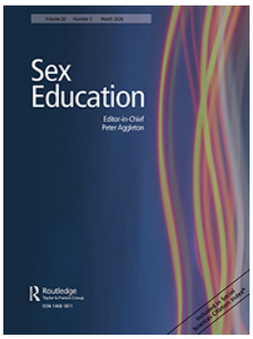

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Factors affecting the implementation of a whole-school relationships and sexual health intervention: staff perspectives from trial-nested qualitative research in English secondary schools

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ABSTRACT

Whole-school relationships and sexual health interventions represent promising approaches to promoting healthy sexual development. However, data from a randomised controlled trial of the *Positive Choices* whole-school intervention demonstrate these may be challenging to implement in English secondary schools. We draw on qualitative data to examine staff perspectives on the implementation of the intervention and the factors affecting delivery. Interviews were conducted with 52 staff in 22 schools. Analysis was guided by May's General Theory of Implementation, focussing on how processes of sense making, cognitive participation, collective action and reflexive monitoring were shaped by intervention capability, school capacity, and staff potential. Quality training, materials and support, alongside a strong commitment to delivery of statutory relationships and sex education promoted curriculum implementation. However, whole-school components were viewed as more challenging to implement and often beyond the 'core business' of schools. Successful implementation of whole-school components was facilitated by a supportive school culture, school leads having the authority

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to enable collective action and close alignment with school priorities and institutional processes. For whole-school interventions to succeed, sufficient time and resources must be allocated. A pragmatic approach might be to develop whole-school approaches that address health more holistically and build effectively on existing provision.

Introduction

Despite significant declines over the last two decades, the UK still has the highest rate of teenage births in Western Europe, with teenagers also being the age group most likely to undergo an abortion (ONS 2024). Rates of sexually transmitted infection (STI) diagnoses are highest among those aged 15–24 (Migchelsen et al. 2024) and a substantial proportion of young people report not being 'competent' at first sex (in terms of autonomy of decision, judging the timing to be right, partners' equal willingness and use of effective contraception method) (Palmer et al. 2017). Dating and relationship violence (DRV) in adolescence is also widely reported (Meiksin et al. 2020; Young et al. 2018).

In 2020, statutory relationships and sex education (RSE) was introduced for all secondary schools in England (DfE 2019). Schools are required to deliver a comprehensive, incremental curriculum covering biological, social and legal aspects, tailored to reflect the needs of local pupils and communities. There is good evidence internationally that comprehensive RSE can contribute to improving sexual health by addressing the knowledge, skills and attitudes that underpin safe, respectful and positive relationships and sexual experience (Denford et al. 2017; Goldfarb and Lieberman 2021; Haberland 2015; Lohan and Lopez 2023; UNESCO 2018). In addition, some studies demonstrate impact on behavioural outcomes including delayed sexual debut, increased condom and contraception use and the prevention of DRV (Farmer et al. 2023; Goldfarb and Lieberman 2021; Lopez et al. 2016; Oringanje, Meremikwu, and Eko 2009). However, effects vary and evidence of impact on biological outcomes such as rates of teenage pregnancy, HIV and STIs are rarely detected in trials (Mason-Jones et al. 2016; DiCenso et al. 2002). The school-based provision of RSE alone may be insufficient to address complex sexual health outcomes influenced by wider social determinants and inequalities (Lohan and Lopez 2023).

Alongside the delivery of comprehensive RSE, experts increasingly advocate for whole-school actions that go beyond classroom learning and account for potential variability in its delivery by modifying school organisation and environments to make these more supportive of sexual health (Gilsenan and Sundaram 2025; Renold and McGeeney 2017). This may include actions to strengthen student participation, belonging and engagement; shift unsupportive school culture and peer and institutional norms; improve access to sexual health services; and increase parental involvement. There is growing evidence that whole-school approaches can be effective in promoting positive sexual health behaviour and outcomes including delaying sexual debut, increasing contraceptive and condom use, reducing teenage pregnancies and preventing STIs and DRV (Basen-Engquist et al. 2009; Coyle et al. 2001; Coyle et al. 1999; Hill et al. 2014; Patton et al. 2006; Peterson et al. 2019; Taylor et al. 2013; Shackleton et al. 2016).

