SERVICE STANDARDS FOR SEXUAL AND REPRODUCTIVE HEALTHCARE

Introduction

These Service Standards have been developed by the Faculty of Sexual and Reproductive Healthcare (FSRH) to support both providers and commissioners in providing safe, high-quality sexual and reproductive health services. They are based on current evidence of best practice. The Standards are recommended for use by all providers commissioned or contracted by the National Health Service (NHS) or Local Authorities who provide and manage all aspects of contraception and sexual health. It also covers services providing pregnancy planning, pregnancy choices, abortion, community gynaecology, sexual wellbeing and health promotion. There are some areas where the standards indicate that they are for specific service types such as Specialist Community SRH services.

The Standards have been developed to be applicable to all countries in the UK. Key documents from England, Scotland, Wales and Northern Ireland have been used to inform their production and they have been subject to consultation in the four countries. These standards can be applied irrespective of the commissioning system in operation.

This core document outlines **eleven** general service standard statements. Standards have also been produced by the Clinical Standards Committee of the FSRH in relation to specific issues e.g. medicines management and resuscitation, which can be found in the appendices and also on the FSRH website. The Standards are auditable and have been developed by the committee by a process of review of all evidence of best practice. This process is repeated every 3 years with new evidence incorporated. After each Standard is reviewed it is placed onto the FSRH website for consultation. This is an ongoing process hence each document has a different review date.

There has been variation in the background of clinical leaders of community SRH services. All services should have appropriately trained leadership to ensure quality of service provision, service development, patient safety, training and clinical governance **(Standard Statement 1)**. It is envisaged that all specialist SRH services should be consultant-led and should link with other contraceptive care providers, e.g. general practice, to provide support. Specialist services should engage with local commissioners and have an active role in planning sexual health services in their area.

Services should provide comprehensive sexual and reproductive healthcare **(Standard Statement 2)**. There should be access to all methods of contraception including emergency intrauterine device (IUD) insertion; pregnancy and abortion advice; screening of sexually transmitted infections and treatment where appropriate, partner notification, community gynaecology and psychosexual assessment. Where in-house services are not available, patients should be referred in a timely manner. Services should conform to the Service Standard; **Workload in Services** (**Appendix 1)**.

Services need to be patient focussed ensuring good communication, and provide clear patient information **(Standard Statement 3)**. There should be patient pathways and services should adhere to FSRH Standards on **Consent (Appendix 2)** and **Confidentiality (Appendix 3).**

Services should demonstrate that user and public involvement has been fundamental to the planning, development, provision, monitoring and evaluation of a service (**Standard**

Statement 4). User engagement should be encouraged on a regular basis, and evidence provided that it has been incorporated into the process.

Services should provide open access with a mixture of booked appointments and 'walk-in' clinics **(Standard Statement 5)**. There should be information available about the timing of services and there should be easy and non-discriminatory access for all.

All staff working in SRH services should be appropriately trained **(Standard Statement 6)**. For doctors, the minimum standard would be the of the Diploma of the Faculty of Sexual and Reproductive Healthcare(DFSRH) and it is intended that the Nurse Diploma for Sexual and Reproductive Healthcare will become the optimal qualification for nurses. For those performing intrauterine and subdermal procedures, appropriate Letters of Competence should be held and competency maintained. All other health professionals working in all levels of SRH services should be trained to the competencies laid down by their educational bodies and administrative staff trained to deliver confidential and patient-focussed care.

SRH service provision should be evidence-based, which will include the use of national and local guidelines and policies **(Standard Statement 7)**. This document outlines which standards should be used for different aspects of service provision. A comprehensive list of clinical standards produced by the Clinical Standards Committee can be found on the FSRH website and should be used to inform specific issues, for example **Resuscitation (Appendix 4)** and **Medicines Management (Appendix 5)**.

All clients seeking SRH services should be confident that their right to confidentiality will be respected **(Standard Statement 8).** Record keeping should be of a high standard to provide maximum benefit in patient management and to facilitate audit and record the process of obtaining valid consent **(Standard Statement 9)**. Services should work to the Service Standards for **Record Keeping (Appendix 6)**.

