A Model for the Future: Developing the Sandyford Initiative

THE SANDYFORD INITIATIVE REPORT

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Introduction

The Sandyford Initiative provides a progressive model bringing together a variety of health services in one building under one ethos, developing a health care service which links to and is shaped by the social determinants of health.

Sandyford operates at many levels. Firstly and most obviously, it is compromised of and involves a variety of physical spaces and locations. Sandyford operates in a number of settings, primarily at Sandyford Place in Glasgow's city centre, as well as in a wide range of other community sites in the city. Secondly, it provides a variety of services which are evolving a new model of sexual, reproductive and emotional health care alongside other forms of advice and support. Thirdly, it has a city-wide role bringing together a community and access agenda which reaches out to people, many from some of the most deprived areas of Glasgow. Fourthly, Sandyford is an idea, developing a new model of health which has a wider relevance to practitioners, the policy community and professionals in Scotland, the UK and internationally.

This report attempts to tell the story of the Sandyford Initiative, how it was brought together, the ideas it drew from, what it has achieved, and what lessons this has for the Sandyford, health services and wider policy. Sandyford was brought together in practice in 2001 by Greater Glasgow NHS Board which recognised the potential of bringing together a range of services who all shared common characteristics in providing sexual health services and agreed to put the appropriate funding, resources and skills behind the proposal. The aim was to develop a pioneering new project integrating services to deliver a pioneering and path-breaking project informed by a public health agenda.

This report has been commissioned by Greater Glasgow NHS Board, to wider publicise and disseminate the experience of Sandyford. The Health Board recognised many years ago the need to tackle Glasgow's stark health record in a variety of innovative ways, and came together with Glasgow City Council to support and give backing to the idea of the Sandyford.

The process of writing this report has seen a number of stages. Firstly, a number of the key personnel in the Sandyford and in the Board have been interviewed for background information. Secondly, a range of Board commissioned documents and reviews were read to assess the on-going development and audit of the project. Thirdly, wider policy discussion was examined at a Glasgow, Scottish Executive and UK Government level linking into the increased profile given to tackling health inequalities and developing a social model of health.

The Sandyford Initiative is a pioneering project and one that has broken new ground - in Scotland, the UK and internationally. It has brought a range of services and specialisms together ≤ Family Planning, Genito Urinary Medicine and the Centre for Women's Health, along with the Steve Retson Project ≤ which is unparalleled anywhere else in the UK or further afield. In this there are no precedents or guidelines available. Innovative services like The Place (for young people) have developed as a direct result of developing the Sandyford and now provide services in a number of community locations.

Sandyford of course is not an abstract idea, but a living one. It is made up of the ideas, work, commitment and enthusiasm of staff across numerous professions and work groups in differing roles and grades, the people who come and visit it every day and use its resources and services, and the other services and agencies for which Sandyford is a point of reference or advice for their own work, and the agencies who commission and fund it. The ideals, vision and commitment that can be found in the work of Sandyford has created a model which has wider application for health and other public services, creating a service that is informed by the needs and concerns of service users, and which feels like a welcoming, lively, affirming
environment where people can sense they are safe and respected. The ambience, atmosphere and mood of Sandyford could not be further removed from a cold, clinical setting. It has a sense of the new public sector services of tomorrow shaped by public expectations: of a service that is individualised and personalised and recognises the circumstances of people’s lives.

Sandyford is a work in progress, and a story which has only just begun to evolve and grow. Therefore this report captures Sandyford at an exciting and imaginative point when it is attempting to tackle some of the most challenging health issues and health inequalities, and still clearly developing and learning ≤ the very epitome of an evolving, learning organisation. This is a positive time for Sandyford ≤ of optimism and new possibilities ≤ and thus, within these pages you will find a snapshot of one moment in time.
Health Matters

The Executive has a clear commitment to refocus traditional ill-health prevention strategies with actions to improve health and well-being. As part of that commitment and aligned with the Executive’s strategies for promoting social justice and closing the opportunity gap, tackling health inequalities is a key aim of the health improvement agenda.

Health in Scotland, The Report of the Chief Medical Officer, Scottish Executive 2003

Health matters. It affects every aspect of an individual’s life. It shapes the quality of life, happiness and self-esteem of people. It is a crucial component of such areas as career advancement, job satisfaction, and how we get on with friends, family and work colleagues. And health is about much more than individuals, it is about the very fabric of communities, social groups, and everyone we know.

Health shapes both the life chances and opportunities people face at both an individual and collective level. One of the most reliable determinants of future life chances is the prevalence of low birthweight babies, and it is well accepted across health professions that the incidence of such births is directly related to future outcomes of poverty and material wealth.

Health is thus not some optional add-on to policy or how we view society. It is not a luxury or lifestyle choice which we can bolt on after we have dealt with the serious bread and butter issues such as the state of the economy or public expenditure. Health is central to these debates, and has fundamental consequences for the kind of society we live in.

An appropriate place to start is to acknowledge the realities of contemporary Scottish society. Scotland is a relatively wealthy country by international standards, and one where the majority of the population enjoy a decent standard of living, and one that has been rising for most of the post-war era. However, it is also relatively an unhealthy society. It is a nation characterised by poor health standards compared to the rest of Western Europe. A society in which the scale of health inequalities between those doing well and those living in disadvantaged communities is unparalleled anywhere else in the developed world.

Scottish levels of life expectancy are extremely poor by Western standards, but those of the poorest communities in Scotland are even worse. Glasgow Shettleston has an average male life expectancy of 63.9 years compared to an average female life expectancy of 75.3 years. This is the lowest male life expectancy in all of Scotland and the UK, but also provides the largest gap between men and women, revealing something about gender roles and expectations in this part of Scotland. The gender gap between men and women in the poorest part of Scotland ≤ 11.4 years ≤ is nearly twice the national average.

Economic activity rates ≤ a significant contribution towards health and well-being ≤ are substantially lower in Glasgow and its surrounding areas compared to the rest of Scotland and the UK. At a time of a relatively buoyant labour market, Shettleston with a notional 5.9 per cent unemployment rate has when incapacity benefit is taken into account 33 per cent of the working age population relying solely on benefits.
Traditional notions of health have attempted for decades to tackle these problems. Medical professions have sought solutions in identifying new illnesses, cures and treatments, and hoped that the expanding world of medical knowledge and expertise could surmount these issues to the benefit of the general well-being. The creation of the NHS as a national health service over fifty years ago was a major advancement in debates on health and the general well-being of the nation and the body politic, but it only dealt with part of the problem.

The election of a new UK government in 1997 saw a renewed commitment to making health one of the top issues, with a commitment to significant extra public expenditure targeted towards the NHS. There has also been a sea-change in attitudes towards health and public health, with a much greater acknowledgement of the inter-related nature of health, poverty and social exclusion, than previously existed. However, despite this, much of the health debate and public expectations has still been focused on such visible tangibles as hospitals and reducing waiting lists, rather than actually delivering health improvements, and this is a result of a number of powerful factors: the power of traditional views of health, public understanding of such ideas, and expectation of immediate results, and the pressure of political cycles.

As the first Wanless Report (commissioned by the Treasury to chart health improvements and reform for England and Wales) put it, widespread public involvement in health and healthier lifestyles would create, significantly better outcomes for the same or lower expenditure. (Wanless 2002) A key variable in the health of the British population according to Wanless is not the number of doctors, or the quality of doctors, but the way patients and the public take a degree of responsibility and have a sense of control and ownership over their health. And if this is to occur it requires new notions of health, which break with the traditionalist, paternalist past, and new ideas of health care.
Sandyford: Changing the Way We Work

The Sandyford shows what it is possible to achieve when NHS services integrate the health agenda, the emotional health agenda and meaningful user involvement. Physically, the centre is a world away from the traditional ‘clap’ clinic, providing a non-stigmatising, aesthetically pleasing and therapeutic environment where there are superb support facilities that encourage attendance. By focusing on the psycho-social aspects of health and wellbeing the Sandyford offers support that can extend far beyond the presenting problem, and it provides a genuinely joined-up service to users that departs from the traditional top-down medical model. Indeed, it is the users themselves who are helping to drive the centre’s development, and extremely creative approaches are being taken to encourage involvement - and therefore promote patient empowerment. The Sandyford provides a model of care which can be applied broadly, and it is good to know that it is attracting attention from right across the NHS in Scotland, and beyond.

Penni Taylor, freelance journalist and former BBC Scotland Health Correspondent

The Sandyford Initiative was set up to promote sexual, reproductive and emotional health with a greater understanding within a social model of health and with an emphasis on gender issues. The importance of a gendered perspective of health was seen as crucial to acknowledge given its effects on socio-economic inequalities. These inequalities encompass material wealth but also include areas such as power, powerlessness, issues of status, inclusion and exclusion and their interaction with male and female roles. In addition to gender issues, the social model also recognises these impacts in relation to sexual orientation, race and ethnicity, disability and non-disability and issues of class and poverty.

The strategic objectives of the Sandyford Initiative were set out as:

- Maximising the integration of clinical and social aspects of health in each of the three main services;
- Creating an innovative model of barrier free health which builds on existing collaboration between the three services;
- Implementing ways of working to address unmet needs of current and potential service users;
- Pro-actively informing policy development in different organisations to promote sexual, reproductive and women’s health.

