

Service Standards for Consultations in Sexual and Reproductive Health Services



The Faculty of Sexual and Reproductive Healthcare (FSRH) is the largest UK professional membership organisation working in the field of sexual and reproductive health (SRH). We support healthcare professionals to deliver high quality healthcare including access to contraception. We provide our 15,000 doctor and nurse members with NICE-accredited evidence-based clinical guidance, including the UKMEC, the gold standard in safe contraceptive prescription, as well as clinical and service standards.

The FSRH provides a range of qualifications and training courses in SRH, and we oversee the Community Sexual and Reproductive Healthcare (CSRH) Specialty Training Programme to train consultant leaders in this field. We deliver SRH focused conferences and events, provide members with clinical advice and publish *BMJ Sexual & Reproductive Health* – a leading international journal. As a Faculty of the Royal College of Obstetricians and Gynaecologists (RCOG) in the UK, we work in close partnership with the College but are independently governed.

The FSRH provides an important voice for UK SRH professionals. We believe it is a human right for women and men to have access to the full range of contraceptive methods and SRH services throughout their lives. To help to achieve this we also work to influence policy and public opinion working with national and local governments, politicians, commissioners, policy makers, the media and patient groups. Our goal is to promote and maintain high standards of professional practice in SRH to realise our vision of holistic SRH care for all.

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Published by the Clinical Standards Committee

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First Published: 2015

Review dates: 2020

Next review date: 2023

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SERVICE STANDARDS FOR CONSULTATIONS IN SEXUAL AND REPRODUCTIVE HEALTH SERVICES

Changes introduced since review

- ▶ Inclusion of standards for online and remote consultations in addition to face-to-face consultations.
- ▶ Additional standards supporting patients where English is a second language or need for alternative provision.
- ▶ Update to standards for confidentiality to include General Data Protection Regulations.
- ▶ Update to standards for special groups.
- ▶ References are added as footnotes.

Introduction

This standard provides guidance on the best practice for healthcare professionals conducting Consultations in Sexual and Reproductive Healthcare to provide safe, efficient, and effective healthcare that is patient centred and equitable.

It can be adapted and used in all clinical settings where patients request contraception. This includes Integrated Contraception and Sexual Health Services (CASH), Genitourinary Medicine Clinics, Outreach Services, General Practice, Pharmacy, Termination of Pregnancy Services and remote consultations such as telephone or online. Remote consultations and prescribing provided online, over video-link or by phone can benefit patients using healthcare services, save resources and help meet public demand for more convenient access to healthcare advice.

However, there are potential patient safety risks to consulting remotely and patients can expect to have effective safeguards in place to protect them not only when they attend a face to face consultation but also when they receive advice and treatment remotely. Safeguards are necessary whether the consultation happens in the context of an ongoing clinical relationship, or is a one-off interaction between the patient and healthcare professional.

This standard should be used by all healthcare professionals, who are required to assess a patient's sexual and reproductive healthcare needs.

Unlike the specific guidance published by the Clinical Effectiveness Unit (CEU), this is not a tool to support clinical decision making, nor is it designed to be prescriptive in the information required to make such decisions. The role of this document is to address the factors required to create an environment conducive to both the healthcare professional and patient to obtaining accurate, relevant, and concise information. This will facilitate the clinical decision.

The standard may be used to assess consultation skills prior to a clinician entering training for any of the FSRH qualifications. The aim of this standard is to improve the care received by

patients, and it should be used in conjunction with the following service standards to support clinical best practice:

- ▶ Record Keeping
- ▶ Confidentiality
- ▶ Quality Standard for Contraceptive Services
- ▶ Risk Management
- ▶ Workload
- ▶ Obtaining Valid Consent
- ▶ Standards for Online and Remote Providers of Sexual and Reproductive Health Services

1 Standard Statement on Promoting Privacy, Dignity and Confidentiality

A service or practice policy/statement on confidentiality should be displayed prominently in a patient area.

