FSRH consultation response: Facing the Facts, Shaping the Future – a draft health and care workforce strategy for England to 2027 by HEE

The Faculty of Sexual and Reproductive Healthcare (FSRH) welcomes the opportunity to respond to this consultation on the health and care workforce strategy for England to 2027 by Health Education England (HEE). The Faculty is very pleased to see the Government’s commitment, as seen through the launch of this consultation, to workforce planning, something that is long overdue and fundamental for the sustainability of the NHS and ensuring individuals and communities get the quality care they are entitled to.

FSRH is the largest UK professional membership organisation working at the heart of sexual and reproductive health (SRH), supporting a diverse range of healthcare professionals in the delivery of high quality SRH care. The Faculty’s membership is comprised of 16,000 members, the majority of which are General Practitioners (GPs). FSRH members also work in Obstetrics and Gynaecology and other related specialties.

FSRH is responding to this consultation in its capacity as the UK organisation setting clinical, service and educational standards in SRH. FSRH provides various national qualifications in SRH care and oversees the Community Sexual and Reproductive Healthcare (CSRH) Specialty Training Programme. It produces service standards and evidence-based clinical guidance to support good quality SRH care in the UK across the various community and primary care settings where it is delivered.

In light of the above, the scope of our response is limited to issues affecting the SRH workforce and what FSRH sees are the most pressing challenges in SRH workforce planning as well as possible solutions. We have also included in this consultation response an annex describing the importance of availability of consultants in SRH at local authority level. FSRH believes the SRH workforce is well-positioned to further the long-term aims of the health and social care system and with the right investment, it can help HEE meet its mandate.

Questions

Question one: Do you support the six principles proposed to support better workforce planning; and in particular, aligning financial, policy, best practice and service planning in the future?

FSRH generally agrees with the six principles proposed in the draft strategy. The Faculty would like to make the following comments regarding the six proposed principles:

Principle 1. Securing the supply of staff that the health and care system needs to deliver high quality care in the future. Since the NHS began patients have been well served by staff from around the world. However, maximising the self-supply of our workforce is critical. It cannot be right for the NHS to draw staff from other countries in large numbers just because we have failed to plan and invest.

FSRH strongly believes that securing a safe supply of staff is one of the most important measures to tackle the pressures on the healthcare system in the face of growing demand and an ageing population.
With regard to drawing staff from other countries in the context of the UK leaving the EU, FSRH strongly endorses the position adopted by the Academy of Royal Medical Colleges (AoRMC)\(^1\). The NHS depends heavily on NHS staff from the EU. It is essential that assurance is given to current staff over their residency status in the UK. It is also crucial that, in the future, there are sensible and workable immigration regulations, so the NHS can recruit staff both from the EU and beyond as required. In line with the AoRMC, FSRH also recognises that, whilst Brexit is an important issue for doctors, it is even more pressing in the case of nursing. Concurrently, the NHS must become more effective in recruiting and investing in training UK staff.

Community Sexual and Reproductive Healthcare (CSRH) & Brexit

CSRH is a medical specialty unique to the UK. Overseas doctors cannot usually work within specialist services without further UK-based training, as consultant-led care within SRH requires detailed understanding of the complex UK healthcare system as well as managerial and leadership skills. CSRH trainees are equipped to become future SRH leaders responsible for overseeing care delivery at the population-level.

CSRH training is the second most competitive specialist training programme in the UK, and there needs to be further investment in this specialist training provision because the current predicted output of the programme falls well-short of replacing the vacancies that will arise due to retirement, let alone address the fact that current consultant numbers relative to population numbers are inadequate.

Further, albeit consultant-led, SRH is and will be increasingly delivered by nurses and other healthcare professionals, which points towards the growing importance of these professionals in clinical care. Yet Nursing & Midwifery Council (NMC) data shows that the number of EU-trained nurses and midwives joining the register for the first time (Initial Registrations) has dropped steeply since the Brexit referendum, from 988 in June 2016 to 85 in May 2017. In turn, the number of professionals leaving the register has increased from 177 to 372 in the same period\(^2\). It is fair to assume that this will have an adverse impact considering the current crisis in nursing staffing levels, with spill-over effects on SRH workforce capacity.