The decision to create the Sandyford Initiative came out of a process whereby three distinct strands of services came together with key stakeholders to form an alliance:

- Family Planning
- Genito Urinary Medicine
- Centre for Women’s Health
These three main strands or branches of the Sandyford tree currently provide six main services:

- Family Planning
- Genito Urinary Medicine
- Centre for Women’s Health
- The Steve Retson Project
- The Place Health Service for Young People
- Sandyford Library

Within Sandyford the disciplines of Genito Urinary Medicine and Gynaecology and Counselling are practised to the highest level and meet all quality standards set by leading national organisations such as Health Departments, Royal Colleges and the GMC, but the individual medical disciplines have been mixed together and extended to achieve more.

A number of key strands can now be identified through the work of Sandyford:

**Sexual and reproductive health services for those with symptoms of ill health**

Individuals with symptoms are offered open access and are also referred by general practitioners, hospitals and other sources. Traditional diagnosis and management occurs excluding or arranging treatment for major diseases, e.g. cancer and undertaking an extensive range of outpatient treatments.

Common presenting symptoms include sexual health issues such as discharge, ulcers, lumps, or pain; and reproductive health issues including abnormal vaginal bleeding, pelvic pain, painful periods, painful sexual intercourse, erectile dysfunction, loss of libido, hot flushes, and infertility. Possible treatments include self-help, information, counselling, medication within an environment that is as relaxed and informal as a hairdressers and less like a traditional clinical atmosphere.

Whatever the reason for client presentation, or treatment given, all Sandyford visits include a health promotion aspect, which include encouragement of individuals to take responsibility for their own health and an examination and explanation of underlying social determinants. All decisions about treatment and management plans are focused on ensuring that the client has the maximum say and control over what happens to them.

**Services for people who seek to improve and protect their sexual, reproductive and emotional health**

This includes services such as contraception, sexual health screening, menopause advice and treatment, and health information. Central to the Sandyford ethos is that when an individual requests a health screen this is not simply to provide a test for chlamydia. Instead it is used to provide an opportunity to look at risk taking behaviour and a range of factors in a non-judgemental manner which looks at the wider social determinants of health. The ultimate aim of this approach is to empower the individual to make decisions for themselves and take measures as far as possible to protect themselves and others.

This approach also ensures that information about the key factors which determine the health of the population attending Sandyford is recorded for policy and planning purposes. Counselling and listening ear services provide a valuable resource here, as does the generic work of the Centre for Women’s Health. Sandyford has developed a range of counselling services for women, men and young people supporting primary care developments around broader models of emotional and mental health services informed by an awareness of social determinants. Other key examples include the Centre for Women’s Health Eating Disorder Service which is unique in both its accessibility and individual group work and is increasingly seen as a vital part of the continuum of eating disorder services funded by the Health Board, meeting the needs of many women, and some men. These services provide advice and support that is integrated and offered in a way that is wider than traditional medical approaches, and instead, offers an approach informed by social, economic and cultural factors.

**Services tailored for groups with specific needs aimed at improving health and reducing inequalities**

Examples here include Base 75, the Steve Retson Project, The Place, Sappho and the Centre for Women’s Health. These services recognise that specific communities as well as individuals per say have identifiable
needs. Their intention is to set a comfortable environment to allow ease of access and discussion of life factors distinct to particular community groups. Interventions can therefore be made more effective, for example, gay host helpers at the Steve Retson Project, youth services workers within The Place, social work counsellors at Base 75, and links to Routes Out of Prostitution for Base 75.

All services share the following characteristics:

- **Look at the social determinants** - recognising the influence of gender, sexuality and poverty and integrating this into assessment and care.
- **Deal with causes and not just symptoms** - actively looking for factors that pre-dispose ill health and prevent recurrence rather than just treating presenting symptom.
- **Work in partnership** ≤ with other relevant organisations e.g. Steve Retson Project works in partnership with voluntary sector agencies like PHACE Scotland to deliver outreach.
- **Open Access** - There is no need for referral from a general practitioner or registration with a general practitioner.
- **Highest Quality** ≤ developing services which meet the individual needs and expectations of users.
- **Choice of methods of access** - drop-in and appointment.
- **Encouragement to access services** ≤ instead of various mechanisms to prevent uptake and hence waiting lists.
- **User Involvement** - supported by the Community Access Worker all services actively engage with clients to shape the development of each service.

The Sandyford Health Screen is one of the innovations brought about by the creation and development of Sandyford which is leading to new ways of delivering health care and advice. The Health Screen is an assessment tool used when individuals come to the sexual and reproductive health services in Sandyford to assess their health in a broader and more inclusive way, rather than narrowly address only the presenting condition within a medical context. It thus involves a wider understanding of the social determinants which shape health, encourages wider access to health services at Sandyford and elsewhere, and expands the entry points to the Sandyford and other services. It encourages people to see their health as a whole entity, and importantly, bases health advice and services on the personal experience of the individual, rather than compartmentalising conditions and making the specialist professional expertise the determinant of how services are organised. The information prescription offered as part of the screen encourages client engagement with the Sandyford Library, and is a highly successful way of integrating information provision with clinical intervention.

It should also be noted that all the services that were previously offered by the traditions that came together to form the Sandyford are still offered. What has changed, particularly in relation to medical services, is that they have improved by the process of interaction that is central to Sandyford. Such services have been cross-fertilised by other services and traditions, by the public health agenda, and a recognition of the social determinants of health.

Some of the specific services provided by Sandyford include:

The Sandyford Library and Information Service

The Sandyford Library is a lending library and reference service providing books, audio tapes, videos, journals and publicity and promotional materials covering all aspects of health and well-being. The library is open to all members of the public and inter-library lending facilities are also available between the Sandyford Initiative, Glasgow City Council Libraries and NHS libraries. The library is involved in developing integrated working between health and council library services. There is also a separate women’s reference library located in the Centre for Women’s Health.

The library is situated on the ground floor of the Sandyford Initiative by the reception area. Directly across from it free internet access is provided. This is unusual for NHS premises, and is possible because of the link up with Glasgow City Council libraries and funding. The library is positioned in an open, friendly and busy setting where all kinds of different groups can see it and access it with a variety of enquiries. It also contributes to the feel and culture of the Sandyford reception as being as far removed from a hospital waiting area as possible!
The Place Health Service for Young People

Within the Sandyford Initiative this drop-in service is dedicated to young people aged up to 20. It aims to encourage young people, particularly those who may not otherwise visit their doctor, to seek help and advice in a non-threatening and confidential environment. It provides a range of services including counselling, nursing and clinical support, and provides young people with a wide range of information covering many aspects of life that may affect their health and well-being, such as sexual health, substance misuse and problems at home, school or work. This service is jointly delivered with Glasgow City Council Youth Services.

The Steve Retson Project

This provides a range of services for gay men and men who have sex with men with host helpers aiding the running of services in the project. As with the GUM clinic this service provides information, testing and treatment of sexually transmitted infections. It also provides a support system for those using the service with a counselling service and advice on living a healthy life. The Steve Retson Project began as an independent gay men’s community run project named after a Glasgow gay man who died of an AIDS related illness and is now a specialist part of the GUM service. The project is advised and supported by a Community Stakeholders Group.

Sappho Service and Clinic for Lesbians

The Sappho Service project provides counselling and clinical support for lesbians and bisexual women. It promotes positive sexual health and easier access to sexual, reproductive and women’s health services for lesbians and bisexual women. This is a unique service in Scotland and is provided by staff from reproductive and women’s health, supported by an Advisory Group that involves voluntary organisations and lesbian and bisexual women’s community representatives.

Sandyford Creche

The Sandyford Crèche provides a free, safe and friendly environment for children whose parents or carers use any of the services of the Sandyford Initiative.

Both the Sandyford Library and Crèche originated in the Centre for Women’s Health and have subsequently been mainstreamed and expanded to meet wider needs. Their respective origins are important to understand the values and ethos of each service, such as the kind of books and materials on health the library first began collecting. Thus, very different and dynamic models have been integrated into the mainstream, yet have still maintained a sense of their origins. At the same time, their influence has spread much wider and contributed to changing the mainstream.

The Road to Sandyford

The motivation behind bringing together the original strands in the Sandyford Initiative was aided by the individual journeys that the services were embarked upon prior to the decision to create the Sandyford, as well as the desire of the Health Board in creating and facilitating the Sandyford and supporting its continued development. Family Planning underwent a transformation from a community health service which was mostly feminised in the inter-war years, developing pioneering work without getting the acknowledgement or funding it deserved. It had increasingly become a core mainstream service of the National Health Service, with the Sandyford one more step in its journey. Genito Urinary Medicine had previously been seen as one of the last bastions of the medical establishment, advancing a paternalist notion of health care. It has been radically altered by the experience of dealing with HIV/AIDS, and with an influx of gay sensitive staff, and gay men as patients, which made it change as a profession and embrace the need for a social model of health. And the Centre for Women’s Health, a path-breaking project addressing all aspects of health in women’s lives, had increasingly become aware that if it was to take issues of gender inequalities into the mainstream it needed to be part of that mainstream, and engage in a dialogue to shift attitudes and practices.