Increasingly, nurses are working autonomously in SRH services and their role should be supported and developed **(Standard Statement 10)**. Finally, all services should continually monitor and evaluate themselves in order to maintain and improve performance **(Standard Statement 11)**. A process of **Risk Management** should be evident to ensure that services provide safe, high quality patient care **(Appendix 7)**.

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Scope of the Document

This document is intended to make recommendations with regard to service quality and can be used to maintain levels of excellence and to inform commissioners and all other providers as they plan SRH services for the future.

Introduction[1]

Within UK countries there is considerable variation in how SRH services are provided. These vary from distinctly separate general practice and community-based contraceptive provision with hospital-based abortion and genitourinary medicine services, to fully integrated SRH services in the community.

The FSRH acknowledges the great differences that exist between services and this document provides a framework of standards, which can be applied to all SRH services to enable equitable service provision. These include services within general practice, hospital- and community-based clinics and pharmacies, as well as voluntary and independent-sector organisations.

This document incorporates elements from the following key documents and is based on available evidence and best practice where evidence is lacking:

- FSRH. Better care a better future: a new vision for sexual and reproductive healthcare in the UK[1]
- Department of Health. A Framework for Sexual Health Improvement in England.[2]
- The Scottish Strategy, *Respect and Responsibility*[3]
- Sexual Health Services Standards 2008 Healthcare Improvement Scotland[5]
- The Medical Foundation for AIDS & Sexual Health (MedFASH) *Recommended Standards for Sexual Health Services*[4]
- Sexual Health and Wellbeing Action plan for Wales 2010 – 2015 WAG[6]
- Investing for Health, Sexual Health Promotion (Northern Ireland Strategy)[9]
- BASHH Standards for the Management of STIs[7]
- Public Health Outcomes Framework (first published 2012 Department of Health)
- A Quality Standard for Contraception Services FSRH April 2014 [8] http://www.fsrh.org/pdfs/FSRHQualityStandardContraceptiveServices.pdf

1. Standard Statement on Leadership

All sexual and reproductive health services should be led by appropriately trained clinical and managerial personnel to ensure quality of service provision, service development, training and clinical governance.

Currently there is considerable variation in the background, training and experience of consultants/lead clinicians working in community-based SRH services. This is due to the absence of appropriately structured training programmes in the past. It is expected that all Level 3 services in future will become consultant-led. These consultants will have the postgraduate qualification and structured training approved by the FSRH/the Royal College of Obstetricians and Gynaecologists (RCOG), the Academy of Royal Medical Colleges, and the General Medical Council (GMC).

1.1 All SRH services at Level 3 as specified in the Framework for Sexual Health Improvement in England[2], and equivalent services in the rest of the UK, should be **consultant-led** with one full-time consultant per population of 125,000. The consultant should be accredited in SRH and hold Membership of the Faculty of Sexual and Reproductive Healthcare (MFSRH) to ensure adequate quality of service provision, training, clinical governance and risk management across all three levels of service provision.[8]

1.2 Consultant leads should not work in isolation and should be supported by consultant colleagues and a team of associate specialists/specialty doctors, specialty trainees and other specialists in SRH. Where this is geographically not possible clinical networks should be developed.

1.3 Specialist services should collaborate with other services providing SRH to support quality of clinical service provision and provide clinical governance.[2,4]

2. Standard Statement on Service Provision

Service provision should include a range of sexual and reproductive health services.

2.1 Contraception

2.1.1 SRH services should provide unrestricted open access services with clear clinical pathways. They should be supported as appropriate by clinical networks between providers commissioned through different routes i.e. Local Authorities, Clinical Commissioning Groups and Public Health England[10,11]

2.1.2 Access to and availability of the full range of contraceptive methods should be provided and include choice within products (e.g. a range of different combined hormonal contraceptives and intrauterine contraception) to maximise patient acceptability.[11,12]

2.1.3 Provision of counselling, direct referral and signposting for male and female sterilisation.[8]

2.1.4 Provision of emergency contraception, including timely access for postcoital IUD insertion.[2,10,13]

2.2 Pregnancy and abortion

2.2.1 Services should provide basic counselling/information for pregnancy planning and preconception care.[4,10]

2.2.2 Services should offer pregnancy testing with immediate results at point of care .[4]

2.2.3 Services should offer women with unplanned pregnancy access to empathetic, unbiased information and decision support.[2,4]

