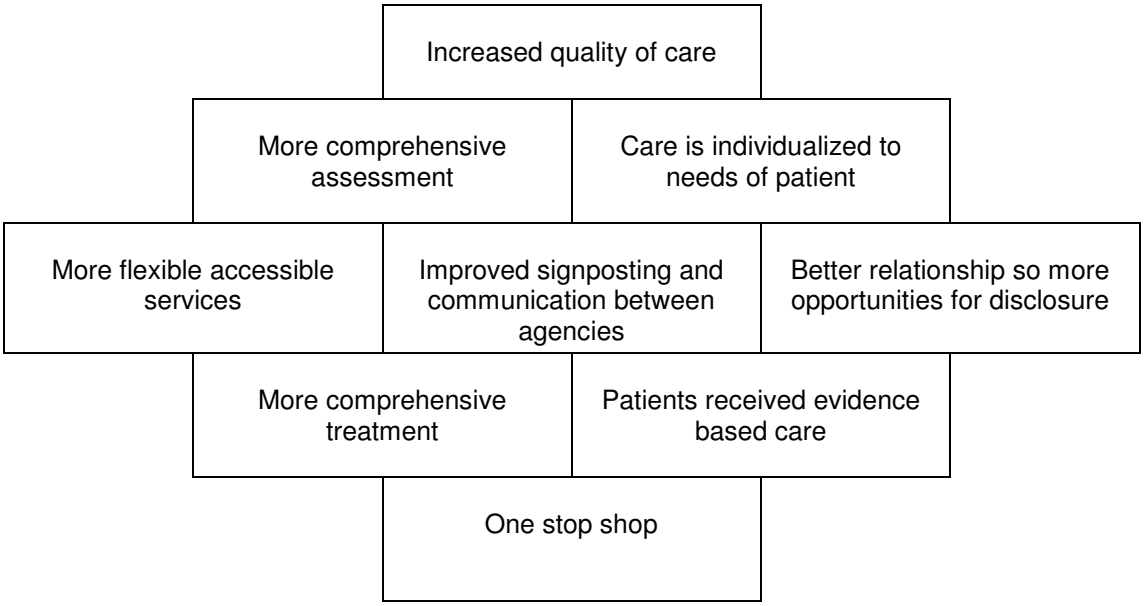
disclosure, care is individualised to the needs of the patient, more flexible and accessible services and increased quality of care. The students were also given two blank cards to use as wild cards, on which they could identify impacts that the researchers had not provided. The results of the activity can be seen in Figure 3. Students in Group 1 annotated the diamond with a number of comments, which reflected their own experiences in practice, for example 'we've always given quality of care' and 'hasn't changed' referring to 'more comprehensive treatment'. Groups A and B did not annotate the diamond and group B did not position a priority at the bottom as they were unable to reach a consensus.

Overall the diamond ranking activity generated significant discussion amongst students and across all three groups there was agreement that the modules had enabled them to provide more comprehensive assessment for their service users. During their discussions the students indicated that, although they would like to have made an impact on the service user experience to a greater extent, structural restraints, such as not offering an integrated service, limited their impact. The 'one stop shop' card was placed at or near the bottom for one of two reasons; either the students were already working in a service where this was provided and so the impact of their learning was limited in this area, or the structural restraints meant that delivering both sexual health and contraception was not feasible and again, they were not able to implement this service model. Offering more comprehensive assessment is influenced to a much greater extent by the skills of the individual practitioner and therefore the students felt that their learning had significantly impacted on their assessment technique.

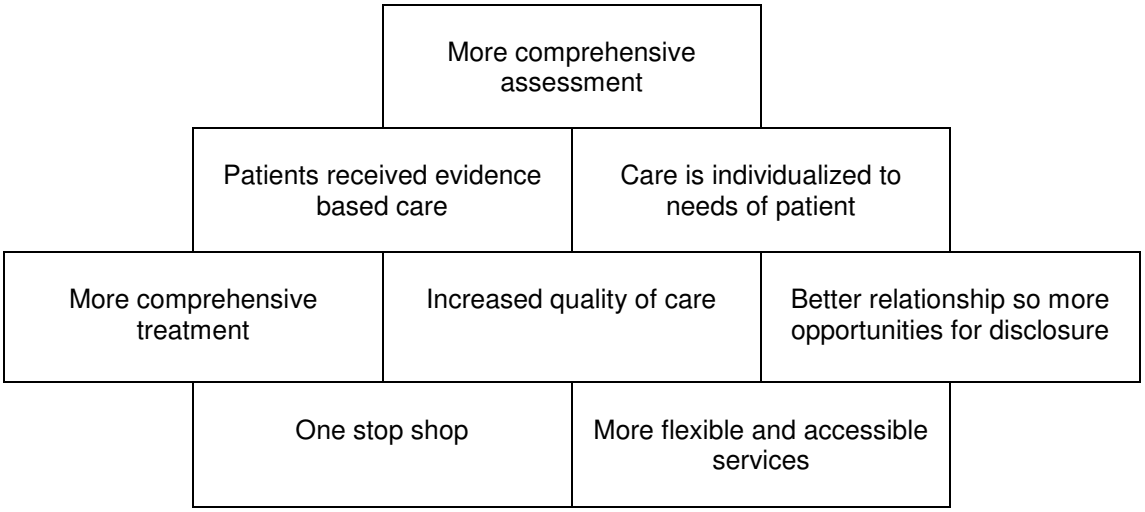
Figure 3: Diagrams to illustrate the results of the three diamond ranking exercises



Focus Group 2 Group A



Focus Group 2 Group B



Clinical Service Manager Perspectives

Six service managers responded to the invitation to take part in the study and these self-selecting participants were interviewed separately by telephone, using semi structured interview technique. Using thematic analysis, five themes were defined: integration, service delivery, mode of course delivery, content of the course and logistics of placements and mentors. These themes are explored in the following section using extracts from the data to support the discussion.