An important influence in developing a different kind of health service was the pioneering work provided by the Ballantay Well Woman Centre in Castlemilk which set out over a decade ago to provide clinical services in a way that recognised the broader social context, acknowledged the importance of women’s own experiences and developed health services which recognised this. The work of the Women’s Health Working
Group of the Glasgow Healthy City Partnership from the late 1980s onward was another important and influential factor bringing together a range of policy-makers, practitioners and experts. This also provided a framework for the Glasgow Women’s Health Policy - for developing women-sensitive services and policies, that contributed to the development of the partner organisations in Sandyford and to the creation and evolution of Sandyford.

This common set of experiences and journeys was mirrored by the Steve Retson Project which increasingly realised that the issues they were dealing with required joint work with GUM staff, and also involved common ground with the gender analysis of the Centre for Women’s Health. It is true that for some within the Centre for Women’s Health and Steve Retson Project, the idea of coming in from where they were shaped by the agendas and concerns of specific communities and campaigns into what could be perceived as a larger, less sympathetic environment - was for some in their organisations a painful experience. To put it simply, many in both institutions felt they were gaining something influence, a chance to shape something new, exciting and pioneering, but also that by so doing they were losing something. For some this was a worthwhile positive experience, for others a more negative one.
Bringing Sandyford Together

The Sandyford Initiative has developed a unique and innovative approach to sexual health services in Glasgow. It has brought a strong focus on gender and health to its work which potentially offers a model for service planning and design elsewhere. We know that Scotland ≤ and Glasgow in particular - faces significant challenges in improving sexual health, particularly in terms of young people and hard to reach groups within the community. The Sandyford Initiative has responded to those challenges by bringing together key services, such as GUM, Family Planning, and the Centre for Women’s Health, within a single site, whilst working also with a strong emphasis on outreach and accessible local service provision through a network of clinics across the city. The Sandyford Initiative is a tangible example of a social model of health in practice and a success story for Glasgow.

Duncan Booker, Co-ordinator, Glasgow WHO Healthy Cities Partnership

The process of bringing about the Sandyford Initiative from an idea to an actual reality has been a story of developing an agreed vision, managing organisational and cultural change, with naturally, a degree of nervousness and tension at different points, as the pace and direction of change accelerated. Pre-Sandyford there was a comprehensive staff review and consultation which concluded with the recommendation of a new, larger and more integrated management structure. This was seen as both a break with the specialist and fragmented practices of the past, offering a new way of working collaboratively, and a new model for Sandyford.

The Sandyford Initiative’s management team comprises:

- Director
- Associate Director (External Affairs)
- Associate Director (Health Inequalities)
- Associate Director (Nursing)
- Associate Director (Governance and Quality)
- Support Services Manager

The Director is responsible for the overall management, development and strategy of the Sandyford Initiative, taking forward internal priorities, and liaising with key external agencies from funders to policy-makers. The Associate Director (External Affairs) has responsibility for Sandyford’s external profile in a variety of media settings and with key audiences and informers ranging across the Scottish Executive, politicians and policy-makers as well as specialist audiences and forums in health and medicine. The Associate Director (Health Inequalities) has a remit involving advocating a public health agenda with a range of national public agencies, while taking lead responsibility for a holistic and joined up approach within Sandyford. Sandyford is part of a number of important partnerships and multi-agency networks. This includes the Sexual Health Planning Implementation Group of GGNHSB which oversees all of Glasgow’s sexual health planning and service delivery, as well as the GGNHSB Women’s Health Policy Planning Group and the Women’s Health Working Group of the Glasgow Healthy Cities Partnership which has contributed to developing a gender aware and informed model of women’s health.
The Associate Director (Nursing) leads on taking forward a pan-Sandyford approach to nursing in all services, and inputting into national debates and discussions. The Associate Director (Governance and Quality) ensures that in all that it does Sandyford complies with national standards and procedures, while the Support Services Manager has responsibility for the administrative side of Sandyford and ensuring the smooth running of all operations and activities.

This is very different from what existed before Sandyford. Then three services existed in carefully demarcated territories, whereas now work is organised around cross-cutting themes which have an internal focus, bringing people together in Sandyford, while also bringing this experience and expertise to external discussions on policy and practice.

The creation of these new posts has encouraged the development of cross-cutting working across specialisms in a variety of areas such as nursing and counselling. Fundamental to the idea of Sandyford has been the aspiration of delivering services in an integrated way informed by the development of a specific Sandyford ethos. However, this has generated tensions with the need for the original three strands to maintain distinctive elements which relate to the type of health care provided by each, while retaining a sense of value of the original distinctiveness of each service.

This can be seen in different ways from differing perspectives. From one viewpoint, Sandyford offers the prospect for the original three separate and distinct traditions to come together and co-operate at a bilateral and tripartite level, while still retaining areas unique to their own specialisms. Another perspective sees the constant discussion and emphasis upon these traditions as looking to the past, and is impatient to see the creation of a one service, one ethos culture ≤ namely one informed by the integrated model of Sandyford and the social model of health.

The truth of course lies in-between these two models. In a world where the medical professions of Family Planning and GUM operate externally to the Sandyford in their own respective worlds supported by Royal Colleges and specialist research and training agendas as well as within a Sandyford agenda, this is always likely to be so. For example, the system of accreditation for consultants in Family Planning and GUM through their respective Post-Graduate Training means that each of these medical professions has to operate within this framework and retain a commitment to their distinctive values. Only in a far-off future, where the wider medical school of thought begins to dissolve would it be possible to see this situation change fundamentally.

Sandyford became possible because of the changing nature of services such as Family Planning and GUM both locally and nationally. At the latter level, these two services have begun to develop more co-operative ways of working and converging in a number of areas. Sandyford has been at the forefront nationally and internationally of developing an integrated model which brought Family Planning and GUM together. In this case, the convergence of the services with the Centre for Women’s Health in a social model of health is highly unusual and predicated upon a set of circumstances unique to Glasgow.

One unique and important strand of Sandyford is the importance given to the Community Access remit. This has advanced the wider NHS agenda of aiding public involvement and shaping of health services and wider notions of empowerment. At Sandyford, this has involved developing processes and structures for consultation with a wide range of users about existing services and how to develop services in the future across the range of Sandyford services and seen the appointment of a designated Community Access member of staff. For example, a detailed consultation across Glasgow has taken place upon the twenty-four well women clinics which are run in some of the city’s most disadvantaged communities, on what users think of the service with a view to service development and redesign.

Sandyford has attempted to develop a decision-making structure that is open and transparent, with a management structure that is accessible and inclusive, and a broader Sandyford Council, which includes representatives of a wider range of Sandyford staff. A variety of diverse user groups and consultative processes also tap into a wide, inclusive audience, and aim to move beyond tokenistic gestures.
Different Ways of Thinking About Health

...the factors that determine health \( \leq \) for good or ill \( \leq \) lie in a profound chemistry of individual and social circumstances. Economic status, quality of housing, social relationships, genetic inheritance and each person’s self-confidence about their own lives are key ingredients.

Chris Spry, Who Decides on Scotland’s Health?, 2002

The Sandyford Initiative would not have been possible without a fundamental shift in how people think about and understand health. To understand change in recent years we need to set this in a historical setting.

There are numerous different ways of thinking about health. One model conceptualises these differences into three different dimensions:

- Individual or collective
- Functional fitness or welfare
- Preventive or curative

The Individualistic or Medical Model of Health

In general in Western European societies, the individualistic concept of health has tended to predominate, and has usually been associated with related ideas of functional fitness and curative approaches. This sees the causes of illness within the biological systems of individuals, and attempts to provide a specific cure for illness in order to make individuals fit to play their full part in society \( \leq \) integrated into work, society and life.

The collective concept seeks on the other hand to identify the causes of illness within a broader framework \( \leq \) namely the environmental and social systems in which people live, and attempts to prevent illnesses arising by tackling the unhealthy aspects and results of the systems.

For most of the 20th century, the individualistic account aligned with functional fitness and a curative approach, has had most influence. This is commonly called the medical model of health where doctors, hospitals and medical skills and expertise are centrestage to concepts and understandings of health and ill-health. The medical model has two primary parts: a disease component, whereby illness results from pathological processes in the biology of the body, and an engineering component, whereby the body is seen as a machine to be repaired.

The medical model of health is vital to understanding the pre-eminence of the medical professions in health matters, and in helping to explain the structures and powers in the NHS, and the patterns of investment in health services. Within the NHS, the bulk of resources are allocated to personally orientated, general and acute hospital services. Much less importance is attached, and significantly less resources and prestige to collective, preventive and welfare approaches.

Health has not always been seen in such a restricted way and this helps to understand how and why change has happened in recent years. The medical model became the dominant model when it replaced the
collective idea at the early part of the 20th century. Before then the focus of health policy was upon public health measures centred upon the relief of poverty rather than the organisation of medical services. There was from the early 19th century onwards a great Victorian tradition of public health combined with a missionary zeal about improving the lives and conditions of the majority of the population, particularly in the cities affected by the industrial revolution. This was very true of a city like Glasgow which grew at an unprecedented rate in the 19th century, as hundreds of thousands of workers migrated from the Highlands, Ireland and England to work in the expanding shipbuilding, iron and steel, and railway industries, and which thus developed a reputation for pioneering public health work under James Burns Russell, the city’s first Medical Officer in 1872, and his successors.