2.2.4 Referral to abortion services should be available without delay, including the option of self ref – this should meet the standards set out in the current RCOG abortion guidelines.[14,15]

2.2.5 Abortion providers should include advice and facilitate supply of a full range of contraceptive methods as part of the episode of care (including insertion of intrauterine contraception and implants where clinically appropriate). This may be provided by close liaison or integration with contraceptive services.[14]

2.3 Screening

2.3.1 Cervical cytology screening should be available in line with national[16] and local guidelines.

2.3.2 Services should offer screening for Chlamydia infection (including as per NCSP) with protocols for treatment and partner notification, or appropriate onward referral, according to national guidelines.[16]

2.4 Sexually transmitted infection (STI) services

2.4.1 Services should offer advice and information (through a variety of media) on STIs, including HIV .[4,10,11]

2.4.2 Appropriate testing, treatment and partner notification for STIs for both men and women should be available through all SRH services, with onward timely referral to more specialist services when appropriate.[4]

2.5 Psychosexual services

2.5.1 Services should offer psychosexual counselling or appropriate onward referral.[2,10]

2.5.2 Services should offer people with organic sexual dysfunction treatment or appropriate onward referral.[2]

2.6 Other reproductive health services

2.6.1 Services should offer advice and information on medical gynaecological issues such as menopause, premenstrual syndrome, and menstrual dysfunction, and onward timely referral to appropriate services.

2.7 Services for patients with special needs

2.7.1 Appropriate arrangements should be in place to enable patients with special needs to access SRH services without undue delay [4] for example

- Young people (including those in local authority care)
- Patients with communication difficulties
- Patients with physical or learning difficulties
- Complainants of sexual assault
- Sex workers

2.7.2 Outreach services should be provided for patients unable to access mainstream services.[10]

2.8 Training and support in SRH

2.8.1 Specialist services should have structures in place to provide easily accessible clinical advice and support to professionals working in other services including those in primary care.[2]

2.8.2 Specialist services should have structures in place to provide and support training in sexual and reproductive healthcare in line with FSRH guidance [4]

2.9 Sexual Health Networks (or Referral pathways between services)

2.9.1 Specialist services should be involved in establishing local Sexual Health Networks[4,11] and there should be clear referral pathways between services.

3. Standard Statement on Patient Focus

Services need to be patient-focussed ensuring good communication, clear patient information and working to Faculty standards on consent and confidentiality.

3.1 SRH service providers should ensure clear information is available to patients regarding timing and location of all services provided, through a variety of media. Services should be advertised through easily available routes such as /websites/local press/leaflets.[4,18]

3.2 If the provider does not offer certain services, clear information on alternative sources for service provision locally should be made available.[4,18]

3.3 Services should be organised so that the user finds them easy to navigate.[4]

3.4 Objective, evidence-based resources such as those created by Family Planning Association (FPA) and NHS choices should be available in a variety of media appropriate to the patient's preferences. There should be a choice of languages/formats appropriate to the patient groups served by the provider, including those with sensory impairment.[4,18]

3.6 Consultations should be conducted with due regard to the privacy of patients regardless of age, gender and sexual orientation.[4,18]

3.7 Adequate time should be given for all consultations.[19] First visits, initial counselling and provision of all contraceptive methods, STI treatment and partner notification, counselling for sterilisation/vasectomy and referral, pregnancy information, decision support and referral for abortion, will require more time compared to uncomplicated repeat visits for supply of hormonal contraception.

3.8 Patients undergoing intimate examinations should be offered the presence of a chaperone, irrespective of the gender of the clinician[20,21]here should be prominent notices displayed in the waiting and clinical rooms informing patients of their right to request a chaperone if desired.

3.9 The Department of Health's *You're Welcome* criteria should be met by services.[18]

4. Standard Statement on User and Public Involvement

Services should demonstrate that user and public involvement is fundamental to service development, provision, monitoring and evaluation.[22–24]

4.1 An annual user and public involvement plan should be developed and supported by an annual friends and family test[58]

4.2 User engagement should be encouraged (e.g. with suggestion and comments boxes in clinics and regular user satisfaction surveys). An example of a validated patient satisfaction questionnaire is attached as Annex A.