- 1.1 It is a duty and core requisite of all employing organisations to adhere to the Caldicott principles of patient confidentiality. These principles are supported all healthcare professional regulatory bodies.^{1, 2, 3, 4, 5}
- 1.2 Confidentiality is pivotal to trust between healthcare professionals and patients. Without assurances about confidentiality, patients may be reluctant to seek medical care or to provide healthcare professionals with the information required to offer safe, effective management which is essential for the individual patient and the wider community.^{2, 4}
- 1.3 All patients should be offered the same level of respect and confidentiality, regardless of the consultation environment.²
- 1.4 A service or practice policy/statement on confidentiality, applicable to all clinicians, should be displayed prominently. This has been highlighted as particularly relevant for young people.⁶
- 1.5 Confidentiality is not absolute. Information in exceptional circumstances can be shared if:
 - ▶ It is required by law.
 - ▶ It is justified in the patient's or the public's best interest, i.e. child or adult safeguarding concerns.^{1, 2, 4, 5, 6}
- 1.6 The limits of confidentiality should be individually communicated to patients with vulnerabilities.⁷
- 1.7 Information about individuals must be held confidentially and comply with the 2018 Data Protection Act (DPA), the General Data Protection Regulation (GDPR) and any

¹Department of Health and Social Care, 2013. [Caldicott Principles](#).

²General Medical Council, 2017. [Confidentiality](#).

³Nursing and Midwifery Council, 2018. [The Code](#).

⁴Department of Health, 2013. [Information to share or not to share: Information Governance Review](#).

⁵Health & Care Professions Council, 2018. [Confidentiality Guidance](#).

⁶HM Government, 2010. [Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children](#).

⁷Department of Health, 2015. [Patient confidentiality in SH/ SRH services](#).

regulations pertinent to Sexual and Reproductive Health.^{8, 8, 9, 10}

- 1.8 The provider must ensure that all records relating to the service user (including assessments, care and treatment plans, correspondence and referrals) are kept securely for the required retention periods.^{11, 12, 13, 14}
- 1.9 The healthcare professional should be confident that they are talking to the correct patient and should confirm this by asking confirmatory demographic questions prior to commencing face to face or remote consultations.
- 1.10 Patients should not be required to present proof of identification or UK residence. These documents can create obstacles which may prevent patients from accessing services.
- 1.11 For remote consultations, if the patient is not available or the confirmatory demographic questions are not answered satisfactorily, the consultation should be drawn to a close, providing appropriate reasoning. Information or the nature of call should not be disclosed.
- 1.12 For remote consultations, the healthcare professional should explain the reason for the call and make sure the patient is happy to continue with the consultation. It is advisable to set a timeframe with the patient for clarification.
- 1.13 A remote consultation should not take place if either party is driving, or unable to fully partake in the consultation.

⁸ HM Government, 2018. [Data Protection Act 2018. \(c12\)](#)

⁹ European Parliament, 2016. [General Data Protection Regulation.](#)

¹⁰ General Medical Council, 2018. [Confidentiality: good practice in handling patient information.](#)

¹¹ Faculty of Sexual & Reproductive Healthcare, 2019. [Service Standards for Record Keeping.](#)

¹² Information Governance Alliance, 2016. [Records Management Code of Practice for Health and Social Care 2016.](#)

¹³ Scottish Government, 2008. [Records Management: NHS Code of Practice \(Scotland\) Annex D, Part 3.](#)

¹⁴ Department for Health and Social Services, Welsh Government, 2015. [Standard 20: Records Management.](#)

2 Standard Statement on Clinical Environment

Information leaflets should be available for both English and non-English speaking patients including British Sign Language and easy read versions.