However, at the turn of the 20th century this public health outlook increasingly came under challenge from a medical view which stressed that the causes of illness are discovered in the work of medical schools. This view emphasised that a key aim of health policy should be to make sure that the results of medical science are made widely available to the general population through a co-ordinated hierarchy of health services in which the medical schools and professions were central.

A New Public Health Agenda

As the 20th century progressed, and the wealth of society increased, the conventional view that the well-being of all sections of the community would be aided by the slow up-reach of the entire population began to face concerted questioning. Illness and disease remained, and health inequalities significantly increased. These trends were aided by the return from the late 1970s on to a more individualistic notion of society and policy which emphasised individual, rather than collective action, and which saw public action in the form of government and the state as part of the problem, rather than part of the solution. Economic and social inequalities between those groups socially included and privileged in the marketplace or by professional status, and those socially excluded, began widening to an unparalleled degree. In particular, health inequalities in parts of Scotland around the West of Scotland became wider than they ever have been on record.

The medical model increasingly faced challenge and scrutiny from a public health perspective which questioned the extent to which it was the medical profession and knowledge which has brought about the major improvements in health. Instead, it looked at the progress in economic, social and cultural factors in transforming health in the 20th century. The decline in infectious diseases, reduction in death rates, and increased life expectancy, are all part of a wider social transformation in our lives, rather than medical advancement.

Thomas McKeown wrote in the 1970s:
“medical science and services are misdirected and society’s investment in health is not well used, because they rest on an erroneous assumption about the basis of human health. It is assumed that the body can be regarded as a machine whose protection from disease and its effects depends primarily on internal intervention. The approach has led to indifference and personal behaviour which are the predominant determinants of health.”
(McKeown, 1976)

From these perspectives, a new public health agenda began to arise which became more and more influential. At first, this agenda grew up at a point when the UK government was turning its back on the links between poverty and health, seen famously in the Thatcher Government’s dismissal of ‘The Black Report’ in 1980 which had substantially examined the causes of health inequalities. But the strength of the argument in health, academic and related professions continued to grow, until an identifiable agenda could be recognised which operated in four inter-linked levels:

- **Biology ≤** aspects of health such as ageing, etc.
- **Environment ≤** external matters to the body
- **Lifestyle ≤** individual decisions which affect health
- **Health care organisations ≤** arrangements made to provide organised health services

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Margaret Whitehead (1995) further developed this when she identified four main levels of health public policy:

- Strengthening individuals
- Strengthening communities
- Improving access to essential facilities and services
- Encouraging macroeconomic and cultural change

While specific health policies and NHS strategies can have an influence on health and ill-health, so can many more factors. This includes other public sector activities such as education, and areas outwith the public sector such as the state of the labour market nationally and regionally, the condition of the world economy, and the inter-relationship between the stock market and pensions.

From Health Service to Health Systems

Traditionally health policy has been focused on the NHS as an institution and service. This is in part because of the body of expertise and influence contained within it as a service, and also because of political pressures for results which can be simply and easily understood such as reducing waiting lists. The tendency has been to see the NHS as a health service, rather than looking at it as one part of a wider health system which includes the NHS but is not defined by it. Instead of being over pre-occupied by the processes of service delivery, public health advocates have increasingly argued we should be looking at how we advance a more inclusive model of health driven by the social determinants of health. This has become known as the social model of health.

This offers a wider challenge to the values, scripts and cultures within public policy and the public sector. Traditional ideas of health and welfare have been shaped by Beveridge’s welfare state which saw public services as a means to eradicate ‘the five giants’ and ‘evils’ of want, disease, ignorance, idleness and squalor, but these should now be replaced by a more positive sense of welfare and well-being based on shelter, nurture, learning, health, and work and livelihood. Such a shift would involve thinking differently about the public realm and health. This can be seen in debates about asset-based welfare, recognising the importance of supporting institutional structures tailored to individual needs which reflect and challenge the huge inequalities of income, wealth which shape life chances and opportunities and the sense of power and powerlessness people feel they have over their own lives.

The Labour Government has made some progress in this direction with the talk of the importance of localism and baby bonds, an asset-based policy, while Hazel Blears, Minister for Public Health in England, has acknowledged the need for a ‘new vision of the public realm’ in relation to health which is driven by a genuine sense of community involvement and ownership (Blears, 2003). Such a shift will require a significant change in how we think about health. As Anne Coote has argued, we need ‘a new kind of dialogue with the electorate about what health means, how it is secured and what to expect from others, including the NHS.’ This should involve an acknowledgement that ‘health is not something we get from the NHS, but a resource that we and our fellow citizens own.’ (Coote, 2003)

The policy agendas of the Scottish Executive and UK Government have increasingly been influenced by this public health agenda and social model of health. This has acknowledged that developing policy and practice in these areas would help the government in other areas such as social justice and criminal justice. Returning to the earlier four types of health policy we can identify some examples of Scottish Executive and UK Government policies in each which highlight an advance towards a broader, more inclusive idea of health:

**Strengthening Individuals:**

- New Deal
- Free nursery places
- Abolition of up-front tuition fees
- Smoking cessation strategies
Strengthening Communities:
- Healthy Living Centres
- National Health Demonstration Projects
- Social Inclusion Partnerships

Improving Access to Essential Facilities and Services:
- Glasgow Housing Stock Transfer
- 'Fair Shares for All'

Encouraging Macroeconomic and Cultural Change:
- Minimum Wage
- Working Family's Tax Credit
- Pensioner's Tax Credit

Traditionally, health policy and practice in Scotland has not been that different from the rest of the UK. Since the inception of the NHS, how we have thought of and prioritised health has been broadly similar across the different parts of the UK, reflecting the post-war aspirations which gave birth to a national health service. Now with the establishment of the Scottish Parliament and Scottish Executive, as well as devolved assemblies elsewhere in the UK, this uniformed character of health may not continue.

This will create new opportunities for Scotland to develop new models of practice and new thinking appropriate to Scottish conditions, which may then have wider relevance in the UK and internationally. New ways of advancing a public health agenda in Scotland necessitate that agencies stop thinking and acting in traditional, institutionally-defined and demarcated ways as the Scottish Council Foundation report, 'The Possible Scot' outlined (1998). Instead, the scale of the challenge of ill health and health inequalities requires that we develop multi-level strategies which range from individual and lifestyle change to cultural change at the level of society.

Client-centred Services

Sandyford has aimed to develop an ethos and practice which advances a very different idea of health, and a public health agenda in one of the most crucial and difficult clinical areas - sexual health, as well as supporting people across a wide range of social circumstances. Services such as the Steve Retson Project, the Sappho Service, and the T Group (for transgender people) recognise individual experiences within a wider societal context and provide client centred services that support individual empowerment. For some people coming to what can be seen as a sexual health service, can be problematic for a number of reasons, one, being the embarrassment people can often feel about talking about such issues, another, being the cultural and attitudinal taboos and barriers which exist in public life about such subjects at both an individual and institutional level. Any matters relating to sex or sexuality have long had a mixture of negative and nervous reactions, and this is more so in parts of Scotland, where a more traditional set of attitudes about sex and sexuality have prevailed until recently.

Sandyford has developed a range of services on sexual health at a time when both ideas of health and wider public services are changing, and also the wider policy debate due to the Scottish Executive’s draft Sexual Health Strategy. Sandyford’s ethos about the individual’s potential to realise a positive and healthy life, and to give people support, resources and choices to make informed decisions about their life, is one that has become an influential message in recent times. And the nature of Sandyford’s services and the importance of dealing sensitively with the subject of sexual health has aided the process of services and individual staff integrating and feeling they are part of a wider mission and a pioneering project.
Policy and External Profile

The Sandyford Initiative is not just a service, but provides a model of wider relevance and understandings to practitioners and the policy community. It offers a demonstration model whereby an understanding of the social model of health, and the influence that the social determinants of health have on the general population's health and well-being, has helped shaped the priorities, values and ethos of the health services which make up the Sandyford Initiative.

Sandyford has a wider relevance because it has brought a range of services in a way unparalleled in the UK and internationally, and developed these into a new way of working within one institutional setting with one over-arching ethos: namely one that is attempting to develop an integrated model of health which shifts from a medical to a social model of health. And it also has a higher profile because of the environment of public health it is working in around the West of Scotland and Glasgow, namely, one of the most disadvantaged and materially impoverished parts of Western Europe. This offers a challenge to all public agencies to address the scale of the problem ≤ in health, poverty, restricted life opportunities ≤ and the embedded nature of inequality which writes off large sections of the city of Glasgow.

Sandyford has seen a rising number of visits from interested parties including:

- Strategic visits from other NHS providers and personnel who want to learn about the Sandyford model;
- Professional visits from groups such as social workers, student nurses, and community workers who want to learn about services, or make individual referrals;
- Visits by groups of service users and prospective users such as organised school visits to The Place.