4.3 The patients' compliments/comments/complaints procedure should be clearly displayed in clinical and waiting rooms.[25]

4.4 Services should respond appropriately to user feedback.

4.5 Public consultation is essential when service redesign or development is planned. This includes involving 'seldom heard' groups, and collaboration and partnership working with the voluntary and community sectors.

5. Standard Statement on Access

There should be easy and quick non-discriminatory access to sexual and reproductive health services for all.

5.1 There should be effective local co-ordination of access to SRH services.[2,4]

5.2 Service providers should clearly advertise location, opening times, and services provided, and keep the FPA, NHS Direct and NHS 24 fully informed. They should have an answering machine outside opening hours to give information on opening times and services including emergency contraception. They should have mechanisms to monitor missed phone calls.[4]

5.3 There should be choice in terms of times (daytime/evening/weekend) and types of clinic/practice services for the population served (walk-in/appointment).[4]

5.4 Clinics should be in easily accessible/convenient locations and clearly signposted.[4]

5.5 It should be possible for patients to access emergency contraceptive services (within the required timeframe). This should be provided on the same day on weekdays . In rural areas where specialist clinics may not be accessible locally throughout the week, development of appropriate alternative services should be addressed.[4,13]

5.6 Arrangements for appropriate provision of emergency contraception as well as contraceptive supplies over weekends and public holidays should be in place eg with local pharmacies.[11]

5.7 Advance provision of emergency hormonal contraception and instructions on use should be offered to all patients where appropriate.[13]

5.8 Walk-in clinics should be adequately staffed to provide safe medical practice and ensure a maximum waiting time of 2 hours.[10]

5.9 Services that operate an appointment system instead of walk-in clinics should provide appointments within 2 working days for routine consultations.[4]

6. Standard Statement on Training

All staff working in sexual and reproductive health services should receive appropriate training and must maintain their skills.

6.1 All health professionals' providing contraception within SRH services should hold a current diploma in Sexual and Reproductive Healthcare (NDFSRH or DFSRH) or be trained to equivalent competencies as stipulated by their educational bodies and show evidence of accreditation.[27, 28, 63]

6.2 All doctors and nurses offering IUD, intrauterine system (IUS) and contraceptive implant insertion should hold the Letter of Competence in Intrauterine Techniques (LoC IUT) and Subdermal Contraceptive Implants (LoC SDI) of the FSRH or have achieved equivalent competencies. [29, 30]

6.3 All health professionals holding the NDFSRH or DFSRH and Letters of Competence should be actively collecting evidence to support their re-accreditation.[60]

6.4 All health professionals, including pharmacists and Health Care Technicians working in SRH services should be trained to the competencies laid down by their educational body.[31,32,33]

6.5 All administrative staff involved in SRH services should receive appropriate training, including confidentiality, child protection and customer care.[64]

6.6 Dedicated young people's services, and those working with special needs and vulnerable groups, should be staffed by health professionals who have an understanding of adolescent development and experience of working with young and vulnerable people, including training in CSE and safeguarding. [34,35,36, 61]

7. Standard Statement on Clinical Practice

Sexual and reproductive health service provision should be evidence-based, which will include the use of national and local guidelines and policies.

SRH services should have the following local policies in place:

7.1 Policies governing SRH service provision should follow the guidelines outlined in the Department of Health document ;Commissioning regional and local HIV, sexual and reproductive health services .Clinical policies for the management of sexual infections and contraception provision should be based upon nationally recognised guidelines, for example BASHH guidelines, FSRH guidelines and standards, and NICE. [2,8, 10, 11, 37, 38, 63]

7.2 Policies governing abortion that should follow current RCOG abortion guidelines.[14]

7.3 Policies relating to child protection/safeguarding children[34, 61] and vulnerable adults[36] that follow national guidelines.