The six managers held positions in different sexual health service provider organisations across the South West of England and were responsible for a range of styles of service delivery. Three of the organisations offered a fully integrated sexual health service, two were partially integrated and one was not integrated at all. The six participants represented the broad range of service provision accessible to patients and offered an equally broad range of views on the process of integration, the suitability of the course content and mode of delivery and the challenges of placing students and supporting mentors.

Integration

Despite the range of service provision, all managers accepted that integrated service delivery was the most favourable model, primarily because of the benefit to the patients. Even in those services that were not described as integrated, mangers attempted to implement systems that emulated the model.

> We saw the writing on the wall about seven years ago and we realised if you are in that area of the anatomy and they had unprotected sex the probability is that they need some contraception so it seemed crazy to make them go to a different service to get some contraception so anybody that needs contraception opportunistically we will give it to them. (Manager 3)

Integration of sexual health and contraception services was described as a journey, which required a certain amount of tenacity from the managers. Some areas had successfully completed the transition and others had tried and failed, only to try again with a different approach.

> I think mainly for the patients you know it's always patient focused what we want to do and it definitely would be the best option for patients but yes for various reasons unfortunately we've got close a few times but it's never actually happened. (Manager 1)

> I am a big, big strong believer in that and think that's something that we pushed you know with the [Trust name] for quite a few years now and it was a massive turnaround for a lot of staff to that way of working who were historically weren't working in that way. (Manager 2)

Barriers to delivering integrated services were associated with contracts and finance but also attitudes of the workforce. Workforce skills and education were not seen by managers to be an issue by most managers as most staff members were now dual trained; there would be an expectation that new recruits to more senior nursing posts would have skills in both contraception and sexual health. However, there was still reluctance from some practitioners to take on the dual role.

> I am very supportive of it [integrated services] but some of my colleagues have been less keen to do that and not seen the relevance particularly GU staff. (Manager 5)

> We've got a lot of nurses here who have both you know are dual trained so no we are not... we are not held back by sort of capabilities and education. (Manager 1)

> Especially recruiting at band 6 level we never have a problem and the staff that are recruited are dual trained now that's an expectation they have to come in dual trained so... (Manager 2)

However, one manager felt that maintaining high levels of expertise across all aspects of sexual health work was a challenge to working in an integrated way. The manager argued that expertise was developed through both theoretical and experiential learning and it took many years to gain experience, traditionally in either GUM or contraception. This could be eroded very quickly if that practitioner then worked in a less familiar area to build up new competence, which in turn was a risk for service delivery.

> If I'd put that HIV nurse specialist through the [university] course to train him in contraception no way would he be an expert in contraception and no way could he run his own nurse led clinic in contraception he would have to spend a good 18 months full time in contraception to be coming up to that level by which time he would have lost a lot of his skills in HIV you see? (Manager 6)

Opinion was divided about the impact of new experience in new placements on practitioners. One participant raised the fact that if a student had come from either a contraceptive or GUM clinic, placements in fully integrated services had the potential to be unsettling. However, another participant who felt strongly that experience in an integrated service was beneficial in terms of motivation and innovation countered this.

> They are doing the course and then they are going back into a service that isn't integrated and it's a real frustration because once you start to work in an integrated way it's very difficult to see how you cannot continue to do that. (Manager 4)

> I have got a couple of staff…one has worked in an integrated service before…and had a much more strategic view and a way of thinking and my nurse that's doing this course, they are starting to actually see and come up with suggestions and they are starting innovative practice. (Manager 5)

Service Delivery

The participants were asked whether supporting students to undertake the course had impacted on service delivery. Responses either referred to the challenges of releasing students from the workforce to study or experience practice in other placements, or to the development in skills, knowledge and confidence that impacted on the level of service a student was able to deliver. One manager with a small team of staff had to make changes to service delivery in order to release the student to be able to attend different clinics. The manager felt this was a worthwhile investment but recognised that it had been challenging for the whole team.

> We have a very small nursing team so one person is out completely who is full time plus having another member of staff having to be taken out of the training has actually closed our nurse led clinic for a period of time so we've had to make serious compromises in order to facilitate this. (Manager 5)

The participants highlighted the fact that the increased expertise of the students led to innovation and change in the workplace. This was not met with unanimous acceptance by existing staff members and this resistance was an additional challenge for managers. The participants valued the opportunity for the students to reflect on how they were working and consider the issues from a wider perspective. There was no agreement that the skills the students were developing were leadership skills but they were acknowledged to be more confident to suggest service developments and to have a greater ability to think strategically about the issues that affect both individuals and services once they had completed the course. One participant emphasised the fact that it wasn't the clinical competence that enabled them to develop professionally but the 'peripheral learning' that encouraged the students to become more professionally motivated.

> I am not sure leadership is quite the right term perhaps maybe it just gives them you know maybe slightly more confidence to actually come and discuss things….I think it just sort of opens your mind up wider doesn't it…. it sort of gives somebody time to sit down and really reflect on how they're working. (Manager 1)

> It makes people more open minded and they actually see their service in the context of people's lives as well and what they are struggling with and why they can't get there on time and why some people are booked and some people are drop in, it's that whole... it's that bigger picture of patients as well as service. (Manager 5)

Mode of Course Delivery

The integrated module was predominantly achieved through e-learning and support to develop clinical skills in practice from the mentor and the PEF. The amount of work to be completed in the nine-month period was felt to be onerous, especially if a student had not had much experience in sexual health practice prior to commencing the modules. Whereas the e-learning package was flexible to allow the student to study in their own time, service managers, like students, felt that the e-learning platform was challenging to navigate. One manager suggested that there are other established e-learning resources that could have been used instead. The clinical element of the modules was described as lacking in detail and two managers felt strongly that it was essential to offer additional teaching to her students on the specifics of clinical practice. This was highlighted as a challenge as in house training has the potential to perpetuate poor practice.