Therefore, whilst the Faculty would like to re-affirm the importance of attracting and recruiting EU and non-EU talent to increase the wider system’s capacity and promote a healthy knowledge exchange, it is imperative to stress the need for a home-grown, trained and qualified SRH workforce.

Principle 2. Enabling a flexible and adaptable workforce through our investment in educating and training new and current staff. Individual NHS professions have distinct roles but there is scope for more blending of clinical responsibilities between professions. This flexibility is rewarding for staff and can provide the NHS with more choice in how we organise our services.

FSRH is pleased to support the principle of development of a flexible and adaptable workforce which is particularly important for the multidisciplinary service models we support. In SRH multidisciplinary teams, the SRH workforce is adapted so that healthcare assistants

---


are utilised to their full potential. Nurses deliver most clinical care, with medical leadership overseeing and performing more specialist interventions.

Therefore, FSRH champions multidisciplinarity in service delivery and calls for the development of more opportunities for multidisciplinary training such as the FSRH Diploma, a recognised qualification for both doctors and nurses. Indeed, the Faculty would like to recommend that the Diploma becomes a compulsory part of the GP and Obstetrics & Gynaecology training, two specialties that would greatly benefit from acquiring a more solid foundation in SRH, creating opportunities for more blending of clinical responsibilities and rewarding flexibility in staff roles. Ultimately, FSRH believes that our training models would be of benefit to other specialties.

The Faculty also believes there is scope for further developing nurse qualifications, particularly with regard to abortion care and sexual assault service delivery. There is also scope for developing multidisciplinary qualifications to suit other healthcare professionals, especially considering the current emphasis on deploying new associate roles, mainly Physician Associates (PA).

PA roles will become increasingly central in the delivery of healthcare in a strained healthcare system. Given this reality, FSRH acknowledges the constructive role that PAs play in providing healthcare and the potential for this occupation to tackle workload pressures in primary care, which makes statutory regulation even more urgent. Therefore, FSRH supports statutory regulation of PAs, which would enable high standards of practice and competence to be set, requiring PAs to hold the right level and set of professional qualifications and ensuring the quality and safety of practice, thereby effectively protecting the health of the public.

FSRH believes that PAs who deliver SRH care should be required to undertake appropriate SRH training such as that provided by FSRH. PA training currently focuses on general adult medicine in hospital and general practice, rather than specialist care. Training includes theoretical learning in key areas of medicine, and it includes 80 hours in Obstetrics and Gynaecology, but no specific training in SRH. There is evidence of PAs being trained to fit intrauterine devices (IUDs) in some practices, but this is not the rule. Therefore, FSRH calls for training to be consistently reinforced by regulation in order to guarantee the delivery of high-quality SRH care.

Finally, it is essential to highlight that around 80% of SRH care is undertaken in general practice, and it is vital that a specialist SRH workforce is available to train and support Primary Care healthcare professionals. One of the major problems faced is that fragmentation of commissioning of SRH services between the NHS and local authorities means that budgets for training are often lost or unspecified. We believe HEE should set out clear plans to identify and protect training funds as well as generally support training of all healthcare professionals in Primary Care.

**Principle 3. Providing broad pathways for careers in the NHS, and the opportunity for staff to contribute more, and earn more, by developing their skills and experience.**

Structured career opportunities which enable staff to progress both within and between professions will enhance retention and make the health and care system more resilient and attractive in the face of changing demands from staff.

FSRH believes that there should be a structured career pathway for nurses working in SRH. We have already begun a stream of work looking at competencies required by nurses working in sexual health. HEE support for this work would be of great value, and FSRH is
open for collaborating with HEE on this line of work as well as other initiatives that could enhance career pathways.

FSRH would also like to propose a new concept of training: a Broad-Based Training Programme in women’s health that some doctors could undertake following their Foundation Training. The aim of this programme would be to provide post-foundation experience around women’s health and community-based care.

The Faculty envisions a programme that would last two or three years and incorporate specialties such as Obstetrics and Gynaecology, one which presents vacancies amongst junior positions and a high attrition rate; Psychiatry, a less popular training programme for which essential skills in general practice and women’s health could be of great use given the need for improved mental health support pre and post-conception; General Practice and also CSRH, which would provide a foundation for SRH skills across the healthcare community. Skills and competencies obtained would be transferable and allow for a shorter training time in the final specialty of choice.