7.4 Policies that address the recommendations in the Framework for Sexual Health in England [2] its implementation plan and commissioning toolkit [10] and the sexual health promotion toolkit[10] or its equivalent in other UK countries[5,6,9]

7.5 Policies that address MEDFASH recommended standards for sexual health services.[4]

7.6 Locally applicable standards for administrative staff.

7.7 Appropriately managed IT services and provision for staff to access up-to-date guidance on using and storing electronic information[62]

7.8 Services should aim to achieve standardisation of delivery of care (e.g. record keeping) as described in the Faculty standards.[40]

7.9 Services should work to Faculty standards on record keeping, medicines management, resuscitation and obtaining consent in sexual health services.[40–43]

8. Standard Statement on Confidentiality

All users seeking sexual and reproductive health services should be made aware that their right to confidentiality will be respected and maintained in line with GMC, NMC and other professional bodies' recommendations.[44–46]

8.1 Services should prominently display their confidentiality statement at their premises. [44- 46, 50]

8.2 Confidentiality training should be provided to all staff. [48, 50]

8.3 Staff providing SRH services to young people and vulnerable adults should be familiar with the law, and local and national policies, with regard to confidentiality and specifically Fraser Guidelines, and attend regular safeguarding training.[34, 35,44,45,46, 48, 50]

8.4 Patients should have the assurance of confidentiality with regard to their consultations regardless of age, gender, sexual orientation, religion or ethnicity unless the clinician has concerns about wellbeing and/or safety of the patient or others.[44,45]

8.5 Staff should be aware of policies both local and national for sharing patient information[59]

8.6 Services should work to the FSRH Confidentiality Standards.[50]

9. Standard Statement on Record Keeping

Record keeping in all services should be of a high standard, to provide maximum benefit in patient management, to facilitate audit and record the process of obtaining valid consent.[45]

9.1 All services should work to the Faculty Record Keeping Standards.[40]

9.2 The offer of a chaperone during an intimate examination should be documented. If it is accepted or declined, this should also be clearly recorded in the notes including the name of the chaperone (see also 2.8.).[20, 41]

9.3 In line with new guidance, services should screen for, and record cases of CSE and FGM and submit reports as per local and national policy [61,67]

9.4 Clinical records must be kept confidential at all times. For those using paper notes these should be stored in a secure place as per your local guidelines.[40] Adequate protection of electronic patient records (EPR) should also be enforced.[59]

9.5 All record systems, whether written or computerised, must have processes in place that follow the Caldicott Guidelines[51] and are compatible with the Data Protection and Freedom of Information Acts.[52, 53]. All staff working in SRH should be familiar with and receive regular information governance and data protection training

9.6 In recognition of the work being developed by the Department of Health in England on a common Sexual and Reproductive Health Activity Dataset (SRHAD) and similar work in the other UK countries, all services should be working towards computerised systems.[54] Data should be submitted to commissioners and the appropriate body in a timely and appropriate manner.

9.7 Contemporaneous, legible and signed records of consultations must be maintained. Each entry in electronic records should include the name of the clinician (who will be logged on to the system as a registered user).[40]

10. Standard Statement on Nurse-Led Service Provision

The role of nurses in sexual and reproductive health service provision should be enhanced.[39]

10.1 Services should have mechanisms in place to support nurses to supply and administer, or prescribe all methods of contraception, either through adequately supported patient group directions and/or nurse prescribing initiatives for example non-medical prescribing.[55, 63]

10.2 Experienced nurses working in contraception should, when appropriate, be supported to acquire competencies for intrauterine and sub dermal implant techniques and other new technologies as they are developed. They should also be supported when appropriate to attain the NDFSRH or become Faculty-registered nurse trainers.[63]

10.3 Services should fully develop the scope of nurses in service delivery including adequately supported fully nurse-led clinics providing the full range of SRH services, including counselling for abortion, menopause and vasectomy.[63] Services should be encouraged to develop a mentoring programme for all their staff with regular one-to-one training and annual appraisal.[65]

10.4 Other health care practitioners who work alongside and support nurses (ie. Health Advisors and Health Care Assistants) should have a job plan and be encouraged by the service to develop their roles, including active participation in audit and service development

11. Standard Statement on Monitoring and Evaluation

All services should continually monitor and evaluate themselves in order to maintain and improve performance.