> I don't expect them to come out as experts because the expertise happens after you have been doing it for a while but you know I really felt if we hadn't had the input that we had to put in that they would have come out with very little. (Manager 3)

> I am aware in an isolated service that you reduce the amount of experience because people trained in house and that I think is quite dangerous in a lot of ways. (Manager 5)

The managers identified the benefit associated with face-to-face learning at the University. Contact with lecturers and other students encouraged networking, exchange of ideas and peer support for students, particularly important for more isolated services.

> She would have preferred to have more sort of group and you know get together in the classroom because it would have helped her I think with getting to know people better and having that support system from peers and colleagues. (Manager 1)

> You can bring in ideas and you can mould and you can change but it just opens you up to those conversations all those ways of thinking about working and when it's somebody else that's doing it, it's not so scary. (Manager 5)

All managers felt the role of the PEF added value to the course, especially towards the beginning when students and mentors were getting used to the e-learning systems. However, practice visits were sometimes difficult to arrange and, although they were easily contactable by phone or email, their presence in the clinical environment was not high, possibly as a consequence of the large geographical area that the PEFs were covering. Where good relationships were formed between the PEF and the manager, their clinical experience and knowledge was valued and respected.

> I mean she [PEF] was really helpful, really positive… it was just fraught sometimes for her and I think she handled it very well. (Manager 3)

> They were really good the practice educators you know if you rang and left a message if they weren't there somebody would have always got back to you um so I have to say the practice educators were very helpful, very supportive. (Manager 6)

> I found all of them very supportive and very helpful and certainly with online and with the learning and the questions were answered very quickly…but they don't clinically come in and work alongside or support the clinical environment. (Manager 5)

Content of the course

The managers all discussed the educational content of the course. The majority felt that the content was appropriate, especially in conjunction with the guidance and additional clinical input from a mentor. It was seen as a refresher for nurses who had some experience of sexual health work prior to starting the course and theoretically comprehensive for those new to the field. One manager felt that it was unsuitable for a very experienced practitioner. The content could have been enhanced if it was offered with a degree of flexibility to align with local practice, so for example the need to complete contraceptive implant training was deemed unnecessary if it was never going to be offered as part of the service.

> The content of the course is great. (Manager 1)

> So we'll take on new staff member who has never done any contraception, sexual health I think it will be much more beneficial for them… the online I know it's had its issues but actually it was comprehensive. (Manager 4)

The competences were described as too broad, requiring more specific outcomes for the mentors to feel confident that they could sign them off. The non-clinical core elements of the e-learning package attracted a range of views from managers, from being seen as inappropriate and 'managerial' to setting the context and offering a strategic perspective. The content attracted most criticism where it differed from local practice, but this was also seen as an opportunity to broaden the thinking of the students and encourage them to appreciate national drivers for change. This was particularly important to one manager who felt that this was the added value of the course, the element that it was not as easy to deliver in-house.

> MI2: I felt the competency document was quite maybe flowery if that's the right word in places some of the statements were quite sweeping and I felt patchy in areas so and I certainly felt round contraception it wasn't specific enough.

> MI3: Well the coverage was inappropriate the stuff that's on Pebble Pad it was mostly managerial it was very repetitive and it wasn't about the disease process I think it would have been much better if they'd had a series of lectures discussions, talks, projects on sexual health.

> MI5: and that is a big, big benefit over the university course compared to BASHH [British Association for Sexual Health and HIV]. BASHH do clinical and quite honestly we can deliver it here and we can deliver it in house and it costs us nothing.

Logistics of Placements and Mentors

There was a strong feeling that placing students with appropriate mentors was challenging for the managers. Students often started the course with particular strengths in either sexual health or contraception so placing the student with a mentor who had the appropriate skills to develop their areas of deficit was essential. This entailed juggling clinics and placements so that the service could still be provided, the student could work with the mentor and develop specific areas of practice. Students were often established members of the workforce, already practicing within their area of competence so backfill when they were on student placement was an additional complexity, compounded by other workforce deficits in the teams. One participant managed this situation by employing the student in a supernumerary context but even this arrangement proved challenging to the team.

> Now that did cause us some difficulties because obviously we were a member of staff down during all that time and so the rest of the team had to support the learning but they were trying to support the deficiency really. (Manager 6)

The role of the PEF was important, as they were able to support the manager with the assessment of student learning need and reduce the burden on the mentor. Crucially it was also identified as essential that the mentors could be relied upon to only sign off competent students, those that they were confident could work safely and independently behind a closed door.

> At times it has been a big challenge people trying to get you know timings of people on annual leave or some people on study days you know it's trying to match them up and people tend to actually work part time so others have jobs elsewhere you know so it has

been a challenge certainly but you know we have worked our way through it. (Manager 1)

My time is obviously at a premium and it's good that I don't need to be sorting out what the student needs I can go to the mentor and say this student needs this can you, you know are you happy to take them and work your way through that and our mentors have been very good really. (Manager 4)

Because she's a competent GU nurse she is part of our service she's part of our numbers and she delivers clinics we have had to pull her out and facilitate her training in contraception and that's been challenging at times with service delivery. (Manager 5)

Mentors were viewed as key to the process and managers particularly appreciated the opportunity for them to be updated by the PEFs. In addition one manager identified that it would be useful for the mentors to have access to the e-learning course content so that they could support the students to a greater degree with their learning.

Discussion

Mode of delivery

The higher education landscape has changed dramatically over the last ten years, particularly in relation to expectation and the importance of student experience in attracting and retaining students in a highly competitive higher education market. In parallel, developments in communication and media technology have driven expectations of slick, intuitive, interactive e-learning packages that rival the quality of the social media and gaming applications that many students interact with daily. Recent research in to e-learning has considered the use of innovative didactic methods such as collaborative and cooperative activities to enhance learning (Amhag & Jakobsson 2009, Paechter 2010), as oppose to traditional self-instructional materials and independent study. Biasutti (2011) argues that such approaches offer a constructivist perspective and active learning approach in line with the theories of Vygotsky (1978). The results of this study clearly indicate that many of the participants were disappointed in the quality of the platform employed in the Integrated Sexual Health module, which can be attributed in part to the fact that the module did not draw on innovative technology. Biasutti (2011) found that the aspects of e-learning associated with student satisfaction were the collaborating and comparing of ideas, analysing different points of view, peer learning and the usability of the platform. It is unsurprising therefore that some students expressed dissatisfaction with a package that was not revised to match technology advancement or employ contemporary approaches to e-learning. Unfortunately, some students became distracted by the perceived lack of quality of the platform and this preoccupation shifted their focus away from the comprehensive content and affected their motivation to learn. The platform used was developed in 2010 and unfortunately it was not possible to transfer it mid programme to a new platform without creating disruption but this is an area in which significant development is planned.