However, evidence from a recent trial of the Positive Choices whole-school relationships and sexual health intervention, involving 49 secondary schools in England, suggests that implementation of such interventions in English secondary schools may be challenging (Muraleetharan et al. under review). As well as an RSE classroom curriculum, Positive Choices involved a student needs survey; a staff/student action group to review needs and decide and implement local priorities; student-led social marketing campaigns; a review of school and local sexual health services; and parent information (intervention described in more detail in the methods section). We found that Positive Choices was not effective in promoting 'competent' first sex (primary outcome) or preventing pregnancy, STIs, DRV, and other adverse outcomes when compared to usual provision (Ponsford et al. 2025). Quantitative data collected through a process evaluation suggest that this may have been due to sub-optimal implementation, particularly of whole-school components of the programme. Around half of the intervention schools implemented action groups, while very few reported implementing student campaigns, a review of sexual health services, homework activities, or parent communications beyond informing parents about the lessons (see Table S1 in online supplementary material).

There is a substantial literature on how school-based public health interventions are implemented and the factors that affect this (Herlitz et al. 2020; Pearson et al. 2015). Enablers include: building commitment and support among school leaders; staff observing positive impacts; staff confidence in delivering interventions and belief in their value; and embedding interventions in school policies and systems. Barriers include: schools prioritising educational over health outcomes; insufficient time, funding and other resources; staff turnover; and lack of training. Some of this literature has examined the implementation of whole-school interventions. Reported enablers include support from staff and students across the school, good communication, a supportive school culture, framing health education and health promotion as core school business, support from national policy, use of local data to demonstrate need, and high-quality training (Bonell et al. 2013; Ponsford et al. 2022; Sadjadi et al. 2021).

This literature has not greatly considered the implementation of whole-school approaches to relationships and sexual health. One of the few studies that did this is an earlier pilot trial of the Positive Choices intervention. The pilot found that implementation across the four participating secondary schools was good. In addition to the above factors, implementation was promoted when: schools prioritised sexual health; staff leading delivery had the authority to make decisions; schools had mechanisms to support student participation; and schools already had an inclusive culture supportive of RSE (Bragg et al. 2022).

The lack of evaluations of the implementation of whole-school relationships and sexual health interventions and the factors that can enable or impede this are important given their potential role in addressing adverse sexual health outcomes and recent policy attention to whole-school approaches in the UK (DfE 2019; Ofsted 2021; Renold and McGeeney 2017). Understanding implementation processes is also essential for considering the transferability of interventions and, in the case of our trial, understanding limited effectiveness and the factors affecting this.

May's general theory of implementation (May 2013) provides a useful framework for understanding the social processes through which interventions are enacted and how local context influences these. The theory conceptualises implementation as occurring

through four kinds of work: 'sense-making' (understanding the intervention, its value and one's role in enacting it); 'cognitive participation' (committing to delivery); 'collective action' (collaborating to implement); and 'reflexive monitoring' (formally/informally assessing implementation and need for further actions). These processes may be affected by intervention 'capability' (whether it is workable and can be integrated within a system), local 'capacity' (whether the necessary material and cognitive resources, and social roles and norms are present), and implementer potential (whether providers have supportive individual intentions and collective commitments).

Informed by this framework, we explored the implementation of Positive Choices as part of our trial-nested process evaluation. Our analysis addressed the following question: what do teachers' accounts suggest about the local factors affecting the implementation of Positive Choices?

Methods

Our qualitative research was nested in a cluster RCT of the Positive Choices whole-school relationships and sexual health intervention. Full details of the study methods are reported elsewhere (Ponsford et al. 2021). We aimed to recruit a diverse sample of secondary schools in southern and central England to participate in the trial of the intervention. Eligible schools were of any type, excluding special schools, or those with an 'inadequate' national-school-inspectorate rating. Schools were recruited via email followed by a phone call with interested schools. Head-teachers signed consent forms for schools to participate in the trial. After baseline surveys with year-8 students (aged 12/13), schools were randomly allocated to intervention or control, stratified by school-level GCSE attainment and local deprivation.