11.1 All providers should have a programme in place to regularly audit clinical service provision[4, 56] in terms of quality as well as access, process and outcome issues from a consumer viewpoint. This should include auditing complaints and near misses. The results of audits should be acted upon to ensure appropriate improvements in service provision.

11.2 Commissioners and local authority providers for sexual health, together with specialist services, should establish structures and processes for the monitoring and evaluation of initiatives introduced to improve local sexual healthcare provision[4]. These should include the identification of any inequality gaps which may exist within their local services through needs assessment. User involvement is essential in this process.[4, 10]

11.3 Sexual health commissioners should assess the need for sexual health service provision and the inequality gap in accessing the service on regular bases to inform service models[66]

11.4 All services should provide quarterly reports (e.g. SRHAD) to the appropriate body in a timely manner.[54]

11.5 Services should work to FSRH standards for risk management.[57]

References

1. FSRH. Better care, a better future: A new vision for sexual and reproductive healthcare in the UK (November 2015): http://www.fsrh.org/pdfs/FSRH_Vision.pdf

2. Department of Health. A Framework for Sexual Health Improvement in England (March 2013) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/142592/9287-2900714-TSO-SexualHealthPolicyNW_ACCESSIBLE.pdf

3. Scottish Executive. Respect and Responsibility. Strategy and Action Plan for Improving Sexual Health. January 2005. http://www.gov.scot/Publications/2005/01/20603/content

4. Medical Foundation for AIDS & Sexual Health (MEDFASH). Recommended Standards for Sexual Health Services. http://www.medfash.org.uk/uploads/files/p18dtqli8116261rv19i61rh9n2k4.pdf

5. NHS Quality Improvement Scotland. Sexual Health Services – Standards. March 2008. http://www.healthcareimprovementscotland.org/previous_resources/standards/sexual_health_services_final_s.aspx

6. Welsh Assembly Government. Sexual Health and Wellbeing Action Plan for Wales, 2010–2015. June 2010. http://www.shnwales.org.uk/Documents/485/Strategy%20(English).pdf

7. BASSH. Standards for the Management of Sexually Transmitted Infections, January 2010. http://www.bashh.org/documents/2513.pdf

8. FSRH. A Quality Standard for Contraceptive Services. http://www.fsrh.org/pdfs/FSRHQualityStandardContraceptiveServices.pdf

9. Department of Health, Social Services and Public Safety; Sexual Health Promotion; Strategy and Action Plan 2008–2013. November 2008. www.dhsspsni.gov.uk
Sexual Health Promotion Strategy addendum (Dec 2015)

   Letter from the Health Minister – addendum to Sexual Health Promotion Strategy and Action Plan (March 2014)

10. Department of Health. Commissioning local and regional HIV and sexual and reproductive health services. November 2013. https://www.gov.uk/guidance/commissioning-regional-and-local-sexual-health-services

11. Department of Health. Commissioning Sexual Health Services and Interventions: Best Practice Guidance for Local Authorities. March 2013.

https://www.gov.uk/government/publications/commissioning-sexual-health-services-and-interventions-best-practice-guidance-for-local-authorities Last updated 14th January 2015

12. National Institute for Clinical Excellence. Long-acting reversible contraception. October 2005. https://www.nice.org.uk/guidance/cg30

13. Faculty of Sexual and Reproductive Healthcare (FSRH) Guidance. Emergency Contraception. August 2011, further updated January 2012 http://www.fsrh.org/pdfs/CEUguidanceEmergencyContraception11.pdf

14. Royal College of Obstetricians and Gynaecologists (RCOG). The Care of Women Requesting Induced Abortion - Evidence-based Guideline (No. 7). Updated February 2012. https://www.rcog.org.uk/en/guidelines-research-services/guidelines/the-care-of-women-requesting-induced-abortion/

15. Teenage Pregnancy Independent Advisory Group. Contraception and Sexual Health Services for Young People. June 2009. http://www.apho.org.uk/resource/view.aspx?RID=74843