One of the greatest benefits of this programme would be greater exposure to community-based women’s healthcare before beginning a specialty training programme, which would hopefully mean less attrition as the chosen specialty is likely to be a “better-fit”. It might also improve recruitment in less popular specialties by affording exposure that would provide a better feel for a given specialty before committing to any specialty training programme.

**Principle 4. Widening participation in NHS jobs so that people from all backgrounds have the opportunity to contribute and benefit from public investment in our healthcare. This enshrines the public duty to provide equal opportunity for all and will ensure the NHS workforce of the future more closely reflects the populations it serves. If delivered successfully it will increase the pool of people available to be recruited into the NHS.**

Tuition fees in England are considered to be higher in comparison with other developed countries³. FSRH is concerned that those from less privileged backgrounds are discriminated against with regards to access to medical and nursing education, particularly regarding the removal of NHS bursary schemes for nurse education. A report by the House of Commons Health and Social Care Committee published earlier this year, based on evidence collected from professionals working in the sector, pointed out that there are worrying signs that the removal of the bursary is having a negative impact on applications from mature students, which is concerning given that a significant proportion of trainee nurses are over the age of 25⁴.

While the Health Committee acknowledges that conclusions are preliminary on the impact of the removal of bursaries, it recognises early warning signs of emerging problems⁵. Consequently, FSRH believes that reinstating the nursing bursaries could prove to be an effective step to guarantee equality of opportunity in a profession that traditionally attracts individuals from all ages and backgrounds whilst increasing the numbers of future qualified nurses entering the workforce.

---


Principle 5. Ensuring the NHS and other employers in the system are inclusive modern model employers with flexible working patterns, career structures and rewards. These need to support staff and reflect the way people live now and the changing expectations of all the generations who work in the NHS. To retain dedicated staff now and in the future requires employment models that sustain the values which drive health professionals every day whilst protecting against burnout, disillusionment or impossible choices between work and home life.

FSRH supports the principle of more flexibility for the workforce. The Faculty generally supports the ability of healthcare professionals to move in and out of training as well as their right to train less than full time for diverse reasons beyond parenthood and caring roles.

We also support flexibility through making our qualifications available to non-doctors; i.e., the FSRH Diploma, and believe that SRH services should be consultant-led but delivered by a variety of healthcare professionals such as nurses, pharmacists, healthcare support workers and medical associate professions. Please refer to our comment on Principle 2.

Principle 6. Ensuring that service, financial and workforce planning are intertwined, so that every significant policy change has workforce implications thought through and tested. This will help ensure the NHS gets the best for patients from all its resources. Aligning service and workforce planning fosters realism alongside creativity in considering what the workforce in all the relevant groups can best contribute to a new or changing service. This will also increase the resilience of workforce planning and ensure the NHS workforce is rightly seen as an enabler of improved services, not as a constraint.

The Five Year Forward View (FYFV)

SRH is forward-looking and holistic, in line with the patient-centred, community-based preventative care originally outlined by the Five Year Forward View (FYFV), fitting with the way the NHS needs to develop to meet increasing demand. The focus of the FYFV is shaped by the need to meet demand for healthcare efficiently by utilising resources effectively. The aim is to provide services which are fit for purpose and facilitate access to healthcare by giving patients choice over where and how they are treated. This vision is substantiated by the increasing pressures on hospitals and general practices compounded by staff shortages.

In turn, SRH services are based on a progressive delivery model usually situated in the community rather than acute care settings. Service models can be integrated across patient need and focussed largely on public health interventions which deliver higher clinical efficiencies than acute care models. SRH consultants have public health and leadership skills to enable them to redesign services and develop new models of care. Service specifications should reflect this need for leadership so that service, financial and workforce planning are intertwined. SRH can also have a fundamental role in supporting an already overburdened general practice.