And in the last four years Sandyford has also become more and more regularly a stopping off point for a wide array of international visits and delegations, with 14 visits from 12 countries since 2002, ranging from Holland and Germany to South Africa and Ghana.

Sandyford has gained an increasing profile both in the public, and in policy discussions. It has increasingly been cited in the media, whether TV, radio or newspapers, as an expert source across a range of sexual health areas and services. And it has been used across a range of media, from providing backdrops for more generic health stories, to populist items in the tabloid media, and serious, more in-depth items in the broadsheet press. Changing health attitudes and practices involves developing multi-level responses and strategies, developing messages for the general public, and more specialist and focused audiences.

In policy discussions, Sandyford has increasingly played an important part in some of the Scottish Executive and national debates on sexual health and public health. It has increasingly been seen by politicians, civil servants and policy advisers, as having a body of expertise and evidence which can help shape the national debate across a range of important issues. Numerous examples in recent times are available which highlight this. One is the involvement of the Sandyford in the Reference Group which informed the draft Sexual Health Strategy for the Scottish Executive. Another is its role as part of a group of agencies commissioned by NHS Health Scotland to develop a Gender and Health report for the Scottish Executive.

Sandyford has liaised with Scottish Executive ministers, MSPs, MPs and councillors, media and the wider policy community in a number of ways, and has hosted numerous visits from groups and representations of all of the above. In particular, a significant number of the seventeen Glasgow MSPs have visited and been briefed on the work of Sandyford, with several having been for return visits in the short period of its existence.
What is Different?

Prevention is always better than cure. For too long, a disproportionate amount of time, effort and resource has been spent on treating ill health rather than addressing the root causes of ill health. While much progress has been made to redress this balance over recent years, more needs to be done. Sexual health must be at the heart of that work. We cannot and must not ignore the enormous human, social and economic costs of the near epidemic levels of sexually transmitted infections, not to mention the high rate of unintended pregnancies, particularly in our poorest communities.

The Sandyford Initiative is an excellent example of how a range of sexual health and support services can be brought together in a welcoming, accessible environment. We need to build on the success of this model and ensure that people in all parts of Scotland can get access to the same range and quality of services.

Susan Deacon, MSP

The Sandyford Initiative has attempted to be different in a number of ways from mainstream health services:

- Aims
- Practice
- Ethos

It has attempted to be a mainstream health service project which has taken to advancing the social model of health and to bringing to the heart of the statutory sector an agenda for integrated health care in the arena of sexual and reproductive health alongside an understanding of the importance of emotional health and well-being to individual life choices and experiences.

It has aspired to break down barriers and specialisms and develop cross-cutting ways of working on health across areas such as nursing and counselling. One way of aiding this has been via joint staff training such as the Sandyford Counselling Forum whereby staff come together from distinct services and disciplines to develop a pan-Sandyford ethos and service. In so doing, it has aimed to shift from an illness focused, disease driven model of health which has been influential for long time to a broader vision of health.

In its central location, Sandyford has aimed to offer a selection of services in a one-stop shop some of which are extremely sensitive which avoids stigmatisation and aids access. It has aimed to acknowledge the experience of the user or consumer of health services in everyday life whereby they are increasingly offered in coffee shops, bookshops or supermarkets - a feeling of a welcoming, inviting space that is neither home or work, but offers the allure of a third space. This is one of the challenges modern public services face and one that Sandyford has fully and enthusiastically embraced, and which is explored later.

Sandyford has attempted to provide a similarly welcoming environment which is warm, non-threatening and which feels welcoming and respectful of where people are and where they are coming from. From the reception area with its relaxed atmosphere, free internet service, and library resource, the aim has been to create an initial impression which is as far removed from a clinical, hospital setting as is possible while still being a health service.
The Wider Relevance of Sandyford

Sexual health in Scotland is a problem. Our society is saturated with sexual imagery yet we often find honest communication about sex difficult. We live in an age of sexual freedom yet levels of sexually-related violence and coercion remain high. Never before have we benefited from more access to information and services yet rates of infection are rising and unwanted pregnancies remain high by international standards. It is unlikely that solutions to these profound problems will come from a widespread adoption of, so called, traditional morality or by the adoption of mere technocratic solutions. To move forward we need new models and fresh thinking. The Sandyford Initiative, integrating, as it does, services under a person centred ethos, is a key part of the solution to this profound set of problems.

Phil Hanlon, Professor of Public Health, University of Glasgow

The Sandyford Initiative's model of bringing together a range of services in a new model and with a distinctive sense of values and ethos has implications beyond the boundaries of Sandyford. These include:

- Wider lessons for sexual, reproductive and emotional health
- Wider lessons for health services
- Wider lessons for public services

Sexual, Reproductive and Emotional Health

One of Sandyford's successes has been the coherence and synergy of the services it has brought together. The three original strands have all initiated work in the area of sexual health. More importantly, they have engaged in similar journeys towards a social model of health. This has meant when they have come together in the Sandyford that they have offered the prospect of being more than the sum of their parts.

Wider Health Services

Another perspective sees the Sandyford experiment as offering the potential of developing new models of health services which are more influenced by the public health model and social determinants of health. Examples here include contributing to the development of a new counselling discipline in the NHS in Glasgow and wider integration of emotional support services in primary care settings.

Wider Public Services

A final view sees the Sandyford Initiative as offering wider lessons beyond the world of health services. In this account, the success of the Sandyford in bringing together health services, and working with other partnership agencies such as Glasgow City Council, offers the prospect for a more joined-up and innovative model whereby services are more client-focused, centred on the personal journey, and aware of the need for a new kind of ethos to drive public service. Thus, the challenge to the medical model in the health service is seen as an example of shifting from internal influences such as producer vested interests in a wider public sector agenda.
A New Public Health Ethos

One objective is to improve life expectancy for all men and women in Scotland, as well as reducing inequalities between the most affluent and the most deprived groups. An important part of the health improvement agenda will be partnership working with other sectors. The Executive is leading work on identifying appropriate targets and indicators for reducing health inequalities and the development of ‘healthy life’ expectancy indicators, to supplement current data on life expectancy.

Health in Scotland, The Report of the Chief Medical Officer, Scottish Executive, 2003

The traditional post-war delivery of public services operated within a Whitehall knows best mentality and ‘one size fits all’ approach. Indeed, in the immediate aftermath of the Second World War, this made some sense. Planning and central targets had earned a reputation for efficiency during the war, and the scale of the task in reconstruction and building the welfare state meant that central government was seen as the best instrument to do so with the minimum obstacles. This was a time when the expert was both trusted and unchallenged.

However, the situation is very different today. Command and control diktats no longer deliver the goals they set out to do. Governments of both political persuasions have exhausted the possibilities of command and control mechanisms to get their own ways ≤ whether in the 1980s ≤ with control over public spending and in particular local authority spending, and post-1997 ≤ attempting to deliver national education and health targets set by the centre from the centre.

Both have found that the systems they thought they were in control of work in very different ways from what they imagined. This is because of the environment in which government agencies operate ≤ of the failure to see public agencies in a whole systems context. In particular, the law of unintended consequence has profound consequences here by which government thinking about policy design and delivery does not acknowledge the way in which in the real world acting in one area of policy has wider implications and ripples across a range of policy outcomes. Thus, the prioritisation of one policy goal such as cutting waiting lists can have all sorts of unforeseen and sometimes damaging consequences in other areas which have not been thought through by policy-makers. To begin to alter this will require a very different way of thinking about government and organisations attempting to change public agencies from top-heavy bodies into evolving, learning organisations.

Despite and also because of all of this, attempts have grown up more and more in recent years to develop a very different sense of public sector ethos. The context in which this operates is trying to develop more consumer sensitive services, develop more flexible, learning organisations, and create an environment where new forms of work, engagement and leadership can occur.

Sandyford is part of a much greater trend to develop a new public sector ethos and a new public health agenda. This sits within the idea of more personalised, individual-focused and led services which are more enduring and create a sense of a more self-organising, self-sustaining kind of collective solution than previously. Public services across Scotland and the rest of the UK are slowly attempting to develop new ways of working, new scripts which inform how they work, and new stories.
A Sandyford Story

Sandyford is a story without a proper ending. An important and innovative project that is still learning, growing and evolving, and which in many ways is still at the start of its journey, rather than an end point.

The Sandyford Initiative grew out of a number of developments and factors. The commitment of Greater Glasgow NHS Board to develop a new model of public health innovation and to fund comprehensive evaluation of the developments was the key issue. But other factors were important and played a significant contribution to the development of its distinct ethos. The journeys of Genito Urinary Medicine, Family Planning and the Centre for Women’s Health, along with the Steve Retson Project, all played a part. The role of Glasgow City Council in supporting various aspects of service development has been important. Numerous public health networks, alliances and campaigns contributed as well, developing a culture and practice that was far removed from traditional medical models and thinking on health. Across a range of policy-makers and practitioners there was also a growing realisation that the scale of health inequalities and problems in the West of Scotland required a new way of thinking about health.

