
“Setting standards in contraception - improving sexual health for all”

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March 2013

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Introduction

The FSRH is cross specialty organisation with the following aims:
- Giving the discipline academic status
- Providing information and training
- Developing standards
- Promoting interaction with related disciplines
- Advancing medical knowledge
- Representing those working within it

In 2012 the FSRH established a review to look at four specific areas:

- the role of the medical specialty of Community Sexual and Reproductive Health (cSRH)
- corporate governance
- international role of the FSRH
- the impact of devolution on the FSRH

The document does not cover education, training, guidelines, standards or lay representation as this is being currently or recently been reviewed.

The work is based on 26 individual evidence-taking sessions, one open consultation, and a consensus questionnaire at Current Choices 2012. The work was overseen by a Strategic Review Working Group reporting to FSRH Council. Written evidence has also been submitted by the deanery advisors, the trainees’ network and others. Further details are provided in the attached appendices.

The FSRH has achieved much in its first 20 years and now has firm foundations and a reputation on which to build the next 20 years. This is an opportunity to further develop a vision which maximises organisational, professional and people power.

Role of Specialty

cSRH is a recognised medical specialty within the UK, like GUM and O&G. The challenge currently facing the FSRH is to ensure it becomes established, recognised and influential in practice. The recommendations below cover the essential areas of communication, relationships with other specialties, the impact of the new specialty on the FSRH itself, and the support the FSRH needs to provide to the new (and existing) specialist body.

There are currently around 100 consultants in post, of which 73 have completed SRH/subspecialty training. At present there are 5 subspecialty trainees and 17 cSRH trainees in training, with a further 20 anticipated over the next 3 years.
Recommendations

1. The statement of purpose given below should be the basic official FSRH description of the specialty and used for internal and external communication.

Definition of the role of a specialist in SRH

The Community Sexual and Reproductive Health (cSRH) training programme produces medical specialists who are expert health professionals in contraception, medical/office gynaecology, menopause, unplanned pregnancy and have wide experience in sexually transmitted infection care. They typically oversee the work of open access clinics and receive individual specialist referrals and contribute to public health. They combine the ability to deliver comprehensive cSRH with broad knowledge, clinical experience and leadership.

cSRH specialists deliver services both through their own organisation, and in partnership with a multi-disciplinary team. This team can include general practitioners, genitourinary medicine & HIV specialists, hospital gynaecologists, psychosexual specialists, nurses and other health and social care professionals.

cSRH specialists provide education and training to nationally recognised standards for clinicians working in primary care and specialist services. The skills of cSRH specialists deliver societal and individual benefits for all, including for the most vulnerable and those who are seldom heard. This is achieved by ensuring delivery of high quality cost-effective services, targeting resources according to need, and working in partnership with commissioners, the NHS, Local Authorities and other providers.

In summary, cSRH specialists provide clinical leadership and management in all aspects of SRH for the benefit of patients and the public.

- Evidence of broad support for the principles within this statement of purpose was found in the consensus statement questionnaire and the open consultation meeting at Current Choices 2012.
- Broad internal consensus as to the role of the specialty is essential, if the specialty is to grow and contribute effectively to healthcare in the UK.
- The statement of purpose can be expanded as required, but the core message should be consistent.
- The ability of services located in the community to engage disadvantaged women and reduce health inequalities is widely acknowledged (Tomorrow’s Specialist Working Party Report; RCOG: September 2012 - page 16). The expertise of SRH specialists in this area should be emphasised.
2. The purpose of the specialty should be clearly articulated and communicated.

- Establishing the specialty was a major achievement. Following this, the initial task was to ensure national training numbers were allocated and trainees appointed.
- It is now essential to ensure that the relevant people are aware of the specialty and its potential.
- Where appropriate, it is important to acknowledge that our established specialists may have different skills from those undertaking the new training programme. Those completing this programme will refine their skills further as they gain more expertise in particular areas.

3. A communication strategy to improve knowledge of the specialty and its potential impact on the health of the public and patients should be agreed with the FSRH communications team.

- This should include internal and external stakeholders.
- High priority stakeholders including national and local commissioners in England, but a broad brush approach is necessary, and may require a longer timescale.
- A phased approach is likely to be effective.
- Timescales and outcome indicators should be included.

4. Relationships between the new specialty of cSRH and related clinical specialties should be defined at both local and national levels.

a. Local Level – The FSRH should support the development of clinical networks.