The adoption of e-learning technology to support sexual health education is not new, with the Royal College of Nursing (RCN) (Strodtbeck 2011) and the Faculty of Sexual and Reproductive Health (FRSH 2010) both offering specialist sexual health e-learning courses. Weerakoon et al (2008) found that e-learning, including discussion platforms, increased the practitioners' comfort

when discussing sexual health issues as they were less inhibited and able to develop their skills in a 'safe' environment. E-learning as a medium for educational delivery is known to benefit students due to its flexibility and accessibility and can overcome the unpredictable or possibly limited exposure to specific clinical conditions in practice placements (Feng et al 2013) when used as an adjunct to traditional practice based or didactic teaching. However, Feng et al (2013) found that in terms of improving performance or cognitive ability, situated e-learning (incorporating scenario based activity) was more effective for novice nurses or medical students and had no significant advantage over traditional teaching methods for more advanced practitioners. The average experience in nursing of the participants in this study was 17 years, with six years working in sexual health services. This may also go some way towards explaining the negative responses from the students regarding their experience of e-learning as a mode of delivery for the integrated module and also reiterates the benefits of a blended learning approach with opportunities for face to face learning.

Walkem (2014) acknowledges the fact that students can feel isolated and disconnected when studying online courses and attributes this to the limited opportunity for transmission of non-verbal messages between the teacher and the student. The concept of 'instructional immediacy' (Kim and Bonk 2010) is used to highlight those behaviours that encourage positive learning relationships. Walkem (2014) identified the way that teachers acknowledged the individuality of the student, the provision of timely and accurate information and the use of reliable, user friendly and rich media to support learning, as particularly important for students. Instructional immediacy is closely related to the perception of 'social presence' and both concepts are associated with motivation to learn (Schutt, Allen and Laumakis 2009, Baker 2010), student experience (Russo and Benson 2005) and student self-efficacy and beliefs (Gunter 2007). Although some participants in this study identified a sense of isolation while learning, the role of the Practice Education Facilitator was unanimously praised. The PEF served to bridge the gap between university and practice and offer the instructional immediacy that is valued by online learners. Students only voiced dissatisfaction with this model when the response from the PEFs was delayed or infrequent, which is potentially due to the large geographical area that the PEFs were covering. This is also an indication that translation of the Integrated Sexual Health module from a much smaller patch in the North East of England to the South West region was not possible while maintaining absolute fidelity to the model.

Self-efficacy

Significant evidence now highlights that increasing a student's self-efficacy can improve both acquisition of clinical skills and practice behaviours (Manojlovich, 2005; Wagner, Bear and Sander, 2009; Kuiper, Murdock and Grant, 2010). Self-efficacy is defined as an individual's belief in his or her capacity to execute behaviours necessary to produce specific performance attainments (Bandura, 1977). Within nursing evidence suggests that students' self-efficacy around sexual health is low and many students remain hesitant in proactively addressing sexual health concerns with patients (Kong et al, 2009). In a study by Saunamaki, Anderson and Engostrom (2010), 60% of students reported a lack of confidence in their ability to address patients' sexuality concerns. This is supported by the findings in this study where the initial questionnaires indicated low confidence with some of the challenging aspects of communicating around sexual health issues, with the potential for sexual health concerns not being sufficiently identified or addressed by nurses. It was reassuring that the self-efficacy communication scores increased significantly following completion of the modules, particularly when both modules were completed, with 21 percentage points increase from 68% pre foundation module and 90% post integrated module.

Sung et al (2015) found that in addition to providing students with knowledge and skills in sexual health it is also necessary to explore positive attitudes to sexuality, to enhance student efficacy in supporting patient sexual health in their practice, suggesting that this is an important element to include in module design. Including proactive and positive discussions within education is essential to ensure students are fully prepared in practice and confident in delivering successful sexual health integrated services. The students were asked to score their self-efficacy regarding managing their own emotions with patients, the results of which are represented in the combined score for self-efficacy with evidence based. The significant increase across all three groups is potentially related in part to their personal reflexivity and understanding of their own attitudes and values.

The combined self-efficacy scores increased significantly across all groups for the evidence based practice activities and for the communication activities, indicating a level of success with the modules. This was particularly evident when both module were taken in succession, with an increase of 30 percentage points across both modules for evidence based practice and 21 percentage points for communication. Where the modules were taken in isolation, the increases in both evidence based practice and communication were higher for those taking just the foundation module than those just taking the integrated module. The reasons for this are complex but the qualitative data indicate that several participants identified face-to-face teaching as offering additional value to the learning experience, which may have been the advantage that the foundation module offered. The results could be related to the characteristics of the practitioners who chose to undertake the foundation module. Although there was little difference in the average years of experience in sexual health between these students and those that undertook the integrated module, the age range was wider for those just taking the integrated module. Of the 38 students who completed the foundation module, 18 had undertaken no pervious sexual health education so it is possible that they would be less confident with the activities relating to evidence based practice at the beginning of their study and the potential for increase in self-efficacy would be greater. This is also supported by the comments that some students made about their concerns regarding returning to study after a long break.