16. PHE. National Cervical Screening Overview https://www.gov.uk/guidance/cervical-screening-programme-overview

17. PHE. National Chlamydia Screening Programme. http://www.chlamydiascreening.nhs.uk/

18. Department of Health. Quality criteria for young people friendly health services. April 2011. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216350/dh_127632.pdf

19. Faculty of Sexual and Reproductive Healthcare (FSRH). Service standards on workload in sexual and reproductive health. July 2013 http://www.fsrh.org/pdfs/ServiceStandardsWorkload.pdf

20. General Medical Council (GMC). Guidance on Good Practice - Intimate Examinations. http://www.gmc-uk.org/guidance/ethical_guidance/21168.asp

21. Royal College of Obstetricians and Gynaecologists (RCOG). Gynaecological Examinations: Guidelines for Specialist Practice. RCOG Press. 2002. www.rcog.org.uk/

22. Department of Health. National Health Service Act 2006, Section 242 (1B). http://www.legislation.gov.uk/ukpga/2006/41/contents

23. Department of Health. Guidance. Real Involvement: Working with People to Improve Services. October 2008. www.dh.gov.uk

24. Department of Health. The Operating Framework for the NHS in England 2011/12. December 2015 (updated annually). www.dh.gov.uk

25. Department of Health. NHS Complaints Procedure. http://www.nhs.uk/choiceintheNHS/Rightsandpledges/complaints/Pages/NHScomplaints.aspxhttp://www.dh.gov.uk/

26. Department of Health. Waiting Times for First Outpatient Appointments in England. https://www.england.nhs.uk/statistics/tag/outpatients/

27. General Medical Council (GMC). Licensing and Revalidation. http://www.gmc-uk.org/doctors/revalidation.asp

28. Faculty of Sexual and Reproductive Healthcare (FSRH). Training Requirements for the Diplomate assessment of the Faculty of Sexual and Reproductive Healthcare. October 2015. http://www.fsrh.org/pdfs/DiplomaTrainingRequirements.pdf

29. Faculty of Sexual and Reproductive Healthcare (FSRH). Letter of Competence in Intra-uterine Techniques. January 2010. http://www.fsrh.org/pages/Letter_of_Competence_IUT.asp

30. Faculty of Sexual and Reproductive Healthcare (FSRH). Letter of Competence in Subdermal Implants. September 2010. http://www.fsrh.org/pages/Letter_of_Competence_SDI.asp

31. Royal College of Nursing. Sexual Health Competencies: An Integrated Career and Competency Framework for Sexual and Reproductive Health Nursing. 2009 www.rcn.org.uk

32. Royal Pharmaceutical Society (RPS) http://www.rpharms.com/home/home.asp

33. The Pharmaceutical Society of Northern Ireland. www.psni.org.uk/

34. Department of Health, Home Office, Department for Education and Skills. Working Together to Safeguard Children. March 2015. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf

35. Department of Health. Best Practice Guidance for Doctors and Other Health Professionals on the Provision of Advice and Treatment to Young People Under 16 on Contraception and Sexual Health. July 2004. www.dh.gov.uk

36. Department of Health. Protection of Vulnerable Adults Scheme. 2009. www.dh.gov.uk

37. Faculty of Sexual and Reproductive Healthcare (FSRH). UK Selected Practice Recommendations for Contraceptive Use. 2002. www.fsrh.org

38. British Association of Sexual Health and HIV (BASHH). Clinical Effectiveness Guidelines. Various dates. www.bashh.org/guidelines

39. Department of Health. Commissioning local and regional HIV and sexual and reproductive health services. November 2013. https://www.gov.uk/guidance/commissioning-regional-and-local-sexual-health-services

40. Faculty of Sexual and Reproductive Healthcare (FSRH).
Service Standards for Record Keeping in Contraception in Sexual and Reproductive Health Services (2014)
http://www.fsrh.org/pdfs/ServiceStandardsRecordKeeping.pdf

41. Faculty of Sexual and Reproductive Healthcare (FSRH).
Service Standards for Medicine Management in Sexual and Reproductive Health Services (2014)
http://www.fsrh.org/pdfs/ServiceStandardsMedicinesManagement.pdf

42. Faculty of Sexual and Reproductive Healthcare (FSRH).
Service Standards for Resuscitation in Sexual and Reproductive Health Services (2013)
http://www.fsrh.org/pdfs/Resucitation_January_2013.pdf