- The Current Choices consensus questionnaire gave very strong approval to the establishment of multi-disciplinary networks with cSRH specialists taking the lead in organisation and support. Members working in functional networks almost universally acclaim their benefits and rewards.
- The value of multi-disciplinary networks within a geographical area should be promoted, with the acknowledgement that the composition or leadership of the network will vary in different localities, but should always fall to the best available person for the job.
- The concept of clinical networks is supported by the NHS National Commissioners (England) in a statement in 2012:-

  The National Commissioning Board wants to “encourage clinical commissioning groups and local health economies to develop or
continue their own networks for clinical pathways or for patient groups which would benefit from this kind of focus”.

- The Clinical Standards Committee should consider producing a statement to define best practice principles for cSRH networks to support their development.

b. National Level – The FSRH needs to continue engagement with general practitioners, gynaecologists, genitourinary medicine & HIV physicians, specialists in public health and the general public to agree how to maximise benefit to patients.

- Work with the RCGP should include addressing the important and valuable relationship between cSRH specialists and GPs as well as other practitioners in primary care (such as practice nurses and physicians assistants). A joint statement on clinical networks or endorsement of the FSRH’s clinical standards would be helpful.

- Work should continue with BASHH to acknowledge the close relationship between the specialty of GUM and cSRH and promote collaboration through joint meetings, guidelines, training, standards etc.

- Optimal ways of working together between cSRH specialists and obstetrics and gynaecology generalists undertaking office gynaecology and/or termination of pregnancy should be agreed between the RCOG and the FSRH. The RCOG, in its publication Tomorrow’s Specialist Working Party Report, clearly states it supports this work and acknowledges it, as part of the remit of its Tomorrow’s Specialist Project Implementation Group. This work needs to include defining and acknowledging the different knowledge, skills and resources the various specialists tend to have, and possibly using this to produce models of best practice. The RCOG support of, and contribution to, the communication strategy is desirable. This strand of work should be overseen by a senior level joint RCOG/FSRH liaison group.

- The FSRH needs to develop closer links with the Faculty of Public Health so as to demonstrate how our roles complement each other nationally, regionally and locally. Both faculties need to explore the potential contribution of cSRH specialists and the SRH clinical networks. It would be beneficial if the Faculty of Public Health was able to cascade this to their members. Consideration could be given to inviting Directors of Public Health, who are not doctors but have an interest in SRH, to become associate members of the FSRH.

- It is of upmost importance to talk to our own members in established disciplines, seeking their views and input into the specialty of cSRH. A particular group of members whose views could be pivotal are GUM physicians. The FSRH’s aim should be to encourage them to invest in the future of the FSRH with their energy and intellect.
A separate review is currently underway concerning consumer representation into the wider work of the FSRH.

5. Impact of the new specialty on the FSRH and its work needs to be considered.

- The FSRH must continue to represent interests of all its members including GPs who tend to be diplomates and nurses who are associate members. Specialists from the new cSRH training programme are required to hold MFSRH. Doctors working the majority of their time in SRH who have not taken the new training pathway should be actively encouraged to seek membership status.
- The FSRH should encourage specialist trainees in closely allied fields such as GUM or Gynaecology to take the MFSRH examination, and all diplomates and members should be encouraged to take an active role in the work of the Faculty.
- The FSRH must ensure that lay input into the role of and the development of the specialty is continued. New arrangements for corporate governance should safeguard this.
- Workforce Planning Committee should consider the most useful statistics to collect as the specialty is established. Methods of collection may also need to be reviewed. The inter-dependence of workforce planning with other specialties e.g. general practice and hospital gynaecology and other disciplines needs to be considered.
- The Specialty Advisory Committee (SAC) needs to ensure training is fit for purpose in producing specialists. It is important training does not remain static, but is able to evolve to take advantage of opportunities presented by networks etc.

6. The FSRH should give consideration to the welfare and support of newly appointed consultants in the specialty.

- The appointment to consultant status is a major change in role and can be isolating and challenging, especially when working single handed. The FSRH should consider the role of buddying and mentoring in supporting new consultants and indeed, to a lesser extent, those at other points in their careers.
  
  Buddying can be defined as the support provided to a newly qualified clinician by a more experienced colleague. It is different from mentoring, because it gives specific practical professional advice on issues in the work place.
  
  Mentoring is the support provided by a skilled helper who guides another individual through a process to help them achieve their potential or reflect on problems to move forward.

- Effective arrangements need to be set in place to help support single handed consultants who are in the majority in our specialty, at a time when other
specialties are moving away from such arrangements. Consideration should be given to the promotion of geographical networks of cSRH consultants.