Whilst it is recognised that confidence may be related to both years of sexual health nursing experience and qualifications, it is apparent that this is an area that needs further exploration. Improvements in self-efficacy through the development of knowledge, skills and increasing experience (Kear 2000) are associated with positive impact on competency and confidence in practice. In addition studies carried out by Manojilovich (2005) and Sung et al (2015) highlight positive associations of increased knowledge, skills and self-efficacy with observable improvements in nurse's sexual health practice, therefore increasing self-efficacy may result in positive and beneficial changes in practice. All the participants in this study successfully completed the practice element of the modules, demonstrating a level of practical competence, which aligns with general increases in self-efficacy scores.

The integration agenda

Allotey et al (2011) argue that working in sexual and reproductive health is not merely about clinical competency but also about negotiating the complexities of a speciality steeped in social values, ideology, religion and morality. The fact that sexual ill-health is also inextricably linked with inequality, disadvantage and debate about human rights makes it inherently political. The

policy agenda (DH 2013a) in the UK reiterates the need for broader based service delivery, which in turn requires a broader based education programme for practitioners in the field of sexual health, to enable holistic work with patients (Kane and Wellings 2003). The clinical service managers in this study reiterated this value of 'peripheral learning', which was described as learning outside of clinical competency and core skills but still essential to developing motivated and rounded professionals, who could consider the service not only on the individual but also the strategic level. This also reiterates the desire to move away from a medically dominated discourse on sexual health to one that acknowledges the importance of a holistic, public health perspective. The students discussed the role of the modules in enabling them to negotiate the political landscape but expressed frustration at their lack of influence and ability to undertake leadership roles in the integration agenda.

Both service managers and students were convinced that integrated service delivery was the appropriate model but both sets of participants expressed frustration at the slow pace of change. The marked differences in practice experience had a powerful impact on the students; once they had worked in an integrated way they found it hard to offer separate service delivery. However, there was a sense that students were so committed to the integrated agenda that they found their own ways of subverting the system so that they could offer patients a holistic service; patients received both sexual health and contraception advice and treatment despite the challenges. This suggests at least some change in workforce culture in the last five years. McNall (2012) found that nurses delivering sexual health services reiterated the separation of services by continuing to work in silos and offering reactive rather than preventative care, despite the policy agenda to develop integrated services, which focus on both treatment and prevention. The actions of the nurses in this study can be related to the concept of street level bureaucracy (Lipsky 1980), where employees of government agencies (in this case the NHS) exercise substantial discretion in the way they carry out their roles, in part to overcome conflicts between their own beliefs and commitments and the demands of their jobs and in part to fulfil an obligation (perceived or otherwise) to remain advocates for their patients. This is only possible due to the high level of professional judgement that specialist practitioners such as sexual health nurses are expected to exercise and the 'human' dimension of the work that they do. The nurses must respond with compassion and flexibility to the needs of the individual patient (Cummings 2012) and such idiosyncratic response may unintentionally undermine the broader organisational goals. Summer and Semrud-Clikeman (2000) found that school psychologists, when faced with conflicts between their professional integrity and beliefs and organisational context, developed coping strategies that included rising above the job demands to provide needed services to children and their parents. Ironically, the actions of the sexual health students in this study may in turn influence local policy, demonstrating the very leadership skills that they felt that they had not developed.

The outcome of the diamond ranking activity was a further indication that the messages from national policy are not necessarily being enacted at local level. The three student groups who completed the exercise reached consensus within their groups but the chosen priorities were not consistent across all three activities. The impacts on services users that were given priority tended to focus on those that students felt they could influence on an individual level as they increased in skill and knowledge. Those impacts that required wider organisational or structural support, were not identified in the diamond, or given low priority. In reality, policy-making and implementation is a complex activity that is influenced by a range of factors (Bunn and Kendal 2011). Evans et al (2013) discuss these influences on commissioners and service managers when

implementing policy at local level and highlight the important part that financial implications, government targets and local political issues played in the decision-making processes, often influencing to a greater extent than research evidence. Rütten et al (2009) also propose that organisations can exhibit different levels of 'readiness' to adopt policy, which incorporate factors such as supportive environments, organisational goals, organisational resources, organisational duties and external 'windows of opportunity' that may be present. This compounds the work of Gerrish *et al* (2007), who recognised that practitioners face a number of barriers to introducing new evidence and policy in to practice, not least lack of time, authority and support to implement findings. Some of the participants in this study were frustrated by their inability to move the integration agenda forward, depending on the service provider that they worked with. It may be that their focus on individual, patient centred care in the diamond ranking activity was a way of reconciling themselves with the structural barriers that they experienced. Students were encouraged to complete their sexual health education as part of a more extensive programme in which they could take additional modules connected to leadership. At the point of data collection these had not been completed by the participants in the study but it may be that additional competence and confidence in leadership and managing change would have enabled them to work more effectively in their practice contexts.

Limitations

A sample of 49 student participants offered a large amount of qualitative data, resulting in rich descriptions and detailed interpretation, however more participants would have strengthened the power of the quantitative data collected. Greater insight could also be gained by more detailed analysis of the individual evidence based practice and communication activity self-efficacy scores form the questionnaires, as improvements in self-efficacy were not demonstrated in all areas. The data was time bound, geographically located and culturally specific. Although there are clear messages that will have resonance with other educational programmes, clinical specialities and regional areas of educational delivery, it is not possible to extrapolate these findings to national practice.

Delivery of the practical placement element of the integrated module in the South West of England was modified to meet the challenges that providing education over a large geographical region presented. Therefore comparisons between the effectiveness of the module in the original region and that in the South West cannot be direct or absolute.

The researchers conducting the interviews were not associated with the delivery of the programme but were employed by the University. This association with the same university that would assess the students and award their academic qualification may have had a limited impact on participants' disclosure, in terms of their willingness to share more controversial issues.

The study would have been enriched by the involvement of service users, particularly to gain their perspective on improvements to service delivery by students who had completed the modules. In addition, the perspectives of practice education facilitators and commissioners would have broadened the scope of the study. It is a recommendation of this report that further research is

conducted to explore the perspective of a wider range of stakeholders and gain a more comprehensive view of the impact of the learning.