However, if the CSRH model of integrated care is to meet the goals of the FYFV, an investment in training posts is essential to meet the future demands. The aspirations of the FYFV necessitate recruiting the right numbers of staff at the right competency levels and enabling them to work cohesively by shaping their training to provide them with the skills necessary to deliver the service. New models of care will require a greater investment in training of the current and future workforce equipping them with the skills and flexibilities required to deliver the service all the while without compromising on patient safety.
SRH consultant workforce crisis

FSRH is concerned that the CSRH consultant workforce is in a succession crisis. It is estimated that one third of the current medical workforce could retire in the next 5 years6. Without this leadership, there will be no sustainability for new care models. There are still very few CSRH consultants and the number of funded training places needs to be increased. As mentioned in our comment on Principle 1, there needs to be further investment in this specialist training provision because the current predicted output of the programme falls well short of replacing the vacancies that will arise due to retirement, let alone address the fact that current consultant numbers relative to population numbers are inadequate.

The CSRH specialty has been recognised by the GMC and HEE as a highly fit-for-purpose curriculum that supports community-based patient-centred care. HEE’s Small Specialty Report on CSRH rightly points out that training numbers are small and unlikely to provide the service required for the future, specifically when looking at potential retirements and the increasing feminisation of the workforce. The report recommends increasing consultant posts and fully implementing the Centre of Workforce Intelligence (CfWI) advice to increase training posts to 357.

SRH consultant demand

A SRH consultant can provide leadership to a population of at least 125,0008 and will support the restructuring of services to ensure they are patient centred, efficient and based on public health principles. In particular there is a need for leadership by SRH consultants to support the nursing and GP workforce to deliver all aspects of contraceptive care, inclusive of Level 3 (specialist, complex care).

Although there are not enough CSRH consultants available to meet the demands of the entire population (HEE estimates there should be 440 Whole Time Equivalents for England alone9), FSRH strongly recommends that in order to meet local need, all commissioning arrangements should ensure that CSRH leadership capacity is available within reason of trained CSRH consultant availability. In particular, complex contraceptive care (Level 3) should only be delivered under the clinical leadership of a qualified CSRH consultant, who has fulfilled a higher specialty training programme.

The key benefits of increasing the numbers of consultants in CSRH would be the sustainability of SRH services, as demand continues to increase based on population growth, and the cost-benefit of providing consultant-led integrated SRH care in the community.

Challenges in understanding the SRH workforce

The full details of the current SRH workforce are difficult to decipher because of the way posts are currently recorded on the Electronic Staff Record (ESR). FSRH would welcome a

---

6 HEE, 2015. Small Specialty Community Sexual and Reproductive Health
7 Ibid.
8 The one SRH Consultant per 125,000 population figure is a widely cited and ratified figure. The figure was most recently recognised in HEE Small Speciality Community & Reproductive Health report (2015) and prior to that was cited by the Centre for Workforce Intelligence (2013). The figure was originally determined and published in the joint Department of Health, Royal College of Obstetricians & Gynaecologists & FSRH report, Developing Specialties in Medicine – The case for recognition of Sexual and Reproductive Healthcare as a new CCT specialty (2008).
9 HEE, 2015. Small Specialty Community Sexual and Reproductive Health
SRH workforce census and an improvement in the ESR. It would also be valuable if workforce data for non-NHS staff were recorded. This is even more relevant due to service reconfigurations by Local Authorities; many SRH services are now delivered by community-interest or commercial non-NHS organisations.

Finally, FSRH believes that HEE must act to ensure that reliable data is available from across all sectors to inform workforce planning. Moreover, future projections of demand should be based on demographics and other factors, rather than solely on affordability.

**Question 2: Do you feel measures to secure the staff the system needs for the future can be added to, extended or improved, if so how?**

As already mentioned in our comment on Principle 4, FSRH is concerned that those from less privileged backgrounds are discriminated against with regards to access to medical and nursing education, particularly considering the removal of NHS bursary schemes for nurse education. SRH services can be principally nurse-delivered under appropriate medical leadership, and FSRH would like to see the reinstatement of nurse bursaries to help support the development of this critical workforce.