- The FSRH should consider how it can support job planning for cSRH specialists, bearing in mind the variability and potential breadth of the role.
- The FSRH should consider an annual meeting aimed particularly at developing the skills of newly appointed consultants.
- Responsibility for mentoring, job planning, supporting regional networks or potential buddying, should be in the job plan of deanery advisors, but will require central co-ordination, perhaps by executive board members. The latter may also take the lead in overseeing life-long learning and the revalidation process.

**Financial implications**
Additional finance required for the role of the specialty recommendations:- NIL
Corporate Governance

As health services develop in the UK the FSRH will need to further embrace professional clinical leadership that facilitates multidisciplinary and cross specialty working. Currently, the FSRH has over 15,600 members and is in good financial health with a solid reputation for training, standards and guidance. Relationships are excellent with partners such as the RCGP, RCOG, RCN and BASHH. Opportunities currently exist to extend and develop its influence and further its goals. These include the potential development of nurse training and membership, and direct input from clinicians specialising in community STIs, office gynaecology in the community and the role of the specialists in cSRH. In 2032, the FSRH could be truly multi-disciplinary and have 30,000 members representing all clinicians working in SRH in the community. Participating in partnership with the RCOG and RCGP, FSRH could be a significant political force acting on behalf of all its members to improve community based specialist services for public and patients.

Work on the following recommendations should commence with immediate effect.

Recommendations:

1. A Board of Trustees should be established.

   The Board of Trustees should comprise:
   - President (Chair)
   - Three elected officers
   - Two appointed members
   - Four lay non-executive members

   The Board would take responsibility for the FSRH’s strategic direction, monitor progress against these recommendations ensuring the Faculty meets its objectives, and oversight of financial and business issues. Trustees will serve a maximum of two terms of three years.

2. A Management Committee should be established.

   The management committee will include the President and other Officers, the Chief Executive, and other Faculty staff. These individuals should be able to act quickly when necessary, and proactively represent the FSRH to stakeholders and partners. They would help develop the FSRH’s vision, mission and strategic goals. In addition they would take responsibility for supporting the FSRH’s committees and working groups.
Members of the management committee will require the expertise, experience and time to do this and would be required to commit two to three days per month (one session per week) and in return their employers should receive modest reimbursement.

- The workload of officers has increased at a time when employers have become more reluctant to release doctors from their clinical duties. It is unreasonable to believe that an organisation the size and complexity of the FSRH can be led by a group of clinicians (however dedicated), in their spare time. Indeed, the President probably requires at least 4 sessions per week to fulfil essential duties.

- The lay membership of the Board of Trustees executive group means that the FSRH will benefit from effective lay input at the highest level. The non-executives are expected to bring external expertise in public health, NHS management, governance and finance. Appendix C lists the person specification which is likely to be required. The appointment of lay members will be by competitive interview.

- Other comparable organisations have reached similar conclusions about the need for such a change in recent years. The RCP effected this around five years ago. The RCOG, GMC and others are currently in the process.

3. **Council is currently responsible for all activities of the FSRH. This needs to be reconsidered with the establishment of the Board of Trustees and Management Committee.**

The Council remit should be changed so that it concentrates on clinical and professional matters:-

- Overseeing the quality of committee work on training, revalidation, standards, examination etc.
- Addressing matters of concern to membership.
- Advising the Board of Trustees and the Management Committee.

Composition should remain largely unchanged, with eleven elected members (six fellows/members, four diplomates, one associate, officers and appointed lay representative). Committee chairs will continue to be invited.

It is recommended that the RCOG continues to have representation on Council. A more formal arrangement for joint working could take place through the establishment of a senior level joint RCOG/FSRH liaison committee.

The frequency of Council meetings could be reviewed and reduced to a minimum of three and maximum of six.
4. Officers: Within a new structure, consideration should be given to the number, remit (and titles) and election of officers.

- Consideration should be given to reducing the total number of officers from five to four and re-designating officers as President and 3 vice presidents ensuring that the membership are represented in these roles and in particular cSRH and general practice.
- If significant nursing membership is achieved, an additional officer to represent this group could be established.
- The President should be an experienced SRH Specialist.
- Consideration should be given as to whether officers continue to be elected by Council or extending the electoral body to include those serving on FSRH committees and deanery advisors (approximately 100 members).

5. A formal workload review should be scheduled for the Chairs, committee members, Editor in Chief and Editorial Board should be carried out.