Conclusion

This study emphasises the real need for appropriate sexual health education to support the transition to delivering integrated services to clients and patients. The education programmes must be fit for purpose; careful thought needs to be given to the curriculum and mode of delivery to ensure that contemporary student expectations are met. A balance needs to be struck between the different aspects of a blended learning approach in order to maximise instructional immediacy and student satisfaction.

It is clear that the delivery of the NISHE workforce development package by the University of West of England evaluated in this study was successful in improving student self-efficacy in many areas, particularly around communicating in difficult situations, holistic assessment and the development of practical skills. However, the evaluation has highlighted the effect of contextual differences on educational delivery, with the geographical and cultural differences between sexual health service delivery in the North East and the South West of England impacting on the effectiveness of the transition. Future planning should also include leadership and change management theory and practice, as both students and service managers acknowledge that strong leadership is key to the integration agenda for sexual health. Students were demonstrating the use of intuitive leadership characteristics but lacked the confidence to acknowledge their ability to influence practice. More explicit inclusion of leadership development in the modules may in turn facilitate more explicit demonstration of skill in practice and further the integration agenda for sexual health services. Sexual health as a specialism is in a state of flux; practitioners need to be equipped not only to work effectively with patients and clients but also to develop a resilience that allows them to play a central part in developing excellent, accessible services that meet the needs of the users.

Recommendations

Recommendations for education

- Consideration should be given to the balance of e-learning and face to face contact within the sexual health modules, in order to enhance instructional immediacy and increase student satisfaction.
- E-learning packages should be upgraded to meet student expectation by incorporating interactive technology and opportunities for collaborative learning.
- The role of the Practice Education Facilitators should be continued to support links between university and practice. The role should continue to be used to enhance placement and mentor development, including supervision and competency assessment in practice.
- Consideration should be given to flexible module content to align with the needs of local service delivery.
- The sexual health modules should incorporate elements of leadership development to enable practitioners to initiate and manage change in practice and should also allow

opportunities for proactive discussion around student attitudes and values to develop reflexivity in practice.

Recommendations for practice

- Commitment to the integrated service delivery model should continue and a supportive culture, enabling practitioners to propose and implement change in practice should be further developed.
- Consideration should be given to the retention of experienced staff members who require skill development in GUM or contraception.
- Service managers should work closely with education providers to facilitate mentor development and negotiate appropriate placements for students.

Recommendations for policy makers

- Policy makers should recognise the challenges presented by current fragmented commissioning structures to delivering integrated sexual health services and the impact this has on practitioners and service users.
- A plan should be developed to renew motivation for service improvement and practice development by raising the profile of sexual health services in England, reiterating the imperative of accessible clinical choices for service users.
- Research relevant to sexual health practice, service delivery and incorporating the voice of the service user and commissioner should be actively encouraged, financed and prioritised in order to underpin future policy and practice.

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Appendix 1 – Student information sheet

University of the West of England
BRISTOL

Evaluation of the Integrated Sexual Health Programme at the University of the West of England

We have been asked by Health Education England to evaluate the Integrated Sexual Health Nursing Programme. The aim of this research is to assess how effectively the model transfers from the North East of England to the South West. As part of this evaluation we have been asked to explore the expectations and experiences of students on the programme to ascertain whether these were met.

Who is conducting the research?
Judy Brook and Joanne Seal from the Faculty of Health and Applied Sciences will lead the research team. Health Education South West is funding the research. The Faculty Research Ethics Sub-Committee has approved the study.

If I take part what will it involve?
We would like to give all students on the Integrated Sexual Health Nursing programme an opportunity to share their experience of the programme. At the start of your journey you will be invited to complete a baseline questionnaire. This questionnaire aims to explore your perceived education and training needs and your expectations of what you feel the programme will deliver.

Also, at an appropriate point towards the end of your study at UWE you will be asked to complete a second questionnaire. This will investigate your experience of the programme as a student. It will ask you to reflect on your learning from the programme and assess your confidence in using your knowledge and putting it into practice.

Additionally, we will also ask you to provide consent to release the data you provided to the University on the: Application for continuing professional development and equal opportunities monitoring forms. These forms were completed as part of the application process. In giving your permission for the release of this data you will allow the University to provide the researchers named on this form with access to the anonymised data you provided the University on these forms. **You can still choose to complete the questionnaire whilst withholding consent for access to the data on your equal opportunities monitoring forms.**

We may also invite you to take part in a focus group or individual interview later in the programme. You will meet with other people from the programme to discuss your

experiences and expectations, before, during and after your time on the programme. The discussion will be tape recorded, and should last around 60 minutes, depending on how much you have to say. Only the researchers listed here will hear the group discussion or interviews. None of your tutors on the programme will know your identity or the things that you report. If you choose to become involved in this part of the study you will receive more information about it nearer the time.

Confidentiality of information
Your data will be analysed only by the researchers named above. The data they are given will be stored on a password-protected computer and any typed up notes or hard copy questionnaires will be kept in a locked filing cabinet. You will remain anonymous; any identifiable information, such as your name, age, or where you live will be removed from the typed up notes and also from any reports or publications that are produced using these data.

Withdrawal of data
You are free to withdraw from the research at any time. We will explain this in more detail at the times when we ask you to complete the questionnaires and you will have the opportunity to ask us any questions that you have. If you wish to withdraw your contribution after completion of the questionnaires, or interviews please contact the researchers (contact details below).

What happens if I decide not to take part or to withdraw the data?
Nothing! Your studies and your place on the programme will not be affected by your refusal to take part in the research or your decision to withdraw your data. This research is undertaken independently of the delivery of the Integrated Sexual Health Nursing programme.

What should I do if I do want to take part in the research?
If you would like to contribute to this study, please contact one of the researchers and they will send you a questionnaire by email. Alternatively, an opportunity will be identified during your time at UWE this week to complete a hard copy questionnaire and return it to the researchers.