- 2.1 Every effort should be made during face to face and remote consultations to ensure the environment is comfortable and facilitates confidentiality and respect for patient dignity.^{15, 16, 17}
- 2.2 Consultation rooms or offices where remote consultations are conducted should be designed to ensure any information shared cannot be overheard by others.¹⁹
- 2.3 Interruptions to consultations should be kept to an absolute minimum during face to face and remote consultations.¹⁹
- 2.4 Permission must be sought from a patient if observers/students are to be present during face to face and remote consultations.¹⁷
- 2.5 Valid consent must be sought from the patient for a healthcare professional trainee to be present and or undertaking face to face or remote consultations.
- 2.6 Any requests for a specific gender of healthcare professional should be accommodated as far as possible or the patient referred to alternative services if the request cannot be met and they decline to see the healthcare professional on the basis of gender.¹⁰
- 2.7 Clear evidence-based patient information should be available to support the consultation in a choice of languages and formats suitable for the patient.^{17, 18, 18}
- 2.8 Information provided in the form of leaflets/websites should be recorded in the clinical record along with the source. All patient information leaflets available for distribution must be kept up to date by the organisation. The date of publication (or version) of the written information provided should be noted. Patient information leaflets should be stored for 6 years after updating.¹⁷
- 2.9 Locally written information should be evidence based and have undergone a process of ratification prior to use.
- 2.10 Additional support should be available for those who require information to be provided in a language other than English, including British Sign Language and easy read versions.
- 2.11 Healthcare Professionals should establish the most effective method of

¹⁵ Faculty of Sexual & Reproductive Healthcare, 2016. [Service Standards for Sexual and Reproductive Healthcare.](#)

¹⁶ British Association Sexual Health and HIV, Clinical Effectiveness Group, 2013. [UK National Guideline for Consultations Requiring Sexual History Taking.](#)

¹⁷ Rogstad K, Johnston G, 2014. [Spotting the Signs: A National Proforma for Identifying Risk of Child Sexual Exploitation in Sexual Health Services.](#)

¹⁸ Royal College of General Practitioners, n.d. [Communication and Consultation Skills Competency.](#)

communication with each patient and if necessary, consider ways of making information accessible and understandable (for example using pictures, symbols, large print) or a patient advocate.

- 2.12 Services should accommodate the needs of young people as recommended in The Department of Health's *You're Welcome* document or in Scotland as highlighted in the Pregnancy and Parenthood Young People Strategy.^{19, 20}

¹⁹ Young People's Health, 2017. ['You're Welcome', the Department of Health's quality criteria for young people friendly health services.](#)

²⁰ NHS Scotland, 2016. [Outcomes Framework and supporting evidence for the Pregnancy and Parenthood in Young People Strategy in Scotland.](#)

3 Standard Statement on Verbal Communication Skills

Information should be communicated in a manner that is clear and understandable.

- 3.1 The consultation process should be explained in advance and patients should be informed that they will be asked for personal information. In view of this all patients should be given an opportunity to be seen alone first.¹⁷
- 3.2 All healthcare professionals should have effective verbal communication skills and be conscious of their verbal communication throughout the consultation.^{17, 18, 20}
- 3.3 The healthcare professional should be aware of verbal and non-verbal communication and listen to the patient's tone of voice and watch for signs that may indicate the patient does not understand or is not happy with the proposed management plan.
- 3.4 All healthcare professionals should use plain English language and avoid use of medical jargon and acronyms.
- 3.5 For an effective consultation, healthcare professionals should:
 - ▶ Advocate the 'Hello my name is' campaign and introduce themselves.
 - ▶ Check with the patient how they prefer to be addressed, inclusive of gender sensitivities.
 - ▶ Confirm the patient's identity, i.e. check that the name and date of birth on the clinical record are correct.
 - ▶ Confirm contacts details and preferred method of contact.
 - ▶ Use 'open questions' to initiate the consultation.
 - ▶ Use 'closed questions' to obtain or clarify specific information.
 - ▶ Adapt their language so that it can be understood by patients.
 - ▶ Check back that the patient has understood, e.g. by asking them to reflect back.
 - ▶ Discuss, agree and develop/update the management plan, in partnership with the patient in a way which respects patient autonomy.
 - ▶ Information to be shared should be clarified with the patient during of the consultation.
 - ▶ Ensure regular patient feedback is collected by service.
- 3.6 Interpreting services should be available for all patients if required. Relatives and friends should only be used for translation in exceptional circumstances. The translator's unique ID number, the language used and language line number as appropriate should be documented.¹

4 Standard Statement on Non-Verbal Communication Skills

Healthcare professionals should be welcoming, non-judgemental and put the patient at ease.