- No essential change to method of appointment or remit is proposed at present.
- Currently the standing committees and editorial group function well. They are the powerhouse of the FSRH and ensure high quality products (training, guidance, standards, the Journal). The major issues are around the workload of the chairpersons of certain committees such as general training and examinations. Workload remains significant and difficult to quantify, and varies from week to week, as well as year to year. As a minimum, it is essential that going forward, improved support is given, with increased secretarial/administrative access and assistance from the Executive Board/Officer attached to the committee. The workload issue for committee chairpersons, must also be considered when reviewing the staffing of the FSRH.

6. The role of the Company Secretary should be replaced by a Chief Executive Officer.

A CEO has a role as a decision maker, leader, manager and an executive. The main responsibilities would include:

- Developing and implementing high level strategies.
- Managing overall operations and resources.
- Contributing to major corporate decisions.
- Motivating employees.
- Communicating within and outside the organisation.
- Driving change within the organisation.

This may be seen by some as reducing the power and influence of medical leaders on the Faculty, but an organisation requires skills at a senior level that will not always be delivered by those elected to be president or officers. A CEO
also brings, with it, some continuity as officers are on fixed term appointments. The CEO of a Faculty/College has a slightly different role to that of a typical CEO of a private business, but the FSRH could expect that they would:

- Develop with the Executive Board and Council strategies, policies and plans.
- Ensure that effective and efficient systems are in place to ensure that the FSRH achieves its strategic aims and objectives.
- Ensure that the FSRH maintains the highest standards in all its activities.
- Ensure that the FSRH business plans are supported by strong, professional management and effective operating systems.
- Review and monitor the FSRH’s performance against agreed objectives including financial and human resources.
- Develop close and effective working relationships with key external stakeholders.
- Seek out business opportunities that are in line with and support the work of the FSRH.

It should be noted the FSRH will be required to increase investment in this post, if it is to acquire the leadership and management skills such a post requires.

The CEO will report to the President and be accountable to the Board of Trustees and Council.

7. **FSRH Staff** – a review of staff roles and office policies and procedures must be a priority for the new CEO.

8. **Lay input FSRH committee work:** A separate review is currently underway concerning lay input into the wider work of the FSRH - no other recommendations will be made here.

9. **Legal Input:** Legal consultation on the FSRH’s Memorandum and Articles of Association should continue to be reviewed.

10. The FSRH should aim to have the revised structures in place by the end of the first quarter in 2014.

**Financial implications**
Detailed financial costings for the corporate governance changes will be presented at a later date.
Devolution

It is agreed that FSRH should be an effective UK-wide organisation. Despite devolution, clinical work and formal terms and conditions of employment remain similar in all four nations. There are however significant differences between England and the devolved nations. Local NHS structures vary considerably as a result of devolved government / administration. If the service to members by the FSRH is to remain equitable, there should be equivalent or at least proportional liaison activity in all four nations. In England these tasks are undertaken by Officers, often the President. These activities are quite distinct from local influencing which all lead clinicians in the UK are required to do.

These tasks include liaison with:

- government, civil service and other national regulatory authorities e.g. Welsh Medicines Consortium, Health Care Improvement Scotland
  - Attending parliamentary groups, committees and informing members of parliament, ministers and senior civil servants.
  - Influencing policy before it is formed.
  - Responding to formal consultations.
  - Developing systems to implement new national policies and strategies. (Scotland, Northern Ireland and Wales)

- National press and other media
  - The FSRH should review its ability to respond to press enquiries from all 4 countries.

- Royal Colleges and Faculties based within devolved nations

- Postgraduate Deanery systems in the 4 countries.

- Legal institutions for the issues raised by different and/or new legislation

Consequence of working in different political and cultural environments, most notably in Northern Ireland

- The FSRH has a Scottish Committee, Welsh Committee and Northern Irish Committee with each having budgets for administration and travel. The chair of each committee normally attends Council. Membership is arranged to provide geographical coverage of the nation to improve communication and ensure local problems like rurality are taken into account.

- Feedback from national authorities in Wales indicates respect and appreciation for the role of the Welsh Committee. Similarly Senior Scottish Civil Servants value the Scottish SRH Consultants input but indicated they would appreciate an annual planning meeting with a FSRH Officer. This is in addition to the work of the Scottish Clinical Leads Group which concentrates on service issues with less focus on training and to some extent standards and guidance.
This FSRH should raise its profile in the devolved nations and ensure that issues in the devolved nations are understood by the Officers, Council and the Board of Trustees.

**Recommendations:**

1. The FSRH will review its external communications strategy, in particular those with the 4 departments of health and other government organisations.

2. A review of the expectations of the devolved nations’ representatives on council should be carried out. An officer should be identified to support the council devolved nation representatives.