Schools in the control arm continued with their existing statutory RSE provision (DfE 2019) without additional support other than £500 compensation for participation. Schools in the intervention arm of the study were provided with materials and training to implement Positive Choices over the 2022/23 and 2023/24 school years, comprising the following components intended to address sexual health at multiple levels:

(1) School health promotion council (SHPC) (action group) involving six staff and six students, which met termly to review needs and plan and oversee delivery of components 3–6 below.
(2) A student needs report focused on year-8 students (age 12/13, drawing on the baseline RCT survey) which identified learning and sexual health needs by gender, to help SHPCs locally tailor components 3–6 below.
(3) RSE lessons delivered by teachers. 'Essential' lessons were those that were to be delivered in all schools (eight for year 9; five for year 10) informed by the delivery partner, the Sex Education Forum's (SEF's), expertise on key core topics. 'Add-on' lessons were additional lessons that schools were expected to additionally deliver but which they could choose from a menu, the choice being informed by data from the student needs report (two for year 9; one for year 10). Essential and add-on lessons totalled a required 10 hours of lessons for year 9 and six hours for year 10. A list of the topics covered by year 9 and year 10 lessons is provided in Table S2 of the online supplementary material.

(4) Student-led social-marketing (SLSM) campaigns facilitated by teachers and led by 12–18 students per school, diverse by gender and school engagement. Annual campaigns focused on sexual health and relationships topics prioritised by schools.
(5) Parent communication comprising three communications (e.g. articles in newsletters, notices to parents, sharing of resources) prepared by the SHPC, and two homework assignments per year attached to the classroom curriculum, both aimed at increasing parent engagement and supporting conversations at home.
(6) Review of school and other local sexual health services (SHSR) conducted by the SHPC to inform improvements in provision and/or access.

Intervention design and delivery were supported by the SEF which provided a manual to guide the intervention and materials for all components. In year 1, SEF provided: a start-up meeting with each school; one-hour introductory training for school leads; seven-hours online curriculum training for school leads; two-hours online training for staff facilitating student campaigns. School leads cascaded curriculum training to classroom teachers in 1- to 3-hour internal trainings per year. These teachers could also attend six SEF-delivered training webinars in year 1 and one in year 2 covering RSE topics. In year 2, SEF provided: one-hour training for new leads; 1.5-hour SHPC and student-campaigns refresher training; and one-hour curriculum training in teaching about 'tricky topics'. SEF also aimed to provide two online drop-in support sessions per year plus regular communications and ad-hoc support for delivery.

The Positive Choices programme theory (Figure 1) was informed by social influence (Fisher 1988) and social cognitive theories (Bandura 1986) to address: relationships/sexual health-related knowledge, skills and sexual communication self-efficacy; attitudes about gender and DRV; social norms about healthy relationships; and sexual health communication with parents. It was also informed by the social development model (Hawkins and Weiss 1985), with student participation in SHPCs and campaigns theorised to increase school engagement, and reduce risk behaviours (Gavin et al. 2010). Student campaigns drew on social marketing approaches to embed key messages across the wider school and challenge competing norms and attitudes (Fletcher et al. 2008; Hastings and McDermott 2006; Hastings and Stead 2006). The sexual health services review aimed to improve local provision and access to services.

We conducted annual phone or face-to-face interviews with the lead in each intervention school. In four case-study schools purposively sampled for diversity in student attainment in public 16+ examinations and local deprivation rates, we conducted annual interviews with three additional staff-members involved in the intervention activities. Interviews were conducted by researchers using semi-structured interview guides (copies of which are available from the corresponding author on request).

Interviews were audio-recorded and transcribed with identifiers removed and participants allocated individual alpha numeric codes, reflecting their school study ID and participant number. Data were initially coded by one researcher informed by the data and concepts in the interview guide and research question. Axial coding then identified inter-relationships between these codes, and codes were organised into themes and subthemes informed by the general theory of implementation (May 2013). Memos explained codes and themes, informing the construction of a final framework by three researchers (RP, RM and CB) who had read all transcripts (Charmaz 2014).