The idea of Sandyford grew out of these and other discussions. The Health Board gave a commitment to bring the various traditions together, devise the initial strategy, and commit the time, resources and expertise to make it happen. The aim from the outset was to develop an innovative project which would further the Board’s strategic objectives in the areas of emotional, reproductive and sexual health, informed by a social model of health, while creating a public health model which would break with previous models of health delivery, and offer wider lessons for the Board and further afield. The model of Sandyford is felt to be transferable and applicable to other health and social care areas, and to be an important strategic and operational influence.

The experience of Sandyford has created a new model of health service, changing the traditions and services which initially came together. The service has broken with the culture of traditional health services, being shaped by the needs of the individual and their concerns rather than medical specialisms. This is seen in the innovative work of the Sandyford Health Screen. In an area where many people, and in particular, many Scots, still feel a sense of embarrassment, Sandyford has brought a culture of a client-focused service as far removed from the tradition of the ‘clap’ clinic as is possible. And it has a very different feel from other health services, looking and feeling like a welcoming, warm, supportive environment, where people will be treated and respected and their concerns listened too. Sandyford offers a glimpse into a future of very different public services: ones which are personalised and individualised.

Sandyford has helped shift the debate about emotional, reproductive and health services across Scotland. It has acted as a demonstration project developing new services. It has fed into wider policy debates led by the Executive and others. And it has contributed towards individuals thinking differently about their health and well being in a more social and joined-up way.

Sandyford then is a story with a wider relevance and currency. Increasingly across the worlds of politics, business and public policy, a growing awareness has begun to be found of the importance of narrative, or story and storytelling. What a sense of story means in this context is the ability to convey in a series of tales and metaphors, a sense of where you are, the values you wish to embody, and where you want to go. What narrative and story are about in short is what was once called ‘the vision thing’. Story involves bringing people with you, tapping emotions and playing on subjective feelings in a way that linear explanation involving rationale and facts and figures never can do.
Stories matter in less heroic settings as well in such settings as business and public organisations. The common thread to the above is about the evolution of leadership, taking risks and embracing ideas of change which go beyond a calm, rationale cost-benefit analysis of the environment. Instead, this kind of leadership takes chances, and champions daring and new ways of doing things.

Public sector leadership involves a very different kind of leadership to the heroic models we all know from times gone by. The complex demands, expectations and scrutiny which the public sector faces is not just from the public, but politicians, and staff within them calls for a collaborative and shared type of leadership whereby people who lead act as negotiators and mediators, and know how to develop ideas of change which address different audiences at the same time.

The Sandyford Initiative has begun to map out the beginnings of a new story about health and public services. It has advanced a very different way of thinking about health, and set out structures and services which have put these ideas into practice. It has developed new ways of working which have a relevance way beyond the boundaries of Sandyford as a building and an idea: touching wider health and public sector issues in Scotland and the UK, and providing a centre for innovation and excellence which has attracted increasing international interest. The Sandyford Initiative has been shaped by a desire to develop a very different model of health services, which has tapped into the slow evolution of a new public sector ethos which marks a break with traditional, paternalist, the bureaucrat knows best ideas.

It has above all been driven by the commitment of the staff of the Sandyford Initiative at every level and post to making a difference to the health of Glasgow. It is this engagement and sense of optimism which shapes the feel of the Sandyford as a building, an idea and a story and which makes this such a positive story of new possibilities.
Report on the Sandyford Health Screen during the period Oct 1 2002 – Sept 30 2004

Rosie Ilett, Associate Director (Health and Inequalities), with input from Chris Thow, Information Support Manager and other colleagues

1. Introduction

To further explain how adapting practice to encompass a social model of health care can reap benefits, the following report on The Sandyford Health Screen is presented.

The Sandyford Health Screen was introduced in Autumn 2002. Its purpose was primarily to identify those most likely to benefit from a chlamydia test, but it also aimed to explore underlying health and social issues experienced by clinical service users with the aim to better target follow-on services and referrals. Offered initially as a voluntary opt-in, due to client and staff acceptance it is now integrated into clinical assessment.

In the two year period from the beginning of October 2002 until the end of September 2004, nearly 18,000 Sandyford clients participated in the Screen. This is approximately 10% of all clients that access Sandyford’s clinical services although, as will be shown, more clients than this have had a chlamydia test. This report summarises key findings from these engagements. As an intention of the Health Screen was to identify and support where possible clients whose issues had never been fully explored and supported, case studies within the report will give some examples. A further aim of the health screen was to integrate information services into clinical assessment and approaches.

2. Demographic information

As Table 1 shows, nearly twice as many women than men have participated in the Screen, with a majority of all participants (60.7%) falling within the 20 – 24 age group (10, 883:17, 977). Just over 10% of those undertaking the Screen have been over 40.

Table 1: Total by sex and age

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 or less</td>
<td>452</td>
<td>12</td>
<td>464</td>
</tr>
<tr>
<td>16 - 19</td>
<td>2511</td>
<td>508</td>
<td>3019</td>
</tr>
<tr>
<td>20 - 24</td>
<td>4056</td>
<td>1756</td>
<td>5812</td>
</tr>
<tr>
<td>25 - 29</td>
<td>2288</td>
<td>1092</td>
<td>3380</td>
</tr>
<tr>
<td>30 - 34</td>
<td>1066</td>
<td>625</td>
<td>1691</td>
</tr>
<tr>
<td>35 - 39</td>
<td>1100</td>
<td>706</td>
<td>1806</td>
</tr>
<tr>
<td>40 - 44</td>
<td>477</td>
<td>413</td>
<td>890</td>
</tr>
<tr>
<td>More than 45</td>
<td>362</td>
<td>553</td>
<td>915</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12312</strong></td>
<td><strong>5665</strong></td>
<td><strong>17977</strong></td>
</tr>
</tbody>
</table>
Table 2 below indicates that slightly more clients of the family planning and reproductive health services have undertaken the Screen than those using genitourinary medicine and sexual health services. The sex differences in uptake of the Screen (that is, more women than men) reflect the overall patterns of use in all Sandyford clinics.

**Table 2: Sex and clinic of origin**

<table>
<thead>
<tr>
<th>Sex</th>
<th>GUM</th>
<th>FP</th>
<th>B74</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>5623</td>
<td>42</td>
<td>-</td>
<td>5665</td>
</tr>
<tr>
<td>Female</td>
<td>3594</td>
<td>8645</td>
<td>73</td>
<td>12312</td>
</tr>
<tr>
<td>Total</td>
<td>9217</td>
<td>8687</td>
<td>73</td>
<td>17977</td>
</tr>
</tbody>
</table>

3. Chlamydia test – numbers and findings

**Table 3: Chlamydia testing 01/10/02 - 30/09/04 by clinic and sex**

<table>
<thead>
<tr>
<th>Total individuals tested</th>
<th>Sex</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female*</td>
<td>Male*</td>
</tr>
<tr>
<td>Session Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Planning</td>
<td>2618</td>
<td>-</td>
</tr>
<tr>
<td>Genito Urinary Medicine**</td>
<td>210</td>
<td>2931</td>
</tr>
<tr>
<td>Grand Total</td>
<td>2828</td>
<td>2931</td>
</tr>
</tbody>
</table>

(Note: *Chlamydia test recorded on prior clinical system from 01/10/02 – 31/03/04; **Chlamydia test recorded on Access system prior to 01/04/03 database, possible under-recording).

As Table 3 above shows, nearly 30, 000 tests for chlamydia have been recorded in this two year period, which may be under-reporting as earlier tests were recorded on a different system. As the aim was to test those at risk of infection that might not be identified otherwise, it is unsurprising that approximately 2/3rds of those tested were family planning and reproductive health clients who were not initially attending Sandyford for this reason. As Table 4 shows, the overall detected positivity rate is approximately 13%, with anticipated variation by service.)
Table 4: Positive Chlamydia results identified via Sandyford Health Screen

<table>
<thead>
<tr>
<th>Family planning positive Chlamydia by age group</th>
<th>Age group</th>
<th>Total positives</th>
<th>Pos rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Planning – Sandyford (all female)</td>
<td>&lt;16</td>
<td>132</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>16 - 19</td>
<td>914</td>
<td>10.5</td>
</tr>
<tr>
<td></td>
<td>20 - 24</td>
<td>2191</td>
<td>7.6</td>
</tr>
<tr>
<td></td>
<td>25 and over</td>
<td>2949</td>
<td>3.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>6186</strong></td>
<td><strong>5.8</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GU Medicine positive Chlamydia by age group</th>
<th>Age group</th>
<th>Total positives</th>
<th>Pos rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GUM - Female</td>
<td>&lt;16</td>
<td>48</td>
<td>10.4</td>
</tr>
<tr>
<td></td>
<td>16 - 19</td>
<td>1105</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>20 - 24</td>
<td>2472</td>
<td>12.2</td>
</tr>
<tr>
<td></td>
<td>25 and over</td>
<td>3151</td>
<td>5.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>6556</strong></td>
<td><strong>10</strong></td>
</tr>
</tbody>
</table>

| GUM - Male                                  | <16       | 9              | 0            |
|                                             | 16 - 19   | 747            | 22           |
|                                             | 20 - 24   | 2841           | 17.6         |
|                                             | 25 and over | 5793         | 9.8          |
| **Total**                                   |           | **9390**       | **13.1**     |