**Financial implications**

Additional finance required to be quantified.
International Role

The FSRH is aware that its guidelines and standards are widely used outside the UK, yet of the FSRH’s 15,000 plus members only 283 reside outside the UK. However, it has excellent training packages, guidelines and standards aimed at basic and advance service levels. Due to the unique nature of the NHS and College training systems in the UK, these have been rigorously validated. This differentiates FSRH training and guidance from that produced by other established family planning organisations. The limited international work the FSRH has undertaken has largely been in partnership with colleagues in Europe. Here the guidelines have been enthusiastically embraced and an approach to consider collaborating in producing a European/international diploma received. Based on this, and other evidence, the FSRH believes it has products which, with minimal adaptation, could be a significant contribution to the global effort in SRH.

The FSRH recognises it has limited experience in international work and the recommendations will reflect this. However, individual members possess expertise, energy and enthusiasm, which should be supported by the FSRH. Managed well however, international work should bring benefits to the FSRH in terms of visibility, credibility and opportunities for collaborative work as well as benefit to its partner organisations and countries.

Recommendations:

1. Finance

   - International activities should be largely cost-neutral to the FSRH
   - A “small amount of seed money” should be used from FSRH reserves to “kick start” the process
   - On-going funding should be largely from charitable grants and partner organisations, but could be supplemented by voluntary donations from FSRH members and others.

2. Partnership approach – FSRH should deliver the majority of its international work in partnership with the RCOG

   Many Colleges, including the RCGP and RCOG, do outstanding work and have well deserved global reputations.

   Contraception, sexual and reproductive health is complementary to or often an essential component of many of the RCOG global programmes. Most importantly, the RCOG is keen to work with the FSRH in its global role and has offered support and inclusion in all aspects of its work.

   The FSRH has much to gain, by having its proposals presented on common platforms with the RCOG, undertaking joint funding bids and having access to
RCOG’s contacts and partners around the world. The RCOG is clear this is a partnership approach and they will provide support to FSRH led activities as well as vice versa.

3. The FSRH should accept invitations from the RCOG to sit on the RCOG global health board and its five sub-committees

- It would seem sensible for such positions to be offered initially to members of the FSRH’s International Affairs Committee
- The role of the FSRH’s International Affairs Committee would then require review. As the work grows, it may be preferable for individual efforts to be concentrated on input to the RCOG Committee with co-ordination at least initially, by the International Development Officer and the FSRH Officer responsible for international affairs.
- The need, role and funding for an FSRH International Development Worker should be considered.

4. Partnership with the European Society of Contraception & Reproductive Health (ESC) should continue and develop

- FSRH guidelines are extensively used in Europe.
- ESC is developing this training and is interested in a partnership approach to a European/international diploma.
- FSRH members who sit on the ESC Training sub-group should be asked to actively take this forward. There may also be an opportunity for officers of both organisations to discuss practicalities and potential of such a partnership at the ESC global congress in Copenhagen during May 2013.

5. Work to develop international membership.

- Membership to clinicians outside UK should be re-considered once partnerships with ESC and RCOG have been developed.

Financial implications

Whilst it is intended that additional finance will be required during implementation it intended that international work be self-funding.

Implementation of 20:20 Vision

It is anticipated that the current officers should take forward recommendations and actions arising from the role of the specialty during 2013 as this is a matter of
urgency. Changes to the corporate governance of the FSRH should be pursued at the same time, with an aim of having new arrangements in place by January 2014.

Recommendations around devolution should be implemented in 2013 and 2014 as indicated in the text.

There appears to be a window of opportunity to take forward the FSRH’s international partnership with the RCOG, following the recent appointment of the RCOG Director of Global Affairs and the re-structuring of her department. It is therefore recommended, that the recommendations around the international role of the FSRH are also taken forward in 2013, perhaps under the guidance of the officer responsible for international affairs.
Appendix A: Proposal for the strategic review

Background

The FSRH was founded nearly 20 years ago on 26th March 1993. Its Founding Members set the following 6 aims:

1. Give academic status to the discipline of Sexual and Reproductive Healthcare
2. Maintain and develop standards of care and training
3. Promote effective interaction between Reproductive Healthcare and related disciplines
4. To support basic and continuing education in the discipline
5. To advance knowledge, audit and research in the discipline
6. To support those working in the discipline at regional, national and international levels

It is safe to say the Founding Members would have been delighted by the success of the FSRH in taking these aims forward, as well as its current position as a respected Institution with 17,113 fellows and members and 64 honorary fellows.

Why Review Strategic Aims and Purposes in 2012/13?