As mentioned in our comment on Principle 6, we would like to see an increase in training numbers for the medical specialty of CSRH and an end to the current trend of replacing retiring CSRH professionals with those from other specialties; e.g.; Genitourinary Medicine (GUM), who have not received the same systems development training and do not have the same level of gynaecological skills and knowledge. What differentiates SRH and GUM consultants is that Level 3 contraceptive care requires gynaecological training and technical training to carry out skills-based care as opposed to knowledge-based care. CSRH is the only medical specialist training programme that provides this level of competence and expertise for consultant roles including 2 years of gynaecological based training – crucial for level 3 delivery of care. On the other hand, a GUM specialist with a Faculty Diploma does not have the medical training to carry out this level of care. Therefore, SRH services must be led by SRH consultants.

Furthermore, we also support the equivalence pathway for doctors; i.e, doctors who apply for entry onto the Specialist Register with a Certificate of Eligibility for Specialist Registration (CESR) in CSRH. Healthcare professionals may have trained in many elements required for CSRH leadership, and the Faculty would support “top up” training programmes for appropriate candidates. The CESR route offers more immediate advantages such as meeting demand in a shorter period of time; it is also a cost-effective solution and can be targeted at geographical areas where there is identified need.

We would also support the development of skills for non-medical professionals such as pharmacists and PAs in order to support new service delivery models.

**Question 3: Do you have comments on how we ensure the system is effectively training, educating and investing in the new and current workforce?**

FSRH believes that more emphasis should be put on public health and preventative medicine in medical curricula at both undergraduate and postgraduate level. FSRH believes knowledge about public health should be an essential part of the basic toolkit for the next generation of doctors, especially approaches to whole-population care including epidemiology, prevention and health promotion. A strong focus on public health would be beneficial to reinforce graduates’ understanding of the social, economic and environmental
determinants of health, how they affect the individual as well as her/his capacity and will to follow through a course of treatment.

Further, technological advancements already in place and yet to come provide invaluable tools for learning that complement training with real patients. The development of new technologies to support education and training, such as online platforms, will help to support training provision.

Finally, specialty training in CSRH is not only limited by minimal training numbers, but also by the fact that services commissioned by local authorities rather than the NHS often have difficulty finding the 50% funding required to support a trainee. FSRH would welcome fully funded CSRH training posts to help ensure the system is effectively training, educating and investing in the new workforce.

Question 4: What more can be done to ensure all staff, starting from the lowest paid, see a valid and attractive career in the NHS, with identifiable paths and multiple points of entry and choice?

Many medical staff working in SRH are of the Specialty and Associate Specialist (SAS) grade and so receive considerably lower pay and benefits. Work to support this workforce through structured CESR pathways would be incredibly helpful.

Moreover, all workforce should receive regularly focused supervision and annual appraisal and personal development reviews. In January 2018 FSRH published its Service Standards for Supporting Doctors’ Appraisal and Revalidation in SRH10. The standard gives practical guidance on how to complete annual appraisal for those healthcare professionals working in SRH. Guidance includes advice on completing CPD requirements and core activities relevant to SRH. FSRH would like to see HEE support commissioners in ensuring that healthcare professionals are appropriately trained and follow the most up to date clinical standards such as FSRH’s.

Question 5: Do you have any comments on how to better ensure opportunities to; and meets the needs and aspirations of; all communities in England?

Equality and diversity standards need to be met by employers and training organisations. FSRH would like to see more focussed interventions to ensure there is no exclusion of those who are from more diverse backgrounds. Additional support should be given to encourage medical school applications from lower income families. Please also refer to our comment on Principle 4.

Question 6: What does being a modern, model employer mean to you and how can we ensure the NHS meets those ambitions?

The Faculty firmly believes the NHS should support pay progression and reward excellent performance. The loss of the Clinical Excellence Awards scheme may well dishearten the consultant workforce. Regular appraisal and supervision according to the most up-to-date service standards such as the one mentioned in the answer to question 4 may help employees to feel valued.

FSRH’s auditable Service Standards for Workload in Sexual and Reproductive Health should also be used to guide appropriate workload for its professionals. Of note are Standards 4.4, 4.5 and 4.6. Standard 4.4 states that “[j]ob plans for consultants and specialty and associate specialist (SAS) doctors should be in place and updated annually. Job planning allows services to deliver high quality and efficient care and enables personal and professional development”. Standard 4.5 also states that “[t]ime should be allocated within the working week for reflective practice, liaison with colleagues and personal development” and standard 4.6, “[t]ime should be allocated for clinicians to prepare for and meet with commissioners of services to ensure appropriate clinical input into service development”.