43. Faculty of Sexual and Reproductive Healthcare (FSRH).
Service Standards on Obtaining Valid Consent in Sexual Health Services (2014)
http://www.fsrh.org/pdfs/ServiceStandardsObtainingValidConsent.pdf

44. General Medical Council (GMC). Guidance on Good Practice - Confidentiality: Protecting and Providing Information. October 2009. www.gmc-uk.org

45. Nursing and Midwifery Council. The Code: professional standards of practice and behaviour for nurses and midwives (2015)
https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf

46. Royal Pharmaceutical Society: pharmacy law and ethics http://www.rpharms.com/support-resources/pharmacy-law-and-ethics.asphttp://www.rpharms.com/support-resources/pharmacy-law-and-ethics.asp

47. Adults with Incapacity (Scotland) Act. February 2008. http://www.gov.scot/Publications/2008/02/01151101/0

48. General Medical Council (GMC) 0-18 Guidance for all doctors http://www.gmc-uk.org/guidance/ethical_guidance/children_guidance_index.asp

49. General Medical Council (GMC). Consent: Patients and Doctors Making Decisions Together. June 2008. http://www.gmcuk.org/guidance/ethical_guidance/consent_guidance_index.asphttp:

50. Faculty of Sexual and Reproductive Healthcare (FSRH). Service Standards on Confidentiality. October 2015. http://www.fsrh.org/pdfs/ServiceStandardsConfidentiality.pdf

51. Department of Health. Caldicott information government review: Department of Health response. September 2013 https://www.gov.uk/government/publications/caldicott-information-governance-review-department-of-health-response

52. Data Protection Act 1998. http://www.legislation.gov.uk/ukpga/1998/29/contents

53. Freedom of Information Act 2000. http://www.legislation.gov.uk/ukpga/2000/36/contents

54. Public Health England. Genitourinary medicine clinical activity dataset (GUMCASv2). April 2015. https://www.gov.uk/guidance/genitourinary-medicine-clinic-activity-dataset-gumcadv2

55. Royal College of Nurses. Nurse Prescribing. https://www.rcn.org.uk/get-help/rcn-advice/nurse-prescribing

56. Royal College of Obstetricians and Gynaecologists (RCOG). Understanding Audit. Clinical Governance Advice No. 5. RCOG Press. October 2003. www.rcog.org.uk/

57. Faculty of Sexual and Reproductive Healthcare (FSRH). Service Standards for Risk Management. July 2014. http://www.fsrh.org/pdfs/ServiceStandardsRiskManagement.pdf

58. NHS England. Friends and Family test Guidance. https://www.england.nhs.uk/ourwork/pe/fft/

59. NHS England. Information Governance https://www.england.nhs.uk/ourwork/tsd/ig/

60. FSRH. Supporting Doctors' Appraisal and Revalidation in Sexual and Reproductive Healthcare http://www.fsrh.org/pdfs/SupportingDoctorsAppraisalRevalidation.pdf

61. BASHH. Spotting the Signs: CSE Proforma http://www.bashh.org/BASHH/News/News_Items/Spotting_the_Signs_-_CSE_Proforma.aspx

62. NHS. The Care Record Guarantee http://systems.hscic.gov.uk/rasmaFcarertcards/documents/crg.pdf

63. FSRH. The NDFSRH (Nurse Diploma) http://www.fsrh.org/pdfs/Nurses_Academic_Credits19Aug.pdf

64. The Health Foundation. Improving quality in General Practice .Evidence scan No 23, November 2014 www.health.org.uk/sites/default/.../ImprovingQualityInGeneralPractice

65. Nursing and Midwifery Council. How to revalidate with NMC. December 2015 http://revalidation.nmc.org.uk/

66. PHE. Making it work: A guide to whole system commissioning for Sexual Health, Reproductive Health and HIV. March 2015 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408357/Making_it_work_revised_March_2015.pdf

67. Department of Health. Female Genital Mutilation: Risk and Safeguarding- Guidance for Professionals. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/418564/2903800_DH_FGM_Accessible_v0.1.pdf