Within the overall success of the FSRH in the last 20 years, there have been some particular achievements which have been subject to rigorous external and internal review. Examples include establishment of specialty training, guidelines and standards development. However, not all areas of strategic development are progressing with such clarity of purpose which is required in a UK wide healthcare system that is changing fast and also between countries. There are also new opportunities which build on successes achieved and reputation gained such as the FSRH’s international role. It is known that our guidelines are already respected and widely accessed beyond the United Kingdom.

The external environment in which the FSRH operates is also very different from 20 years ago. The FSRH is in a good position because of its reputation and the partnerships which have been developed, but will better represent its member’s interests if it takes a pro-active rather than a reactive approach to events over the next few years. Factors that require consideration are the changes in approaches to women’s and sexual health, the devolved nations, the structure of the NHS and Doctors’ working conditions, amongst others.
Proposal

A focused strategic review is therefore proposed to clarify direction development over the next 5 years. This will provide a reference framework for Council when deciding where the FSRH should invest resources. Once objectives are agreed by Council, the Officers and Executives can examine current strengths and weaknesses of the FSRH and invest to ensure the FSRH continues to be fit for purpose.

Scope of Review

It is suggested that the review should focus on areas where there is a lack of clarity in strategic direction or new opportunities or challenges, in order to make most effective use of resources and deliver in an acceptable timescale.

The consultation strategy within the review should aim first and foremost to give members the opportunity to influence their Faculty. There will be external stakeholder involvement.

The work will focus on four themes detailed below:
- Role of Specialty in the future NHS
- Devolved nations
- International profile and membership
- Structure of the FSRH, specifically in relation to
  - the Officer structure
  - the structure of council
  - the provision of multidisciplinary basic training programmes

The relationship of each of the 4 themes on the following areas of FSRH work will considered as the work progresses:
- Specialty training
- General training
- Guidelines
- Standards
- Journal
- Research.

Areas of development work being considered elsewhere:
- Lay/user involvement in the FSRH: development of this will be taken forwards in a separate group.
- Non-specialty and multidisciplinary training: DFSRH and LoC Evaluation

All the areas under consideration should be scrutinised for both short and long term impact on the FSRH’s financial situation and personnel requirements. Recommendations on the FSRH’s overall personnel requirements and structure will be made.
Method of Working

A short term working group should be established which will report to Council. This group will be responsible for “blue-sky” thinking and proposals. It should include the President, Honorary Treasurer, RCOG representative, a FP Nurse, a new Consultant, a GP, an SAS grade doctor, and a Trainee. Council will also be involved on an on-going basis in the formative processes.

The aim of the group is to provide a blueprint to take the FSRH forward for the next 5 years in areas where there is currently a lack of strategic direction or consensus. Its output will include a document which reflects all members’ interests and can be updated on a regular basis.

To ensure a strong process which allows “out of the box” thinking but is based in reality and takes evidence from all members who wish to contribute, it is suggested an individual is appointed to oversee the review.

This person will:-

1. Chair the short term working group
2. Report directly to Council
3. Take evidence from members
   (It is currently envisaged to involve direct face to face as well as written consultation with individuals, small and large groups, from all aspects of membership. A pro-active process will be required)

This assisted by relevant FSRH committee Chairpersons etc. will:

4. Ensure consideration of all necessary documentation
5. Produce interim documents for consideration
6. Produce a final report for Council

This individual should therefore have:-

- An excellent working knowledge of the FSRH and specialty
- Necessary communication and managerial skills
- The time required (estimated at 25-30 days over a period of 6 months)

Timescale

- Council to consider proposal on 19th July 2012

If agreed:

- Chair of working group appointed and remuneration agreed by Officers in August 2012
- Preliminary meeting of working group to agree scope and method of working in September 2012
- Process undertaken September 2012 to March 2013
- Final report to Council April 2013
In Conclusion

Council asked to consider the above proposal and focus on:-

- Importance of concept
- Scope for review
- Method and timescale
- Cost
Appendix B: List of contributors