Overall total 16,166
4. Experiences of violence and abuse

The Health Screen also identifies the incidence of violence and abuse experienced by clinical service users, partly with the view that many of these individuals may not have previously disclosed in a clinical setting. Although some of these questions were asked within genitourinary services, they were not typical questions for family planning and reproductive health care. The figures, whilst likely to be under-reporting, indicate that physical and sexual violence are real issues for many Sandyford users, although it is important to note that it is likely that many of these experiences are historical.

a. Domestic abuse, street violence or other forms of physical assault

Table 4: reports of experiences of violence 01/10/02 - 30/09/04 by clinic and sex

<table>
<thead>
<tr>
<th>Location</th>
<th>Sex</th>
<th>Yes</th>
<th>No</th>
<th>Not asked</th>
<th>Not Answered</th>
<th>Not Known</th>
<th>NA</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base 75</td>
<td>Female</td>
<td>31</td>
<td>24</td>
<td>0</td>
<td>17</td>
<td>0</td>
<td>0</td>
<td>72</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>3</td>
<td>34</td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>42</td>
</tr>
<tr>
<td>Family Planning</td>
<td>Female</td>
<td>478</td>
<td>7755</td>
<td>11</td>
<td>360</td>
<td>3</td>
<td>45</td>
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</tr>
<tr>
<td></td>
<td>Male</td>
<td>724</td>
<td>4016</td>
<td>137</td>
<td>736</td>
<td>4</td>
<td>8</td>
<td>5625</td>
</tr>
<tr>
<td>GU Medicine</td>
<td>Female</td>
<td>273</td>
<td>2720</td>
<td>126</td>
<td>468</td>
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<td>7</td>
<td>3596</td>
</tr>
<tr>
<td></td>
<td>Male</td>
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<td>137</td>
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<td>5625</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>1509</td>
<td>14549</td>
<td>275</td>
<td>1585</td>
<td>9</td>
<td>60</td>
<td>17987</td>
</tr>
</tbody>
</table>

As Table 4 above shows, of the nearly 18,000 people who participated in the Health Screen during the two years, 8.4% reported experience of an assault, with slightly more women than men having been assaulted (784 : 726). Nearly 13% of all men who participated in the Sandyford Health Screen (723 : 5665) and nearly over 6% of all women (273 : 12312) reported this experience. A reasonably high number of both men and women did not answer this question – more than who answered in the affirmation. These assaults are typically domestic abuse or street-related violence depending on the sex of the informant. The data does not tell us when these experiences occurred, and many are historical. Client notes would need to be interrogated to reveal any other information but it is important to note that as clients are attending for an immediate clinical need, further questioning would not have happened in most cases. Further information could only be achieved through a formal pro-active research process.

Women using Base 75 (a drop in healthy and support service for women involved in prostitution) reported the highest level of violence, as 31 of the 72 women from Base 75 who completed the Screen disclosed physical assault. Full information is not available about Base 75 clients as the Screen was done opportunistically because of the nature of the client group and their needs. However the screen showed that many of the women expressed more concern about gynaecological and reproductive health issues than the core Sandyford sample, as will be discussed later. The following case studies indicate the ability of the Screen to identify unmet needs that would be otherwise invisible.


Case Study One:
A 35 year male student from Uganda, attended with pain in passing urine and a discharge. During his Health Screen, when asked had he ever been physically attacked, he disclosed a recent attack where he suffered stab wounds to the throat and arm. The doctor referred him to the sexual health adviser for crisis work on his day of attendance.

On seeing the sexual health adviser and discussing the attack in more detail, the client became very upset and described how he felt isolated and feared going out alone. He described feelings of depression and was tearful throughout the session. He was later put in touch with Victim Support services and accessed counselling via his GP. He was also given a Sandyford information leaflet about further support and counselling services.

Case Study Two:
A 29 year old Rwandan woman attended the family planning drop-in clinic at Springburn Health Centre for the first time, for contraceptive advice. She is a refugee and has been in Glasgow for 3 years. She is living in temporary accommodation in Sighthill and is awaiting the outcome of an asylum application. She has a 2 year old daughter. When the Health Screen questions were asked, she confided that she had been beaten seriously prior to fleeing Rwanda. Other members of her family and community were also assaulted, and she did not know whether family members had survived. Since coming to this country, she has not told anyone about the physical violence which she experienced and lives in great fear of being sent back home. She has been unable to forget the violence, and described some flashback experience.

She was informed about help available for women who had experienced or were experiencing violence. She felt that she would like to speak to a counsellor. She felt able to make contact herself, and was provided with information about the Centre for Women’s Health as well as the information leaflet on Women and Violence produced by the Centre. Without the Screen, this may have remained purely a contraception consultation, and the previous assaults and help to cope with these would not have arisen. It seemed that the woman was relieved to have been asked about violence and reacted positively to information provided.

b. Experiences of being paid for or having paid for sex

*Table 5: experiences of being paid for/paying for sex by clinic and sex*

<table>
<thead>
<tr>
<th>Paid for/been paid for sex</th>
<th>Location</th>
<th>Sex</th>
<th>Yes</th>
<th>No</th>
<th>Not Asked</th>
<th>Not answered</th>
<th>Not known</th>
<th>NA</th>
<th>Total</th>
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<tr>
<td></td>
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<td>Female</td>
<td>53</td>
<td>8</td>
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<td>10</td>
<td>1</td>
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<td>72</td>
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<td></td>
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<td>38</td>
<td>8016</td>
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<td>394</td>
<td>6</td>
<td>194</td>
<td>8652</td>
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<td>1</td>
<td>36</td>
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<td>0</td>
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<tr>
<td></td>
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<td>588</td>
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<td>4</td>
<td>131</td>
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<tr>
<td>Total</td>
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<td></td>
<td>715</td>
<td>16407</td>
<td>18</td>
<td>638</td>
<td>7</td>
<td>202</td>
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</tr>
</tbody>
</table>
The number of people accessing Sandyford services who report having been paid for sex or who have purchased sexual services is fairly small, but this is likely to be under-reporting. Overall 589 men and 126 women who participated in the Sandyford Health Screen (of whom 53 were Base 75 clients) revealed this experience. This makes a total of 715 individuals - 4% of all those who participated in the Health Screen in this period. Virtually all of the men were clients of GU (588 : 589) and besides women using Base 75, 35 other women were GU clients and 38 were family planning clients. Over 10% of all men who took part in the Sandyford Health Screen and over 1% of all women fell into this category. Again, this data cannot indicate where or when these instances took place, and in what context, and this is currently the subject of further investigation.

c. Experience of sexual abuse and assault

*Table 6: reports of sexual assault/abuse by clinic/sex*

<table>
<thead>
<tr>
<th>Location</th>
<th>Sex</th>
<th>Yes</th>
<th>No</th>
<th>Not Asked</th>
<th>Not answered</th>
<th>Not Known</th>
<th>NA</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base 75</td>
<td>Female</td>
<td>23</td>
<td>29</td>
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<td>72</td>
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<td></td>
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<td>35</td>
<td>0</td>
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<td>0</td>
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<tr>
<td>Family Planning</td>
<td>Female</td>
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<td>7884</td>
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<td>8</td>
<td>60</td>
<td>8652</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>1</td>
<td>35</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>42</td>
</tr>
<tr>
<td>GU Medicine</td>
<td>Female</td>
<td>307</td>
<td>3201</td>
<td>4</td>
<td>79</td>
<td>2</td>
<td>2</td>
<td>3596</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>103</td>
<td>5275</td>
<td>8</td>
<td>230</td>
<td>4</td>
<td>4</td>
<td>5625</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>775</td>
<td>16424</td>
<td>16</td>
<td>688</td>
<td>14</td>
<td>66</td>
<td>17987</td>
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</table>

During this two year period, there have also been disclosures during the Sandyford Health Screen of the experience of sexual abuse and assault as Table 6 indicates. Again it is impossible to identify when and where these incidents occurred, but 104 men and 672 women participating in the Screen discussed this. This gives a total of 776 or 4.4% of the overall group who participated in the Screen. Of those, 4% of all family planning clients and 8.5% of all female GU clients had been sexually abused or assaulted.

5. Unresolved issues about miscarriage/TOP

The emotional impact of miscarriage and TOP is well recognised, and the Sandyford Health Screen has allowed this to be more systematically charted. In the two year period under discussion, 81 men and 495 women (576 of clients in total, or 3.3% of all those who undertook the Screen) regarded this as a still an unresolved issue for them.