How will I find out the results of the research?
Once the research is completed a report will be written and published. This will be available for you to access electronically and read if you should like to. We will be able to provide details of how to access it nearer the time.

Please keep this information in a safe place.

Judy Brook and Joanne Seal,
Senior lecturers and researchers

If you have any questions about this research, please contact:

Judy Brook,
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Glenside, Bristol, BS16 1DD.
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If you have any further comments or complaints please contact:

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Appendix 2 – Questionnaires

University of the West of England
BRISTOL

Research code

Questionnaire for sexual health evaluation

Section A: Personal Data

1998 Data Protection Act, Consent to Process Personal Information

The personal information collected on this questionnaire will be processed by the University in accordance with the terms and conditions of the 1998 Data Protection Act. We will hold your data securely and not make it available to any third party unless permitted or required to do so by law. Your personal information will be used to inform us about the characteristics of the students that we recruit on to the NISHE programme and will be used as follows:

1.The information that relates to you as an individual will only be disclosed to the researchers involved in the study.
3. The information will be kept for six years after the completion of the study, when it will be destroyed.
4. The information will be stored on the secure UWE computer system or in a locked filing cabinet in a locked office.

I agree to the University processing my personal data as described above

……signature.

We would like to find out a bit about your background and why you are undertaking this course.

What is your gender?

……

What is your age?

……

What professional qualifications do you have?

……
……
……
……

How long is it since you gained your initial nursing or midwifery registration?

……

Where are you currently working, and what is your current role?

……
……
……
……

What previous sexual health nursing experience have you had?

……
……
……

Have you under taken any previous sexual health nursing education? If so, what did you study and at what academic level?

……
……
……
……

University of the West of England
BRISTOL

Which of the following statements describes your motivation for applying to undertake the sexual health programme? (Tick all those that apply)

Motivation	**Tick**
1. I want a change from my current role	
2. I want to specialise in this area of practice	
3. I want to work in the public health arena	
4. I want to develop my clinical skills in sexual health nursing practice	
5. I want to develop my professional knowledge	
6. I want to gain academic credits	
7. I feel that working in sexual health services will fit in with family life and children	
8. Gaining additional qualifications will increase my chance of a promotion	

Do you have any other comments about your motivation for wishing to undertake the sexual health nursing modules?

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What do you think are the most important outcomes for you in doing this course? Please identify the **five** most important to you and tick

Outcome	**Tick**
1. To be able to demonstrate knowledge and understanding of sexual health	
2. To gain knowledge and understanding of current strategic and local priorities for practice	
3. To become more aware of the factors that can potentially impact on an individual's sexual health and wellbeing	
4. To be able to evaluate the impact of personal attitudes and beliefs regarding human sexuality and behaviour on the individual and his or her care	
5. To be able to evaluate my interpersonal skills so that I can effectively assess, deliver and respond to sexual health needs	
6. To be able to critically analyse myself and the clinical environment	
7. To be able to appraise ethical and legal factors which influence sexual health practice issues	
8. To be able to develop, implement and improve practice from an evidence based perspective	
9. To be able to appraise frameworks for client assessment to address sexual health and well being	
10. To be able to critically analyse assessment data to identify priorities and plan care in partnership with the client	
11. To be able to integrate evidence based interventions to reduce risk of unintended pregnancy and sexually transmitted infections	
12. To be able to demonstrate clinical competence in assessing, planning and managing holistic care for clients with sexual health need.	

Do you perceive that there will be any particular challenges for you in completing the programme? If so, what would these challenges be?

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Section B: Self-Efficacy Regarding Evidence-Based Practice

Pick one of these numbers and write in the box next to each item below

0 10 20 30 40 50 60 70 80 90 100

Not confident Moderately confident Confident

I am *this per cent* confident that I can complete the following activities that support sexual health nursing practice:

Activity	**Confidence**
1. Routinely ask questions about my sexual health practice	
2. Locate resources in my department and institution to facilitate my understanding of research literature relevant to my nursing practice	
3. Locate resources in my department and institution necessary to institute an evidence–based practice change	
4. Locate and review published practice guidelines that support nursing interventions important to my sexual health practice	
5. Locate and review published research studies that have relevance to nursing interventions important to sexual health nursing practice	
6. Organise the necessary support and procedures to make a sexual health nursing practice change based on evidence (research, clinical practice guidelines, clinical expertise, patient goals / preferences)	
7. Routinely identify patient outcomes to target sexual health nursing interventions	
8. Integrate the various sources of evidence and apply to sexual health nursing practice	
9. Activate the processes to implement an evidence-based sexual health nursing practice change	

10. Modify sexual health nursing interventions recommended for my patient population based on characteristics of the specific unit where I work	
11. Routinely evaluate the research literature and other sources of evidence related to nursing interventions for patients with sexual health issues	
12. Routinely implement nursing interventions that are supported by evidence (research and other sources such as practical guidelines) for sexual health patients	

13. Modify sexual health nursing interventions I routinely implement based on what I learn about my patient's preferences	
14. Routinely modify sexual health nursing interventions based on outcomes and goals	
15. Routinely evaluate the effectiveness of sexual health nursing interventions using measureable outcomes	
16. Obtain proper training and education to be able to effectively implement an evidence-based sexual health nursing intervention or practice	
17. Implement an evidence-based sexual health nursing intervention individualised to my patient situation without losing the fidelity of the intervention (i.e. delivering what was intended to be delivered)	

Section C: Self-Efficacy Regarding Communication with Patients

Pick one of these numbers and write in the box next to each item below

0 10 20 30 40 50 60 70 80 90 100

Not confident Moderately confident Confident

I am *this per cent* confident that I can complete the following activities that involve communication with patients:

Activity	**Confidence**
1. Initiate a discussion with a patient about his or her concerns	
2. Encourage a patient to talk about emotional concerns	
3. Explore a patient's intense feelings of anger	

4. Conclude a patient interview with an agreed problem list and a plan of action	
5. Assess symptoms of anxiety and depression	
6. Break bad news to a patient	
7. Appropriately challenge a patient who denies his or her illness	
8. Help a patient deal with the uncertainty of his or her situation	
9. Manage my own emotions with patients	

Thank you for completing this questionnaire.