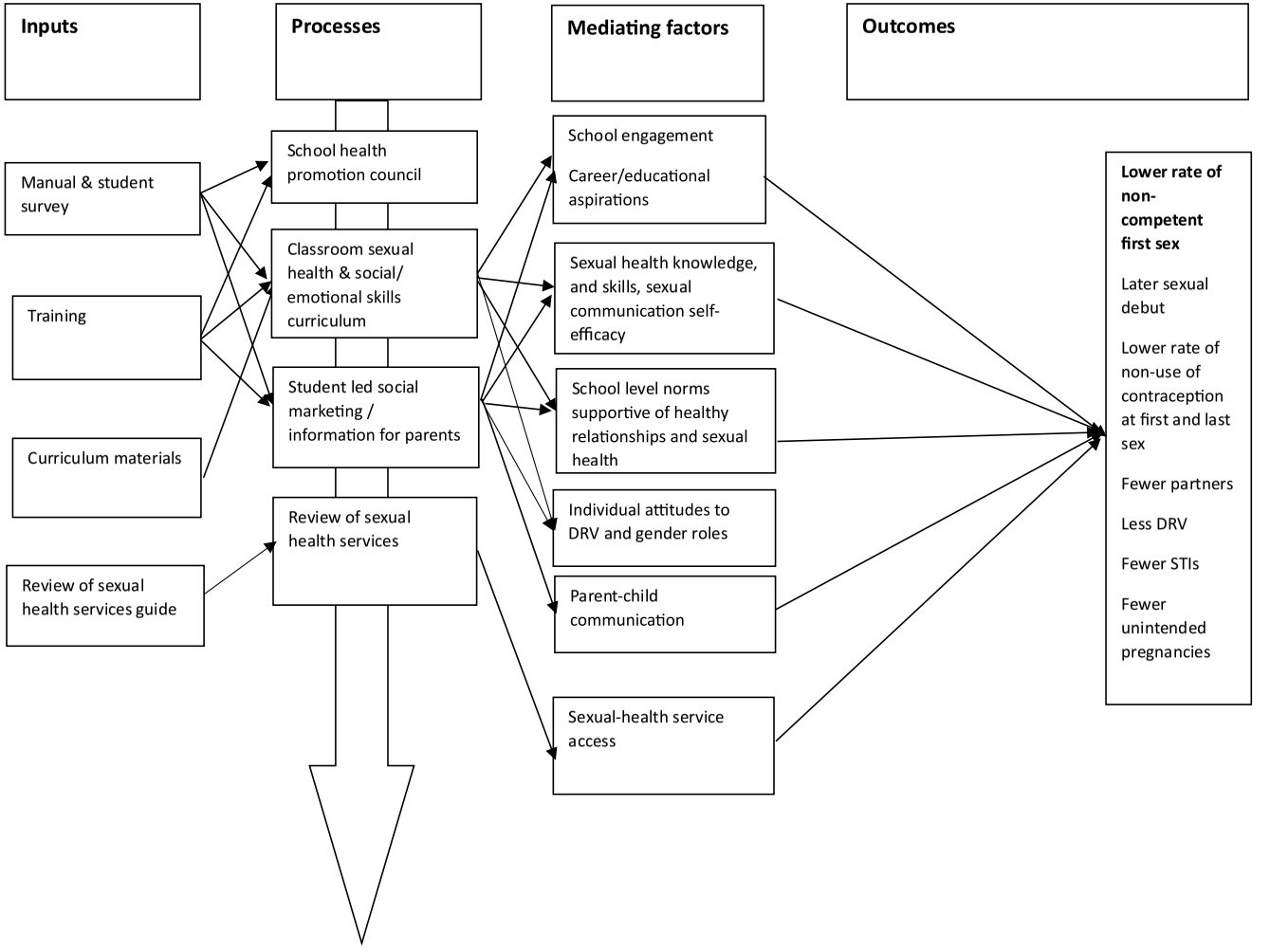

Figure 1. Positive Choices logic model.

This study was approved by the London School of Hygiene & Tropical Medicine ethics committee (Reference 26,411). Research participants received written information in advance about the study. Directly before data collection, participants received oral and written information, and could ask questions before giving signed or recorded oral consent.

Results

Twenty-five schools were allocated to the intervention and all but one proceeded with the trial (see online supplemental material Table S3). We conducted 52 interviews with staff in 22 schools (see online supplemental material Table S4). Below, we explore themes concerning how intervention capability, local capacity and staff potential affected implementation processes of sense making, cognitive participation, collective action and reflexive monitoring. Quotes are attributed using anonymised participant IDs.

Intervention capability

Quality of training and materials

School leads generally reported that the quality and comprehensiveness of the SEF-delivered training and lesson materials positively supported staff commitment and collective action to deliver Positive Choices. The curriculum training was particularly well received, with leads regularly reporting that their confidence to deliver the Positive Choices lessons, and RSE more broadly, had significantly improved as a result. Some leads also reported feeling more confident in supporting staff to deliver lessons. Opportunities provided by the training to discuss implementation with leads from other schools involved in the trial were highly valued.