Individuals and groups who gave evidence to Strategic Review 2012/13

Dr Paula Barrister  Member of International Affairs Committee
Professor Johannes Bitzer  President of ESC
Dr. Alan Cameron  Chair of RCOG Scottish Committee
Dr Dan Clatterbuck  Consultant in Genitourinary & HIV Medicine, NHS Lothian/ NHS Borders
Ms Rachael Cooper  Director of Global Affairs RCOG
Dr Olga Elder  NI Representative NI
Dr Anthony Falconer  President, RCOG
Dr Ailsa Gebbie  Vice President, FSRH
Professor Anna Glasier  Chair of Clinical Studies Group SRH
Mr Peter Greenhouse  SRH/GU Consultant, Bristol
Mr Brian Gunson  Chairman of Munro and Forster PR
Ms Diana Halffnight  Head of Meetings and External Communications
Dr Meera Kishen  Former FSRH President (2005-2008)
Mr Ali Kubba  Chair of International Affairs Committee
Dr Marion Lyons  Director of Health Protection Division of Public Health, Wales
Dr Diana Mansour  Honorary Treasurer, FSRH
Ms Dona Milne  Deputy Director of Public Health, NHS Lothian
Dr Rak Nandwani  Consultant Physician in Sexual Health & HIV, Glasgow
Dr Sarah Randall  Former Chair Associate Members Group
Dr Felicity Sung  National Co-ordinator: Sexual Health & HIV, Sexual Health and BBV Team, Scottish Government
Professor J Walker  Vice President, RCOG
Dr Ann Webb  SRH consultant Liverpool
Dr Chris Wilkinson  President, FSRH
Mr Ian Wylie  CEO, RCOG
Mr Michael Yates  Education Project Officer, FSRH

Groups

Council

Dr Chris Wilkinson  President
Dr Ailsa Gebbie  Vice President
Dr Alyson Elliman  Vice President
Dr Diana Mansour  Hon Treasurer
Dr Amanda Britton  Hon Secretary
Dr Nicola Mullin  Member
Dr Karen Trewinnard  Member
Dr Alison Vaughan  Members Representative
Dr Kate Armitage  Members Representative
Dr Janet Barter  Members Representative
Dr Jenny Heathcote  Members Representative
Dr Nathan Acludious  Diplomates’ Representative
Dr Anne Connolly  Diplomates’ Representative
FSRH 20:20 Strategic review

Dr Pauline Brock  Diplomates’ Representative
Dr Jenny Wilson  Diplomates’ Representative
Mrs Linda Pepper  Consumer Representative
Mr Ian Currie  RCOG Representative
Miss Alison Wright  RCOG Representative

20:20 Strategic Planning Group

Dr Chris Wilkinson  President FSRH
Dr Diana Mansour  Honorary Treasurer FSRH
Dr Zara Haider  New Consultant representative
Dr Anne Connolly  GP representative
Mr Peter Greenhouse  SRH/GU representative
Dr Heike Gleser  Trainee representative
Ms Alison Craig  Nurse representative
Dr David Richmond  RCOG representative
Dr Pippa Brough  SAS doctor representative
Ms Diana Halfnight  Head of External Communications

Chairs of Committees

Dr Anne Szarewski  Journal
Dr Jenny Heathcote  General Training
Dr Kate Guthrie  SAC
Dr Asha Kasliwal  Clinical Standards
Dr Sam Rowlands  Clinical Effectiveness
Mr Ali Kubba  International Affairs
Dr Anne Bennett  Workforce
Dr Marian Everett  Meetings
Dr Aisling Baird  Examinations
Dr Praveen Jaydeva  Trainees
Professor Anna Glasier  CSG-SRH

Scottish Committee

Dr Susan Brechin
Dr Olga Diaz-Morales
Dr Hame Lata
Dr Maggie Gurney  (Chair)
Dr Ailsa Gebbie
Dr Karin Piegza
Dr Ruth Holman
Dr Pauline McGough
Dr Anne McLellan
Dr Ailsa Wylie
Dr Oladapo Erinle
Dr Susan Laidlaw
Dr Mhari Linklater
Welsh Committee

Dr Ruth Frazer
Dr Charlotte Fleming
Dr Clare Lipetz
Dr Louise Massey
Dr Sam Mirando
Dr Meenakshi Sethupathi
Dr Joanne Hoddinott
Dr Arunima Nan
Dr Caroline Scherf
Dr Annette Schlaudraff
Dr Julia Shefras
Dr Kirti Jain (Chair)

NI Committee

Dr Eveane Cubitt
Dr Janet Deacon
Dr Olga Elder (Chair)
Dr Helen Kennedy
Dr Sandra McDermott
Dr Maureen Mcfarland
Dr Sheila McGreevy
Dr John Price

In addition written consultations were undertaken with the Faculty’s trainee network and Deanery Advisors.
### Appendix C: Sample Person Specification for Lay non-executive