For women using Base 75, this was a more prominent issue, with 20% of those participating in the Screen over a 6 month period (11 in total) perceiving this as still problematic. As mentioned above, unmet gynaecological needs were identified within this group, with 36% (20) concerned about menstruation and 20% (11) concerned about urinary incontinence over a six month period.
6. Addiction issues and lifestyle choices

The Sandyford Health Screen has also allowed participants to talk about smoking, drinking, drugs and weight and eating, and where necessary to access other services. In all cases, clients have been asked whether these are concerns for them. It is not therefore possible to know the overall percentage of clients participating in these activities, or whether the concerns being expressed are of significance.

a. Smoking

Of those who participated in the Sandyford Health Screen, 179 men (over 3% of all men) and 1034 women (8.5% of all women) said that they were concerned about their own smoking. It is not possible to know how much these clients smoked. There were some interesting differences however, between the sexes and the services. Over 10% of female family planning clients were concerned about smoking, whereas just over 3% of female GU clients were. Overall, just over 3% of all men and over 8% of all women who took part in the Sandyford Health Screen were concerned about smoking.

b. Alcohol

In relation to alcohol, 440 men (8% all men) and 584 women (nearly 5% of all women) stated during the Sandyford Health Screen that they had concerns about their drinking habits. Although a small number overall (9), over 21% of male family planning clients felt that this was an issue for them. This compares with less than 8% of men using GU. Women seemed less concerned with drinking overall, as less than 5% of all female clients participating in the Screen felt it an issue.

c. Drugs

All those participating in the Sandyford Health Screen are asked whether they are concerned about their use of drugs. Although it is not possible to know the kind and level of drug use that may be being referred to, figures show that quite a low percentage of people disclosed this as an issue. Only 79 men overall (1.4% of all men doing the Screen) and 332 women (2.4% of all women doing the Screen) regarded it as problematic. There may well be inhibitions to disclosure that are decreasing potential reports and the ability of Sandyford to appropriately refer or address any concerns.

d. Weight and eating issues

All those participating in the Health Screen are asked about weight and eating habits and any concerns. Of over 12, 000 women who undertook the Screen during this period, 1392 women (over 11%) saw this as an issue for them, although female clients using GU were less concerned overall than those using family planning and reproductive health. A similar difference existed for male clients, with 6% of male GU users feeling concerned, whereas 13% of all FP users were. The case study below shows the referral made for one male client who discussed his need for help during the Sandyford Health Screen.

**Case Study Three**

This young man in his early 30's, of average build and height, has bulimia and body image dis-satisfaction, and associated stomach problems. He has felt bad about having an eating disorder and found it difficult to access help for men. He was referred via the Sandyford Health Screen to the Centre's Eating Disorder service, and saw a counsellor within three weeks. He had met with a lack of support from his GP who told him 'to give himself a shake, be a man and get on with his life as eating disorders were for women.'

Within a few sessions the client was no longer making himself sick, had increased his intake of healthier foods, and felt that he had made a start. He liked the idea that he could be coming to the Sandyford for anything, and felt no stigma in seeing a counsellor. He was considering bringing his partner with him to later sessions. Having access to a sympathetic professional who knew about eating disorders was a new experience for him, as the only other information he had been able to access before was through the internet.
Case Study Four

James presented at The Place accompanied by his social worker. From age 12 he has been drinking alcohol, at age 13 he was introduced to cannabis. He went on to try most other drugs offered to him at this age, resulting in this young man developing difficulties with Cannabis, Diazepam and Alcohol.

James was extremely open and honest acknowledging that he was keen to address difficulties he was experiencing around his use of alcohol and drugs. He informed the drug and alcohol counsellor that over the years he had experimented with a number of drugs, in particular he wanted help with Alcohol, Cannabis and Diazepam.

He was having difficulty sleeping at night; he suffered pain from a stomach ulcer associated with his use of Alcohol. James’s heavy use of cannabis exacerbated his asthma, he had been informed by the nurse at his G.P. surgery that his cannabis use was slowing down the development of his chest and lungs. He suffered from low moods and extreme anger outbursts.

The counselor saw James on 7 occasions during which a number of approaches have been used. Informing this young man about; safe units of Alcohol, how Alcohol affects the body, explaining that his use of alcohol was impacting on his physical and mental health and the dangers of mixing alcohol and drugs together and its effects. James is now more careful of his alcohol use he is able to calculate the number of units that he drinks in a week. Over the seven sessions this young man managed to stop using Diazepam.

James decided he was not ready to stop his cannabis use, he wanted to reduce it. He smokes cannabis heavily, in buckets, on a daily basis. A harm reduction approach was used. James was given information on the effects of cannabis, he did work sheets and quizzes around cannabis. Safer methods of using this drug were discussed, he has struggled to change the way in which he uses this drug but has successfully managed to gain more control over his use.

Boredom, lack of structure and routine appear to have been major factors in his use of drugs, a referral was made to his G.P. for the Exercise Referral Scheme. This resulted in this young man now attending his local swimming baths. His social worker has now referred him for employment training and he is making good progress. A referral for anger management has been made to Caledonia Youth for this young man.

7. Information Prescription – uptake of information services

The Health Screen has also encouraged the systematic provision of health information through the involvement of the Sandyford Library and Information Services. Clients are encouraged to choose their own information from the Library, or to link to Library staff through a customized sheet with their own requirements. Display stands near the Library are dedicated to the Health Screen, and the use of information has been highly significant. Approximately 13,500 health information leaflets, produced in-house and covering the main Health Screen subjects, are used each month, plus between 1500 - 2000 Health Promotion Department leaflets, and approximately 150 specialist leaflets a month. It is not possible to clarify amounts used before the Health Screen but it is likely to be much less than this. Through the Information Prescription and other enquiries, the Library also print off Internet information for users, accounting for another 100 requests each month.
8. Client feedback on the Sandyford Health Screen

In Autumn 2003, 20 women who had used family planning and reproductive health services, and had undergone the Health Screen, gave feedback to Sandyford’s Community Access Worker. All 20 women said they had not felt pressured and had been happy to take part. Although some staff inconsistency in ensuring client’s knowledge of the Screen and its contents was reported, 19 women (95%) said they did not find the questions difficult, and none were offended or confused, although one woman felt that being asked about paying or being paid for sex ‘was a bit funny’. All thought it important that Sandyford asked these questions, with one saying ‘If I were to expect to be asked these type of questions anywhere; it would be here, so that I can get any help I need. It’s all part and parcel of coming to this type of clinic’.

When asked whether they felt that any issues raised via the Screen were dealt with properly, 14 women (70%) said yes, 5 women (25%) felt this was not relevant as nothing had come up, and 1 woman (5%) said no. When asked whether they had benefited from going through the Screen, 11 women (55%) said yes, 5 women (25%) said no, 1 woman (5%) didn’t answer and 3 women (15%) were not asked this question as pilot feedback questionnaires did not feature this question. Asked if Sandyford could improve the Screen, 17 women (85%) said that it was fine, 2 women (10%) felt that it could be improved and 1 woman (5%) did not answer. Overall comments included:

- Getting tested for chlamydia was something I’d been meaning to do.
- Comforted by the thoroughness.
- It was explained to me why certain questions were asked. For example, ‘such and such’ is on the rise in Scotland. I feel more aware now.
- Take a step back and made me think a bit about things that have happened in the past. I think this is a good thing.
- Had there been anything I wanted to raise, this was a good opportunity.
- It’s an important thing. I have access to counselling should I want it, but some people might not, or might not have the same support networks that I have.
- Good to highlight the other services available such as counselling. I didn’t know Sandyford offered all these services.

These appear to indicate that, although gathered from a small group of women, information suggests that the Screen has been received positively by Sandyford clients.
9. Outcomes

A number of significant outcomes arise from the Sandyford Health Screen, as follows:

- The Screen has identified a previously invisible group of those at risk of Chlamydia, and tested and supported them accordingly
- The Screen has identified some issues and experiences that clients had not previously revealed in a care setting, and referred or supported them accordingly
- The Screen has raised awareness amongst Sandyford staff and clients of the relevance of psycho-social issues and health determinants to sexual, reproductive and emotional health and wellbeing, and offered a supportive response.
- The Screen has been accepted by Sandyford staff as a useful and appropriate tool, and has facilitated a more comprehensive integrated clinical approach.
- The Screen has encouraged wider service integration between clinical and non-clinical services, and supported better links and joint working.
- The Screen provides information about unmet need that can help develop new responses or funding applications (for example, evidence from males disclosing past experiences via the Screen aided the successful funding application for the Choose Life counselling service for male survivors of childhood sexual abuse).

10. Summary and ways forward

The introduction of the Health Screen has been successful as indicated, and its further integration into the community-based clinics will provide new opportunities for clients and for Sandyford to generate appropriate service responses. Following from this, and from the continuing identification of issues via the Screen, there are other ways to maximise the Screen and its outcomes. Currently, a piece of work is being planned to investigate the use by male Sandyford clients of prostitutes, as well as the undertaking of an audit to see where and how rape and sexual assault is being reported and addressed, in relation to The Arch planning process. Sandyford provides an ideal setting for such questions to be raised, but there are arguments to be made for other services developing similar processes. There is interest in the development of the Screen, an article written by senior Sandyford staff will soon appear in the *European Journal of Contraception and Reproductive Health Care*¹, and it can only be hoped that others will begin to follow suit.

¹ *European Journal of Contraception and Reproductive Health Care*, 'Use of a staff administered structured questionnaire to identify relevant lifestyle issues and social health determinants in a sexual and reproductive health service', Bigrigg, Nandwani, Ilett, Thow, Lamont, Bankowska, Brechin, 2004 in press.
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