However, some school leads suggested the training did not go far enough in explaining the purpose and value of the whole-school components and how these could be implemented in their setting, as one participant explained of the SHPC:

> There were ideas bandied around as part of that training. But it didn't look exactly clear as to how those sessions might be run, what the end outcome would look like, and really what we could do in the sessions to support the students. [IIW1]

This was often made more challenging where schools lacked regular mechanisms for student participation, as explored in more detail below.

The curriculum materials were highly rated for their topic coverage and comprehensiveness by those delivering lessons. Teachers reported that the topics and content covered by the curriculum were appropriate for their students, and lessons enabled them to build on and extend the RSE taught in previous years in terms of content and pedagogy. The quality and comprehensiveness of Positive Choices materials, with their detailed slides and teacher notes, could build confidence and commitment to deliver RSE among teaching staff who had previously struggled:

> We've had teachers in tears before delivering RSE because they just don't feel like they can. . . . now you go round and the teachers are much more confident, because, like, the resources are really good and they're appropriate. [ISC22]

Because of this the curriculum materials were viewed as workable by school staff, even among those that were less experienced or with little time for preparation. Staff also judged that the lessons worked well because they were inclusive of different student identities:

> It was nice actually and quite refreshing to see that the scenarios weren't just straight relationships and, a lot of them, you had that sort of mix as well … And I think that's a real positive thing. [IBM12]

However, the capability to deliver such content effectively could still depend on the individual skill and commitment of the staff member selected to deliver lessons, as explored in more detail below.

That the training and materials were provided by recognised experts in the field gave Positive Choices credibility and promoted staff commitment to the intervention. For schools looking to strengthen their delivery in the light of RSE teaching becoming a statutory requirement, gaining access to 'quality-assured' training and materials was a key attraction of Positive Choices.

Intervention fit with existing timetabling and structures

The extent to which the RSE lessons could be integrated into existing school processes and structures helped staff easily make sense of this component of the intervention, commit to its delivery and engage in collective action to implement it. Most schools had already done some work to update their RSE in line with new statutory requirements, and Positive Choices was understood by many to directly build on this:

> Yeah, so we basically agreed to that because of the government's statutory kind of guidance on RSE, PSHE … I thought it would be a really good way of enhancing what the new programme would be, in order to raise the profile of positive relationships and positive sex education. [IVT1]

Most schools already had timetabled lessons for RSE which the Positive Choices lessons could easily be slotted into. In only a few schools was implementation hampered by insufficient timetabled space for the new lessons.

However, whole-school components were often viewed as more logistically challenging to implement, with opportunities for successful integration being more complex or limited. The requirement to co-ordinate new forums and student groups to enable the SHPC and SLSM activities was described by participants as being overly demanding organisationally, and challenging to implement on top of existing workloads and responsibilities. As one dedicated PSHE lead described it:

> They are all great ideas: the marketing group, the wellbeing group. You know, they are all nice. But they are all additional tasks and they don't happen by themselves unfortunately. [ITF1]

Some school staff further reported challenges identifying a sufficient number of students to participate in multiple groups:

> You've got your student [health] promotion council and then there's the student-led social-marketing group. I think it probably would be helpful to have a slightly larger group right at the beginning that deals with everything, rather than having to recruit two separate groups.

> Because that can be time-consuming and, as we're finding now, I'm finding it difficult to recruit that social-marketing group. [IVT11]

The requirement to involve a diversity of students in the groups, including those who were less engaged with school, was also problematic for some school leads because they felt that participating students needed to be self-motivated and relied upon to drive the activities forward. Some leads further reported that the exclusive focus on relationships and sexual health could undermine the workability of the intervention because relatively few students in their schools were comfortable joining groups that focussed solely on this.

Those schools implementing student campaigns mainly drew on students participating in the SHPC to do so. In other schools, the logistical challenges of implementing whole-school components were overcome by integrating these into existing school forums and student action groups. For example, in several schools, SHPC priorities were integrated with existing student councils, while in others, student ambassadors, prefects or LGBT+ groups were drawn upon to deliver SHPC or SLSM activities. In contrast, however, one school lead described a reluctance to implement whole-school components because these were perceived to overlap with existing provision:

> If you were to go in on a blank canvas, the way you guys have done it would be great . . . The only reason we prioritised the curriculum content over some of the other things was just because of some of the things that we already have running as a school. [IGX1]

In almost all schools, a policy of not setting homework for RSE undermined the implementation of this component of the intervention.