Importantly, the SRH workforce is predominantly female so flexible and adaptable working is of particular value.

**Question 7: Do you have any comments on how we can ensure that our NHS staff make the greatest possible difference to delivering excellent care for people in England?**

FSRH supports multidisciplinary models of care and believes that anyone working with SRH should hold the appropriate FSRH qualifications; e.g., the Diploma, Letters of Competence and other more specific qualifications. We support flexible working and a flexible workforce with other professionals also undertaking the relevant qualifications in SRH.

FSRH also supports improved usage of technology, not only to deliver training, but also to deliver patient care, such as online STI testing initiatives. We would like to see the development of standards and guidelines for technological options and recognise that large financial savings could be made with the use of technology, saving limited resources when this is the most appropriate model of care, without compromising on patient safety and face-to-face specialist care.

Above all, FSRH supports patient-centred, high-quality, holistic care that is accessible to all as outlined in our Vision. Our Vision centres around the core principles of patient experience and choice, a well-trained workforce and integrated care. Patient experience means ensuring that patients have access to a comprehensive SRH service delivered by a trained healthcare professional without fear of harassment or stigma. A well-trained workforce, in turn, must have the optimum skill mix to cater for a wide population demand. In turn, integration refers to the establishment of clear referral pathways between services so that care can be integrated around the needs of the individual, not institutional or professional silos.

In order to achieve this, we need to rethink existing workforce design to entail strong leadership and appropriately-trained multidisciplinary teams across different care settings, available to deliver the full range of contraceptive information, support and care.

For further information please contact:
Camila Azevedo, FSRH External Affairs & Standards Officer
Email: externalaffairsofficer@fsrh.org; Telephone: 02037945309

---


Annex 1: Briefing: Importance of Availability of Consultants in SRH at Local Authority Level

Introduction

The CSRH specialty has been recognised by the GMC and HEE as a highly fit-for-purpose curriculum that supports community-based patient-centred care. A SRH consultant can provide leadership to a population of at least 125,000 and will support the restructuring of services to ensure they are patient centred, efficient and based on public health principles. In particular there is a need for leadership by SRH consultants to support the nursing and GP workforce to deliver all aspects of contraceptive care, inclusive of Level 3.

Although there are not enough CSRH consultants available to meet the demands of the entire population (HEE estimates there should be 440 Whole Time Equivalents for England alone), FSRH strongly recommends that in order to meet local need, all commissioning arrangements should ensure that CSRH leadership capacity is available within reason of trained CSRH consultant availability.

In particular, complex contraceptive care (Level 3) should only be delivered under the clinical leadership of a qualified CSRH consultant, who has fulfilled a higher specialty training programme.

Overview points

- Women make up at least 50 per cent of the population. The size of need is by far the biggest across sexual health services and yet the evidence is clear that significant proportions of women do not have access to all contraception methods, and FSRH is receiving regular reports from GPs that they are no longer providing Long Acting Reversible Contraception (LARC).

- Level 3 contraceptive care (see Appendix 1) i.e. highly complex contraception care, can only be delivered by SRH consultants and cannot be delivered by GUM consultants.

- Level 3 contraceptive care requires gynaecological training and technical training to carry out skills-based care as opposed to knowledge-based care. CSRH is the only medical specialist training programme that provides this level of competence and expertise for consultant roles including 2 years of gynaecological based training – crucial for level 3 delivery of care.

13 The one SRH Consultant per 125,000 population figure is a widely cited and ratified figure. The figure was most recently recognised in the Health Education England Small Speciality Community & Reproductive Health report (2015), and prior to that was cited by the Centre for Workforce Intelligence (2013). The figure was originally determined and published in the joint Department of Health, Royal College of Obstetricians & Gynaecologists & FSRH report, Developing Specialties in Medicine – The case for recognition of Sexual and Reproductive Healthcare as a new CCT specialty (2008), page 20.