- 4.1 A patient centred approach should be adopted, i.e. care which is holistic, flexible and collaborative.²¹
- 4.2 Body language should be open and appropriate.
- 4.3 Healthcare professionals should be alert to non-verbal signs of patient anxiety or distress.¹⁸
- 4.4 Where face to face consultations occur, eye contact with the patient should be maintained, unless this would be deemed culturally unacceptable.
- 4.5 Patients should be made to feel comfortable.
- 4.6 Where remote consultations take place, healthcare professionals should consider appropriate opportunities to seek clarification of understanding from the patient and provide feedback.
- 4.7 It is good practice to check with the patient that the process of telephone consultation is working well, remains acceptable to the patient and clinically appropriate.

²¹Royal College of General Practitioners, 2014. [An Inquiry into Patient Centred Care in the 21st Century](#).

5 Standard Statement on Use of a Chaperone

All patients should be offered a chaperone, and this should be documented in the patient's record.

- 5.1 All patients should be given the option to have an impartial observer to act as a chaperone, wherever possible, for all intimate examinations. This is not dependent upon the gender of the healthcare professional and is recommended for all clinical examinations of an intimate nature.^{22, 23, 24}
- 5.2 If a chaperone cannot be provided, the patient must be informed and a decision to continue to procedure should be reviewed. The outcome of any review should be clearly documented in the clinical record.^{24, 25}
- 5.3 A chaperone should be a healthcare professional or a staff member who has completed recognised chaperone training and achieved the required competencies.²⁵
- 5.4 The chaperone will:
- ▶ Be sensitive and respect the patient's dignity and confidentiality
 - ▶ Reassure the patient if they show signs of distress or discomfort
 - ▶ Be familiar with the procedures involved in intimate examinations
 - ▶ Be present for the duration of the examination and be in a position to comment on the healthcare professional's interaction if required
 - ▶ Be prepared to raise concerns if they are uncomfortable about the healthcare professional's or patient's behaviour or actions
- 5.5 A relative or friend of the patient is not an impartial observer and therefore would not usually be a suitable chaperone. The FSRH recommends that the healthcare professional leading the consultation and examination, should comply with a patient's reasonable request to have such a person present as well as a chaperone.^{24, 25, 26}
- 5.6 Cultural or religious beliefs, which prohibit examination by a healthcare professional of the opposite sex, or the presence of a chaperone of the opposite sex should be respected. Any preferences and/or objections should be identified as early as possible to eliminate unnecessary distress. The individual requirements of the patient should be respected, and the preference documented.²⁶
- 5.7 If a chaperone is present, this should be recorded in the patient record, including their name and role. If the patient does not want a chaperone, the offer being made and declined should be documented and organisations should follow their local policies.^{24, 25, 26}

²² General Medical Council, 2013. [Maintaining boundaries.](#)

²³ Royal College of Nursing, 2013. [Regulation in Practice.](#)

²⁴ Royal College of Nursing, 2016. [Genital Examination for Women.](#)

6 Standard Statement on Special Groups^{25, 26}

All healthcare professionals must have completed training in safeguarding of children and vulnerable adults in line with national guidance.