School capacity

School norms and priorities

While in most schools there existed a strong norm supporting the delivery of RSE lessons, whole-school elements were often viewed as more discretionary and beyond 'core business' in terms of schools' perceived role in promoting sexual health. This meant that some staff made sense of Positive Choices as primarily a curriculum rather than a whole-school intervention, as one lead explained:

> I think initially it was sold to me . . . via my former line manager as these are lesson resources, because we were then trying to build up all the resources. We were trying to get you know good-quality materials to deliver and so it was sold to me in that respect and I wasn't really fully aware of all the additional sort of components. [ILK1]

In terms of the whole-school components, staff commitment and collective action to implement these was promoted where these were perceived to align with existing school norms and priorities. For example, in one school where there had been a norm of encouraging student voice over a number of years, Positive Choices was seen as making a useful contribution.

> One of the things that we've worked on as a school, particularly over the past five years or so, is, student voice: getting our student voice to where we want it to be. So [Positive Choices] was another example of being able to get some student voice in there. [IBM11]

However, in schools where these norms and ways of working with students were less established, leads could struggle to make sense of and instigate collective action implement such approaches, with some finding it difficult also to persuade colleagues about the value of whole-school components and their involvement in them. In one school, the lead further described their struggle to recruit students to the SHPC when a norm of student participation and trust between students and staff was lacking:

> One of the problems that we have . . . is our students are very reluctant to engage in anything over and above what's normally asked of them . . . And that is very typical of our students . . . And I think the [SHPC] is in some ways, you know, a demonstration of that. That they don't necessarily want to do anything more than they have to do. [IRU1]

Delivery could also be undermined where schools placed the emphasis on academic attainment. This left some leads struggling to marshal sufficient resources to deliver Positive Choices as intended:

> I think it's really hard when schools are judged on their [attainment] outcomes and we want our best outcomes for our students. So trying to take curriculum time [away from examined subjects] or buying curriculum time is really, really difficult. [ICJ1]

Teacher skill and confidence

The availability of staff cognitive resources to enable collective action to implement Positive Choices varied. Leads reported that teaching the lessons was enhanced when they could call on staff with the necessary skills and confidence to deliver lessons effectively:

> For this topic . . . to have teachers that are familiar and comfortable . . . if you've got somebody who isn't prepared to talk about these sort of things in front of a class then that's going to be felt by the students. [IBM12]

Where staff had teams working together to deliver RSE, supported with dedicated time for planning, they felt well-equipped to deliver lessons, as one teacher described:

> We talked about the language and the issues and it was really useful to have all four of us and the lead, the four people teaching the year group and the lead in a room, talking through, thinking about how we'd address things and where your boundaries are and all of that which was good. [IZE12]

However, in schools that had more limited capacity to develop their RSE teams, leads reported that they were reliant on teachers who they felt lacked expertise to deliver the more interactive and discussion-based content of the programme:

> The expertise of the staff didn't allow for perhaps so much discussion around some of the topics. When . . . you've got a designated RSE teacher who has been doing it for years, you know, some of these discussion points can go on for ages and they're great chats that the kids can have. When the staff are slightly more inexperienced in the delivery of it, I feel like they sometimes want to rush on from things a little bit. [IDL1]

In some schools, staff reported struggling to engage some groups of boys in content about consent, sexual harassment and DRV that addressed issues of gender and power in relationships and sex. These participants described some male students being resistant to or 'sceptical' [IWC21] about the teaching of such topics. They reported that schools were

increasingly 'fighting against' challenging external forces, such as online misogynist influencers [IDL1], and negative family and community views about same-sex relationships, amid a growing 'anti-woke' sentiment, highlighting a need for strategies to counter this.