14 Small Speciality Community & Reproductive Health report (HEE, 2015)

15 The AGC, of which FSRH is a member, launched its new report Cuts, Closures and Contraception in 2017. This research shows that local authority commissioned contraception services are having to cut services and introduce restrictions in many parts of England following Government cuts to the public health budget.
• A GUM specialist with a DFSRH (Faculty Diploma- see Appendix 2) does not have the medical training to carry out this level of care. BASHH and FSRH are agreed on this, as outlined in our respective Standards.

• The FSRH Diploma (DFSRH- see Appendix 2) alone does not equip a doctor or nurse to provide more than Level 1 contraceptive care (Appendix 1) – it is aimed at GPs and nurses working in primary care or specialist services.

SRH Consultants as system leaders

• Having an experienced SRH consultant – who can cover a large geographical area – enables other healthcare professionals/workforce to provide care more confidently, and it facilitates their training and clinical supervision.

• The CSRH curriculum aims to produce medical consultants who are trained both to deliver specialist clinical care themselves; but also to be highly-skilled systems leaders who design and support services provided by others – whether they are GPs, nurses, healthcare assistants or other professionals.

• The specialty was designed specifically to provide leadership to the delivery of the bulk of routine SRH care from nurses, GPs and others whilst the CCT holder also has a thorough clinical understanding and some high-level clinical skills.

• Care would typically comprise of specialist (complex) contraception services, STI/infection testing, community-based gynaecological services, abortion care, menopause care, psychosexual care, sexual assault care, care to vulnerable groups and support to healthcare professionals providing routine STI and contraception care.

• In addition, these consultants have received extensive training in public health to ensure that the design of services are rooted in prevention and health promotion and fit with the wider attempts to promote good health and tackle inequalities among the population as a whole.

• It is important that staff within provider bodies are appropriately qualified to provide clinical leadership for the services being offered whether they are sexual health or reproductive health services (for example, consultant level in Level 3 services). Clinical leadership should be regarded as distinct from service leadership, although in some services, both roles may be provided by the same individual.

• Without appropriate leadership and training structures in place, commissioning bodies risk litigation should a procedure not be carried out to the required standards.
Appendix 1: Level 3 Contraceptive Care

Exert from: FSRH *A Quality Standard for Sexual and Reproductive Healthcare Services*

APPENDIX 3
Levels of sexual and reproductive healthcare*

<table>
<thead>
<tr>
<th>LEVEL 1 (EVERY GENERAL PRACTICE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual history and risk assessment</td>
</tr>
<tr>
<td>STI testing for women</td>
</tr>
<tr>
<td>Assessment and referral of men with STI symptoms</td>
</tr>
<tr>
<td>HIV testing and counselling</td>
</tr>
<tr>
<td>Hepatitis B immunisation</td>
</tr>
<tr>
<td>Provision of oral hormonal contraception</td>
</tr>
<tr>
<td>Information about choice of full range of contraceptive methods and where available</td>
</tr>
<tr>
<td>Cervical cytology screening and referral</td>
</tr>
<tr>
<td>Pregnancy testing and referral</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LEVEL 2 (PRIMARY CARE TEAMS WITH A SPECIAL INTEREST)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Testing and treating STIs</td>
</tr>
<tr>
<td>Partner notification</td>
</tr>
<tr>
<td>IUD and implant insertion</td>
</tr>
<tr>
<td>Management of psychosexual problems</td>
</tr>
<tr>
<td>Vasectomy surgery</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SPECIALIST/LEVEL 3 (SPECIALIST SERVICES)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach for STI prevention/contraception</td>
</tr>
<tr>
<td>Specialised STI management/partner notification</td>
</tr>
<tr>
<td>Specialist HIV treatment and care</td>
</tr>
<tr>
<td>Highly specialised contraception</td>
</tr>
<tr>
<td>Termination of pregnancy services</td>
</tr>
<tr>
<td>Local co-ordination and back up for sexual assault</td>
</tr>
<tr>
<td>Psychosexual/sexual dysfunction services</td>
</tr>
<tr>
<td>Make sure local guidelines and framework for monitoring and improving practice are in place</td>
</tr>
<tr>
<td>Support clinical governance requirements at all levels</td>
</tr>
<tr>
<td>Provide professional training, designing and updating care pathways and developing new services</td>
</tr>
</tbody>
</table>
## APPENDIX 4