We would like to contact you to invite you to take part in the interview or focus group stage of the study. Please indicate in the box below if you would be happy for us to do this:

Yes, I would be interested in taking part in the next stage of the study	

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Research code

Questionnaire for sexual health evaluation

Please read the following statement and score against each outcome using the scale below:

1. Strongly disagree
2. Disagree
3. Neither agree nor disagree
4. Agree
5. Strongly agree

The Integrated Module **has supported me to achieve** the following outcomes:

Outcome	**Score**
1. I am able to demonstrate knowledge and understanding of sexual health	
2. I have gained knowledge and understanding of current strategic and local priorities for practice	
3. I am more aware of the factors that can potentially impact on an individual's sexual health and wellbeing	
4. I am able to evaluate the impact of personal attitudes and beliefs regarding human sexuality and behaviour on the individual and his or her care	
5. I am able to evaluate my interpersonal skills so that I can effectively assess, deliver and respond to sexual health needs	
6. I am able to critically analyse myself and the clinical environment	
7. I am able to appraise ethical and legal factors which influence sexual health practice issues	
8. I am able to develop, implement and improve practice from an evidence based perspective	
9. I am able to appraise frameworks for client assessment to address sexual health and well being	
10. I am able to critically analyse assessment data to identify priorities and plan care in partnership with the client	
11. I am able to integrate evidence based interventions to reduce risk of unintended pregnancy and sexually transmitted infections	
12. I am able to demonstrate clinical competence in assessing, planning and managing holistic care for clients with sexual health need.	

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How has the Integrated Module changed your practice?

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What impact do you think this will have on service users?

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Were there any particular challenges for you in completing the Integrated Module? If so, what were they?

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What might have helped you to overcome these?

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To what extent does your employing organisation facilitate the delivery of an integrated sexual health service?

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Are there any other comments you would like to make about the Integrated Module?

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Section B: Self-Efficacy Regarding Evidence-Based Practice

Pick one of these numbers and write in the box next to each item below

0 10 20 30 40 50 60 70 80 90 100

Not confident Moderately confident Confident

I am *this per cent* confident that I can complete the following activities that support sexual health nursing practice:

Activity	Confidence
1. Routinely ask questions about my sexual health Practice	
2. Locate resources in my department and institution to facilitate my understanding of research literature relevant to my nursing practice	
3. Locate resources in my department and institution necessary to institute an evidence–based practice change	
4. Locate and review published practice guidelines that support nursing interventions important to my sexual health practice	
5. Locate and review published research studies that have relevance to nursing interventions important to sexual health nursing practice	
6. Organise the necessary support and procedures to make a sexual health nursing practice change based on evidence (research, clinical practice guidelines, clinical expertise, patient goals / preferences)	
7. Routinely identify patient outcomes to target sexual health nursing interventions	
8. Integrate the various sources of evidence and apply to sexual health nursing practice	
9. Activate the processes to implement an evidence-based sexual health nursing practice change	
10. Modify sexual health nursing interventions recommended for my patient population based on characteristics of the specific unit where I work	

11. Routinely evaluate the research literature and other sources of evidence related to nursing interventions for patients with sexual health issues	
12. Routinely implement nursing interventions that are supported by evidence (research and other sources such as practical guidelines) for sexual health patients	

13. Modify sexual health nursing interventions I routinely implement based on what I learn about my patient's preferences	
14. Routinely modify sexual health nursing interventions based on outcomes and goals	
15. Routinely evaluate the effectiveness of sexual health nursing interventions using measureable outcomes	
16. Obtain proper training and education to be able to effectively implement an evidence-based sexual health nursing intervention or practice	
17. Implement an evidence-based sexual health nursing intervention individualised to my patient situation without losing the fidelity of the intervention (i.e. delivering what was intended to be delivered)	

Section C: Self-Efficacy Regarding Difficult Communication Situations

Confidence scale 0 – 100 Higher is better
How confident are you to:

Activity	**Confidence**
1. Initiate a discussion with a patient about his or her concerns	
2. Encourage a patient to talk about emotional concerns	
3. Explore a patient's intense feelings of anger	
4. Conclude a patient interview with an agreed problem list and a plan of action	
5. Assess symptoms of anxiety and depression	
6. Break bad news to a patient	
7. Appropriately challenge a patient who denies his or her illness	

8. Help a patient deal with the uncertainty of his or her situation	
9. Managing your own emotions with patients	

Thank you for completing this questionnaire.

If you are happy to take part in a one to one telephone interview for the next stage of the study, please indicate in the box below:

Yes, I would be interested in taking part in the next stage of the study	

Appendix 3 – Semi structured interview schedule

Qualitative one to one interviews for SHE questionnaire

Students

Student experience

Explore how the integrated module has been from a student's experience point of view – accessible, easy to navigate, informative, pitched at the right level.

IT challenges, especially around Pebble Pad? Have there been any challenges to accessing it?

How has the relationship been with the Practice Educators? Does this model work effectively for this module? What are the benefits / challenges to having a practice based element to the programme?

Integrated service delivery

What has been the strongest influence from the module?

Has this prepared you to practice in an integrated way? (How active are you in relating theory to practice?)

Do you think that you will be able to make changes in practice? Implement/influence service delivery? (How ready is the sexual health service for you and the skills that you have gained?)

To what extent does your organisation support you to work in an integrated way?

If you are not working in an integrated way, how easy will it be to maintain your skills?

What do you think needs to happen across sexual health services nationally and locally in order to support a transformation to integrated service provision?

Module content

Is the programme addressing the cultural and social needs of the community that you serve?

Theory practice gap – are you prepared for practice, or are there areas of the content that could have been more thorough?

Are there any barriers to implementing your new skills and knowledge?