In terms of whole-school components, implementation of SHPCs could sometimes be hindered by limitations in teacher skill and confidence to promote meaningful student participation and input:

> What I would say is that it's been very quiet on occasions, where it's had to be kind of led by the staff-members, in order to get any conversation out. So, it has felt at times a little bit like a mini-lesson where you're trying to prompt them to talk more about what they can do and what it all means, what the message for the school is. [ILM1]

Staff time

Time was a critical limiting factor for many schools. While some leads found the time to cascade curriculum training to colleagues, others struggled, thereby limiting their ability to create a supportive environment for the delivery of high-quality RSE, while few teaching staff were able to find time to attend SEF delivered webinars. As one participant explained:

> There's only a certain amount of staff meeting and staff training time that I can have because there are other priorities for the school as well. [ICJ1]

Lack of time also hindered the implementation of whole-school components. One lead, for example, described how implementation of SHPCs or SLSM could easily 'fall by the wayside' [IBM11] when time became squeezed by other priorities. Schools also had differing capacities to reflexively monitor their implementation of the programme and how to improve this. While leads in some schools managed to invest time in surveying parents, students or staff, others struggled to find time to reflect on progress:

> You can't always get the feedback for people to tell you how to make it better, because you can't ever meet with them. [IBM13]

Role and authority of the school lead

In schools that implemented Positive Choices well, leads reported that this was largely facilitated by their having sufficient time and authority as part of their designated role to drive implementation, as one lead explained:

> I think it needs to come from someone on the [leadership team], or potentially the lead on RSE . . . Those are the people that would need to be involved . . . I think it needs somebody high up to really drive the importance of it, so that it's respected across the whole school. [IVT11]

Where a lead lacked such authority, it could be challenging to encourage collective action among other staff to implement whole-school components, as one PSHE lead who was relatively new to her role explained:

> I'm not in a position to tell people that they're going to kind of help out in this, that would have to be my line manager. So really I put it out there to people who are working on this, but people are so busy they're not going to want to kind of just take on something extra, even though it's not a very often thing, but anyway. I just haven't got the power to forcibly do it. [ISC11]

In some schools, personal relationships with colleagues were important enablers of participation and action. Some participants, for example, described drawing on their connections with colleagues they already knew or were friends with to encourage the participation of others in SHPCs or lead SLSM groups.

Staff potential

Staff individual commitment

Staff varied in their commitment towards schools delivering RSE and promoting sexual health, and hence their commitment to implementing Positive Choices. Leads who coordinated their school's RSE generally presented themselves and their leadership teams as committed to high-quality delivery of the subject in line with statutory guidance. However, some reported that other colleagues could have less positive attitudes towards RSE, which could undermine delivery:

> I think some teachers don't see the purpose potentially of RSE, which is why I'm working really hard to raise its profile … with that, some teachers may feel a little bit awkward delivering some of the more sensitive content matter. [ILK1]

Some staff indicated their commitment to delivering the whole-school components, such as the SHPC and SLSM, stemmed from their potential to promote student voice and engage students in the reflexive monitoring and improvement of RSE. Others valued the potential of these to consolidate and build on learning from RSE:

> If they're learning about male violence towards women and girls in a session and they are seeing posters about [this] then this is, kind of, it's a holistic approach isn't it, that they're seeing it more and more pledged [around school], which I think is really important. [IDL1]

However, as indicated above, not all leads or staff understood or valued these whole-school components in this way.

Discussion

Summary of key findings

Curriculum implementation appeared more feasible than the implementation of whole-school components in most schools. Curriculum delivery was facilitated by the provision of quality training and materials alongside dedicated time and support for planning which built staff confidence. Staff individual commitments to the delivery of comprehensive RSE and schools' prioritisation of statutory requirements were also identified as enabling factors. However, many schools continued to rely on non-specialist teachers, whom leads reported could struggle to deliver the more dialogic aspects of lessons where school capacity for cascading training and providing support was limited. This may be reflected more broadly in the results of the most recent SEF poll of 1001 young people in England, in which just over half of respondents (52%) rated their school RSE 'good' or 'very good' (SEF 2025).

While prior research has reported that RSE can be effective in promoting gender-equitable attitudes (Goldfarb and Lieberman 2021), some staff in this study described difficulties addressing student resistance to topics such as consent, sexual harassment and DRV that engage with gender and power. This suggests the need for more targeted

training to equip staff with strategies to more effectively engage pupils in learning about these topics, as other authors have highlighted (Bragg et al. 2021; Setty 2025). As we report elsewhere, this was also reflected in the accounts of some male students taking part in this study, who perceived boys' views as being sidelined or felt targeted for criticism when discussing such topics (Meiksin et al. under review).

Whole-school components proved logistically less feasible to deliver than curriculum elements, with staff often having limited capacity to co-ordinate whole-school activities on top of their existing roles and responsibilities. Constraints on capacity may have been particularly acute given the timing of this study, which took place immediately after the COVID-19 pandemic when schools were grappling with increased student academic, behavioural and mental health needs.