Minimum provision of contraceptive measures by provider

<table>
<thead>
<tr>
<th>CONTRACEPTIVE METHOD</th>
<th>General practice</th>
<th>Specialist/Level 3 SRH services</th>
<th>Level 1 or 2 provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMERGENCY CONTRACEPTION – PROGESTOGEN-ONLY</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>EMERGENCY CONTRACEPTION – ULPRESSRAL ACETATE</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>EMERGENCY CONTRACEPTION – INTRAUTERINE DEVICE</td>
<td>Referral*</td>
<td>✔</td>
<td>Referral</td>
</tr>
<tr>
<td>CONDOMS – MALE</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>CONDOMS – FEMALE</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>DIAPHRAGM</td>
<td>Referral</td>
<td>✔</td>
<td>Referral</td>
</tr>
<tr>
<td>PROGESTOGEN ONLY – ORAL</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>PROGESTOGEN-ONLY – INJECTABLE</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>PROGESTOGEN ONLY – SUBDERMAL</td>
<td>Referral*</td>
<td>✔</td>
<td>Referral</td>
</tr>
<tr>
<td>PROGESTOGEN-ONLY – INTRAUTERINE</td>
<td>Referral*</td>
<td>✔</td>
<td>Referral</td>
</tr>
<tr>
<td>COMBINED HORMONAL – ORAL†</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>COMBINED HORMONAL – TRANSDERMAL</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>COMBINED HORMONAL – VAGINAL RING</td>
<td>✔</td>
<td>✔</td>
<td>Referral</td>
</tr>
<tr>
<td>COPPER – INTRAUTERINE</td>
<td>Referral*</td>
<td>✔</td>
<td>Referral</td>
</tr>
<tr>
<td>NATURAL FAMILY PLANNING</td>
<td>Referral</td>
<td></td>
<td>Referral</td>
</tr>
<tr>
<td>STERILISATION – MALE</td>
<td>Referral</td>
<td>Referral†</td>
<td>Referralª</td>
</tr>
<tr>
<td>STERILISATION – FEMALE</td>
<td>Referral</td>
<td>Referral†</td>
<td>Referralª</td>
</tr>
</tbody>
</table>
Examples of level 3 care

Coincidental medical conditions requiring specialist assessment and planning contraceptive care:
► Often linking with GP and hospital specialist e.g. haematologist or oncologist.
► Endocrine disorders
► Exclusion of endometrial abnormality

Outpatient surgical interventions:
► Failed insertion of devices
► Failed removal of devices
► Missing devices
► Uterine perforation
► Deep implants

Assessment and management of side effects of contraceptive methods

Appendix 2: FSRH Diploma

The FSRH Diploma is aimed at doctors (DFSRH) and nurses (NDFSRH) who are already working in general practice, community and integrated sexual health services. The Diploma is open to doctors with both registration and a licence to practise with the UK GMC or nurses on the UK NMC register (excluding RN Level 2). It is accredited by the RCGP. Diplomates tend to be those not working fulltime in SRH. CSRH trainees undertake the Diploma as part of the specialty curriculum. Clinicians currently holding the Diploma must also be a member of the Faculty to recertify. The FSRH Diploma is a blended learning package, underpinned by an e-portfolio that records progress. It is supported by a network of Faculty registered trainers and training programme directors. The Diploma has three stages, which build on each other.

1. Theoretical knowledge – this is based on the Faculty’s clinical guidelines. Trainees must pass an online knowledge assessment (the ‘eKA in SRH’).
2. Course of 5 – five hours of small group-assessed workshops (locally delivered).
3. Clinical experience & assessments in seven topics (locally delivered).

It has been recognised that the Diploma is in need of review to ensure that excellent standards of medical education & training are delivered, and practitioners are competent and safe to practice e.g. the Peile Report 2012 and other more recent consultation. It has also been recognised that it would be helpful if the Faculty could make it easier for those understanding the Diploma to go through it from a practical point of view.