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience of board or committee membership in a charitable, public sector or commercial organisation.</td>
<td>Essential</td>
</tr>
<tr>
<td>Understanding and acceptance of legal duties, responsibilities and liabilities of trusteeship and an understanding of the respective roles of the Chair, Trustees and Chief Executive.</td>
<td>Essential</td>
</tr>
<tr>
<td>Ability to work effectively as a member of a diverse team whilst maintaining an independent perspective.</td>
<td>Essential</td>
</tr>
<tr>
<td>Experience of guiding and directing an organisation through strategic and structural growth during a period of significant external pressures and change.</td>
<td>Essential</td>
</tr>
<tr>
<td>An understanding of and commitment to the values of accountability, probity and openness.</td>
<td>Essential</td>
</tr>
<tr>
<td>Confident and effective communication skills.</td>
<td>Essential</td>
</tr>
<tr>
<td>A track record of being able to process details quickly and get to the heart of an issue.</td>
<td>Essential</td>
</tr>
<tr>
<td>Demonstrable knowledge of the healthcare sector.</td>
<td>Desirable</td>
</tr>
<tr>
<td>A proven track record of achievement within a related business environment.</td>
<td>Desirable</td>
</tr>
<tr>
<td>An understanding of the issues of global health and SRH in UK.</td>
<td>Desirable</td>
</tr>
</tbody>
</table>
Appendix D: Suggested action plans

Appendix D1: Planned RCOG global administrative structure

GLOBAL HEALTH BOARD
Senior Vice President

GLOBAL HEALTH POLICY ADVISORY COMMITTEE
GLOBAL COLLABORATION COMMITTEE
GLOBAL GRANTS & PROJECTS COMMITTEE
GLOBAL PLACEMENT COMMITTEE
INTERNATIONAL REPRESENTATIVE & LIAISON COMMITTEE

LSTM/RCOG PARTNERSHIP MANAGEMENT GROUP
Chairmanship rotates on an annual basis
### Appendix D2: Role of Specialty

<table>
<thead>
<tr>
<th>Action Plan</th>
<th>Timescale</th>
<th>Responsible individual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree a communication strategy for internal and external stakeholders to promote the specialty of c-SRH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical standards committee to produce ‘best practice’ principles for local c-SRH networks to be promoted (perhaps as part of later strand of communication strategy above). RCGP should be asked to endorse or ‘joint badge’</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RCOG – agree good practice models between c-SRH specialists and obstetrics and gynaecology generalists undertaking office gynaecology and abortion. Active proposals required from FSRH. Request RCOG support for above communication strategy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FPH – start talks as to the potential contribution to public health which could be made by c-SRH specialists and SRH networks. Aim for joint statement. Consider inviting PH doctors to be associate members</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GUM - consider ways of involving more actively I FSRH, including the offer of Hon or associate membership</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workforce planning committee to ensure it is collecting optimal statistics to support growth of the specialty</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SAC to ensure training and supporting documentation reflects definition of specialty</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual or group to be given responsibility for taking forward mentoring, buddies, job planning and regional networks for specialists</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Appendix D3: Corporate Governance

<table>
<thead>
<tr>
<th>Action Plan</th>
<th>Timescale</th>
<th>Responsible individual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appoint interim CEO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consult legal advisors concerning new structure and membership categories eg associate membership for doctors, one off Hon membership for GUM specialist, nurse diploma membership, international membership</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Make arrangements to appoint CEO and executive board to commence work in January 2014</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change Council agenda and reduce frequency of meetings in line with new responsibilities from 2014</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan transition of current officers to new arrangements in 2014 and change arrangements/articles around who will elect officers from 2014 onwards</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review of staff roles and office processes.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Electronic membership index is seen as priority</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Appendix D4: Devolution

<table>
<thead>
<tr>
<th>Action Plan</th>
<th>Timescale</th>
<th>Responsible individual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review political lobbying and liaison in all 4 countries in 2014</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appoint officer to attend devolved national committees in order that there is an understanding of national issues in London and some central liaison with devolved governments</td>
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<td></td>
</tr>
</tbody>
</table>
## Appendix D5: International

<table>
<thead>
<tr>
<th>Action Plan</th>
<th>Timescale</th>
<th>Responsible individual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work with RCOG to ensure FSRH representation on RCOG international board and committees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restructure FSRH international committee or replace with core working group to oversee transition to new arrangements</td>
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<td></td>
</tr>
<tr>
<td>Appoint an international development worker to reside in RCOG international office and collaborate with RCOG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Put financial arrangements in place to allow FSRH members to donate funds to FSRH international efforts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meet with ESC at Global conference in Copenhagen in May 2013 to consider if a European/international diploma could be established</td>
<td></td>
<td></td>
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</tbody>
</table>