In some schools, implementation was further undermined by a lack of recognition of the value of whole-school components which were perceived as falling beyond the core remit of schools. Staff appeared to primarily make sense of relationships and sexual health as a curricular, rather than a whole school, responsibility. Consequently, some school leads treated the different components of Positive Choices as discrete, 'loosely coupled' elements, rather than as interdependent parts of a complex intervention designed to work synergistically to promote health (Skivington et al. 2021; Weick 1976). This was in contrast to the schools recruited to the pilot which appeared more committed to addressing sexual health holistically (Bragg et al. 2022). Recruiting schools to the trial directly after the introduction of statutory RSE may have heightened schools' focus on securing quality-assured curriculum materials and training, potentially creating a situation where alignment with national policy undermined, rather than supported, the implementation of whole-school components.

Consistent with previous evidence, the effective implementation of whole-school components was facilitated by school leads having sufficient time and authority to enable collective action; trusting student/staff relationships supportive of student participation; alignment with wider school priorities beyond the teaching of RSE; and effective integration with existing institutional processes (Bragg et al. 2022; Sadjadi et al. 2021).

Limitations

Data were drawn primarily from interviews with school leads, providing in-depth accounts of those with primary responsibility for delivery. However, the data are more limited in capturing the experiences of classroom teachers and other staff involved in delivery, who may have held different perspectives. Very limited implementation by SHPCs of parent communication, beyond the statutory requirement to inform parents about lesson content, and of sexual health services review components meant that participants were only able to provide very sparse accounts of these elements, constraining the depth of analysis of processes involved in enabling these aspects of the intervention. May's general theory of implementation provided a valuable analytic framework. However, not all concepts were evident in the data. This highlights the importance of theoretically informed but empirically led analysis and the potential for theoretical refinement in the future.

Implications for research and policy

These results go some way to explaining the sub-optimal implementation and lack of effectiveness of the Positive Choices programme and, more generally, why it may be challenging to implement whole-school interventions to address relationships and sexual health within English secondary schools.

In order for such whole-school interventions to succeed, staff must have sufficient understanding, time, commitment and authority to enable these. Action should also be integrated with existing institutional processes and initiatives, where possible. Although a whole-school approach to RSE is promoted by policy (DfE 2025, 2019), clearer guidance may be required to encourage prioritisation of whole-school action alongside curriculum efforts (Gilsenan and Sundaram 2025).

In practice, it may be unrealistic to expect schools to implement multiple, discrete whole-school interventions for each specific area of health, given the overlap between these issues and the burden this places on school and teacher capacity. A more pragmatic approach might be to develop whole-school programmes which address health and wellbeing and its upstream determinants more holistically and enable schools to build on existing provision. To be effective in involving staff and students, SHPCs and similar participatory structures might require initial facilitation and ongoing support from external specialists or internal staff trained in this, as suggested by other studies (Warren et al. 2019).

While it is increasingly feasible for schools to deliver RSE in England now that this has now become a statutory requirement, the quality of provision may be compromised in some schools where teaching is delivered by staff with little expertise or commitment, or where there is student resistance to content (Pound et al. 2017; Ponsford et al. 2025). This underscores the need for schools to invest in dedicated RSE teaching provision supported through continuing professional development which includes skills-based strategies for engaging students – particularly boys – in critical dialogic discussions of gender and power. Recent Government commitments to ring-fenced funding for training to support the implementation of revised statutory RSHE guidance are welcome. However, universal access to training grounded in evidence on what constitutes effective RSE will be essential to ensure consistent, high-quality, comprehensive provision. Strengthening the RSE focus in initial teacher training is also central to ensuring teachers entering the profession are adequately equipped to deliver the subject.

Conclusion

Whole-school relationships and sexual health interventions represent promising approaches to promote sexual health and wellbeing. However, while RSE curriculum elements are increasingly feasible to implement in English secondary schools, whole-school actions can be challenging to deliver where they are not seen as a priority and sufficient time, resource and leadership authority is not allocated. While whole school approaches to RSE and violence against women and girls are increasingly advocated in England, a focus on how these approaches can be enabled and on identifying which actions are the most effective should remain a priority for policy, research and practice.

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Data availability statement

Data may be made available upon reasonable request to the study's principal investigator, Chris Bonell.

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