Faculty of Sexual and Reproductive Healthcare
of the Royal College of Obstetricians and Gynaecologists

SERVICE STANDARDS ON WORKLOAD IN SEXUAL AND REPRODUCTIVE HEALTH

Reviewed & updated: May 2009

Review Date: May 2012

27 Sussex Place, London, NW1 4RG

www.fsrh.org

Published by Clinical Standards Committee

Faculty of Sexual & Reproductive Healthcare
of the Royal College of Obstetricians and Gynaecologists

Committee members:

Dr Asha Kasliwal, Chair

Dr Louise Massey, Vice chair

Dr Ailsa Gebbie, Ex-Officio

Dr Jagruti Doshi, Trainee member

Dr Val Godfree

Dr Wendy Higson

Dr Kate Nash

Ms Lynn Heaney

Dr Jane Dickson

Ms Natika Halil, fpa Representative

Dr Louise Melvin, CEU Representative

First Published July 2005

Updated May 2009

Next review date: May 2012

SERVICE STANDARDS ON WORKLOAD IN SEXUALAND REPRODUCTIVE HEALTH

1. Standard statement on meeting population needs **Page 5**

Services should aim to meet the needs of the population which they serve

2. Standard statement on length of consultation **Page 6**

Clinics should be staffed to allow adequate time for clinical consultation, contemporaneous record keeping and associated administrative tasks, in order to provide clients with a high standard of appropriate care.

3. Standard statement on skill mix **Page 7**

Services should ensure that an appropriate skill mix of clinical staff is employed to maximise each clinician's potential to provide a high standard of care for clients.

4. Standard statement in training **Page 8**

Adequate provision should be made within clinic time for the appropriate supervision of trainees and others in a learning role.

Service Standards on Workload in Sexual and Reproductive Health

Introduction:

Within the UK there is considerable variation in sexual health service delivery, ranging from primary care/community-based contraceptive services which are separate from abortion services and genitourinary medicine services, to fully integrated sexual health services in the community.

The quality of a service can be difficult to quantify and one of the measures which can be used is the workload expected from staff. Adequate time should be given to clients, without compromising quality of advice and service.

These standards apply to dedicated Sexual and Reproductive Health (family planning) clinics working at Levels 1, 2, & 3 for contraception and levels 1 and 2 for sexually transmitted infection services as described by the National Strategy for Sexual Health and HIV for England[1].These services may be located in the community, general practice or hospital. The concept of "levels" may not be replicated in other parts of the UK, but these Faculty recommendations are valid for other health care systems.

Published work on setting standards that has been checked for compatibility include Improving Working Lives[2], Guidelines on Working Patterns for Junior Doctors[3], the recently updated European Working Time Directive[4], the Medical Foundation for AIDS & Sexual Health (MedFASH) sexual health standards[5], the Scottish Standards for Sexual Health Services[6] and the Service Standards for Sexual Health Services from the Faculty of Sexual and Reproductive Healthcare[7].

The original standards document written in 2005 was informed by a pilot questionnaire to members of the Clinical Standards Committee and an audit of length of consultations from one of the largest sexual health services, Abacus in Liverpool. An audit of those standards was undertaken in 2007. Recommendations from the audit have been taken into account when preparing this document[8].

The work of administrative and clerical staff, especially receptionists, in providing a quality service should never be underestimated, but standards for this group of staff are outside the remit of this document.

Workload includes the following components:

- Numbers of clients seen in clinics;
- Length and type of consultation, including specific procedures, e.g. IUD or implant;
- Allowances for trainees, medical students and additional activities, eg research, audit;
- Skill mix and the role of doctors, nurses, clinical support and clerical staff;
- Characteristics of the population served, e.g. minority ethnic groups, asylum seekers, those whose first language is not English, those with other special needs or disabilities.

All services using these standards should be able to audit themselves against them[9]

1. Standard statement on meeting population needs

Services should aim to meet the needs of the population which they serve[9].

1.1 Services should provide a selection of walk-in and appointment-only clinics. They should define open access both in terms of clinic provision and access to information. They should involve the local population in assessing their needs in terms of clinic mix, in conjunction with other sexual health services, eg. by using accurate local data and client surveys[10,11]. Information should be available by leaflet, internet, local telephone directories and as recorded information on an answer phone. The definition of an open access service is one to which clients can self refer from anywhere i.e. they do not need referral by a GP or other health professional. The term walk in refers to sessions for which there are no appointments.

1.2 Clients should be able to access urgent provision the same working day[7].

1.3 Clients should be able to access telephone advice on the same working day.

1.4 Clients should be able to access non-urgent information, advice or services within 2 working days[7].

1.5 For walk in clinics, waiting time should be no longer than 2 hours[7]. Appointments for procedures for long-acting methods should (if clinically appropriate) be offered within 4 weeks of initial contact.

1.6 There should be a mechanism to monitor missed telephone calls (9-5pm)[6].

1.7 Services should adhere to national targets with respect to waiting times, ie. 48 hour access to GUM, 12 weeks to first appointment, 18 weeks referral to treatment for specialist services.