- 6.1 Additional time should be allocated for consultations for individuals with specific needs wherever possible.^{17, 18, 19}
- 6.2 All healthcare professionals should have access to a specific proforma/template designed for use in consultations with young people, such as ‘Spotting the Signs’ or equivalent. This will support the healthcare professionals to confidently assess for the following:
 - ▶ Gillick Competence and Capacity to Consent.
 - ▶ Indicators of possible Child Sexual Exploitation.^{17, 19, 27, 28}
- 6.3 All healthcare professionals should be aware of the additional needs of vulnerable adults and work collaboratively with partnership organisations (i.e. primary and social care) to maintain an individual’s safety as appropriate.²⁹
- 6.4 Provision should be made for patients with disabilities including access to buildings, suitable consultation rooms and appropriate communication methods.^{20, 30}
- 6.5 Healthcare professionals should be able to communicate effectively with patients who allege sexual assault and to refer them to a specialist sexual assault referral centres (SARC) or an equivalent specialist service if necessary.^{32, 31}
- 6.6 All consultations including outreach and remote consultations should have formal processes for identifying anything which may interfere with the delivery of safe, good quality care. These processes should apply to all modes of service delivery including outreach.^{17, 19, 32}
- 6.7 The healthcare professional should adapt communication techniques and materials to help all patients get the most from the consultation.^{20, 31}
- 6.8 Healthcare professionals should be aware of Female Genital Mutilation (FGM) and provide support for victims. Reporting of FGM should be guided by the Mandatory Reporting of Female Genital Mutilation procedural information and in conjunction with

²⁵ Royal College of Paediatrics and Child Health, 2014. [Safeguarding Children and Young People: Roles and Responsibilities for Healthcare Staff.](#)

²⁶ Royal College of Nursing, 2018. [Adult Safeguarding: Roles and Competencies for Health Care Staff.](#)

²⁷ Department for Education, 2018. [Working Together to Safeguard Children: A Guide to Inter-agency Working to Safeguard and Promote the Welfare of Children.](#)

²⁸ General Medical Council, 2008. [Consent: Patients and Doctors Making Decisions Together.](#)

²⁹ National Institute Health Care and Excellence, 2018. [Domestic Violence and Abuse: How Health Services, Social Care and the Organisations They Work with Can Respond Effectively.](#)

³⁰ Department of Health, 2013. [Statement of Government Policy on Adult Safeguarding.](#)

³¹ General Medical Council, 2019. [Good Medical Practice.](#)

³² Faculty Sexual and Reproductive Healthcare, 2017. [Service Standards for Risk Management in Sexual and Reproductive Health.](#)

relevant guidance on FGM and safeguarding.^{33, 34}

³³Home Office, 2016. [Mandatory Reporting of Female Genital Mutilation](#).

³⁴ Scottish Government, n.d. [Policy on Violence against Women and Girls](#).

7 Standard Statement on Child Sexual Exploitation (CSE)

All Clinicians should complete training in Child Sexual Exploitation (CSE).

- 7.1 Services should use a risk assessment tool to quantify the risk of exploitation to the child.^{35, 35, 40}
- 7.2 Points to consider but not limited to:
- ▶ Accommodation
 - ▶ Alcohol use/dependence
 - ▶ Criminal activity or convictions
 - ▶ County Lines involvement
 - ▶ Drug/substance misuse
 - ▶ Engagement with services
 - ▶ Episodes of being missing from home
 - ▶ Education, schooling, attendance
 - ▶ Relationship with family/carers
 - ▶ Sexual health awareness
 - ▶ Sexual behaviour, sexually active, age of partners
- 7.3 Healthcare professionals should be familiar with the local safeguarding children policies and referral pathways and report any concerns appropriately.
- 7.4 Services should encourage a culture of collaboration and information sharing with the police and other care agencies to protect vulnerable children.
- 7.5 Healthcare professionals should undertake risk assessments effectively, communicate information sensitively and respond appropriately to any safeguarding concern.

³⁵ Royal College of General Practitioners, 2014. [An Inquiry into Patient Centred Care in the 21st Century.](#)

⁴⁰ Barnardos, n.d. [Seraf Service.](#)