1.8 Services should address workload in a way which is sensitive to the religious and cultural needs of the population, including asylum seekers eg. female staff in certain clinics, availability of chaperones[12], access to asylum seeker support.

1.9 Services should have systems in place to address the needs of those for whom English is not the first language eg. translated leaflets, access to interpreting services, audio tapes for visually impaired clients, signers for people with hearing impairment.

1.10 Commissioners and service leads should work together to ensure that a sexual and reproductive health needs assessment has been undertaken within the last 3 years to determine the pattern of service provision. This is likely to include that there should be an equivalent of at least 2 full days per week of integrated sexual health clinic provision within 30 minutes travelling time per settlement of 10,000 population[6]

1.11 There should be local co-ordination of access to different services eg. to hub-and-spoke clinics, pharmacy provision, school based services, outreach and primary care.

1.12 Clients should be able to access services at various locations and at various times of the day to suit their individual needs.

2. Standard statement on length of consultation

Clinics should be staffed to allow adequate time for clinical consultation, contemporaneous record keeping and associated administrative tasks, in order to provide clients with a high standard of appropriate care.

2.1 At least 20 minutes should be allocated to a practitioner or clinical team eg. nurse + doctor for the following consultations:

- 2.1.1 A new consultation
- 2.1.2 The first prescription of hormonal contraception
- 2.1.3 An IUD/IUS insertion
- 2.1.4 An implant insertion and/or removal
- 2.1.5 Pregnancy counselling
- 2.1.6 Male or female sterilisation counselling
- 2.1.7 A new contraceptive method

Additional time is needed when multiple issues such as cervical smear taking, sexual health screening or partner notification is also undertaken or when there is a need to address complex contraceptive problems[13,14].

2.2 At least 10 minutes should be allocated to a practitioner or clinical team for a routine follow-up appointment.

2.3 Extra time should be allotted to clients with special needs, eg. very young and those groups which have special needs as identified by individual services eg. those requiring an interpreter.

2.4 Time should be allotted within clinic sessions for contemporaneous documentation, either written or IT input.

2.5 Clinicians should work for no more than 6 hours in the clinic setting with clients without a break (of at least 20 minutes)[4].

2.6 Time should be allotted within clinic sessions for letter writing/email correspondence and related administrative work including IT data inputting.

3. Standard statement on skill mix

Services should ensure that an appropriate skill mix of clinical staff is employed to maximise each clinician's potential to provide a high standard of care for clients.

3.1 Services, but not necessarily individual clinics, should be staffed by doctors, nurses and health care assistants working as a cohesive clinical team, to provide a high standard of effective care for clients and well organised clinic facilities.

3.2 Services should have appropriate senior staff input. When provided, independent nurse clinics should be appropriately supported[7] by the presence of a doctor or senior nurse in the building or accessible by telephone.

3.3 Services should have in place mechanisms to support all clinicians to continue appropriate development, through ongoing training and other initiatives, including appropriately supported patient group directions (PGDs)[7] and standardisation of delivery of care.

3.4 Time should be allocated within the working week for reflective practice, liaison with colleagues and personal development.

4. Standard statement in training

Adequate provision should be made within clinic time for the appropriate supervision of trainees and others in a learning role.

4.1 Clinicians supporting a trainee should have appropriate allocated time, both within and outside clinic time eg. 20% fewer clients in clinics[15] where training is taking place, longer appointment times or additional staff members with appropriate skill mix.

4.2 There should be on going encouragement of regular appropriately trained staff to become mentors/trainers.

References

1. Department of Health. The National Strategy for Sexual Health & HIV. DH 2001.

2. Department of Health. Improving Working Lives Standard: Department of Health. DH 2000. www.dh.gov.uk/iwl

3. Department of Health. Guidance on Working Patterns for Junior Doctors. DH 2002; http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009547

4. European Working Time Directive: February 2008

5. Medical Foundation for AIDS & Sexual Health. Recommended Standards for Sexual Health Services. March2005. www.medfash.org.uk/

6. Standards for Sexual health services- Scotland- NHS Quality Improvement Scotland March 2008. www.nhshealthquality.org

7. Faculty of Sexual and Reproductive Healthcare of the RCOG. Service Standards for Sexual Health Services: (FFPRHC 2006). www.fsrh.org

8. Faculty of Sexual and Reproductive Healthcare of the RCOG. Audit of standards for workload in contraception (April 2007). www.fsrh.org

9. Royal College of Obstetricians and Gynaecologists. Understanding Audit. RCOG 2003.

10. Royal College of Obstetricians and Gynaecologists. Patient Involvement in enhancing service provision – Clinical Governance Advice No. 4. RCOG Press 2002.

11. www.doh.gov.uk/involvingpatients/

12. NHS Clinical Governance support team-guidance on chaperones www.nhs.uk

13. NICE Guidance on Prevention of sexually transmitted infections and under 18s conceptions. www.nice.org.uk

14. Evaluation of one stop shop models of sexual health provision February 2008. www.dh.gov.uk

15. British Association of Dermatologists www.bad.org.uk