Service Standards for Workload in Sexual and Reproductive Health
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INTRODUCTION

Within the UK there is considerable variation in sexual and reproductive health service provision. This guidance aims to quantify the amount of time required to provide a safe and high quality consultations, enabling planning of standardised service delivery.

Guidance used to inform these standards includes:

- Improving health and work: changing lives,
- Guidelines on Working Patterns for Junior Doctors,
- Working time Regulations
- the Medical Foundation for AIDS & Sexual Health (MedFASH) sexual health standards
- the Scottish Standards for Sexual Health Services
- Service Standards for Sexual Health Services from the Faculty of Sexual and Reproductive Healthcare.

Workload includes the following components:

- Number of patients seen in clinics
- Length and type of consultation, including specific procedures, e.g. IUD/Implant insertion
- Time allocation for trainees, medical students and additional activities, e.g research, audit
- Skill mix and the role of doctors, nurses, clinical support and clerical staff
- Specific characteristics of the population served, e.g. young people, minority ethnic groups, asylum seekers, those whose first language is not English, those with other special needs or disabilities.

All services using these standards should be able to audit themselves against them.

Services should meet the needs of the local population informed by a health needs assessment and support user involvement.

1.1 Current local data including patient surveys should be used to inform a health needs assessment to ensure services meet the local population needs.²

1.2 Service users should be encouraged to provide feedback on their personal experience of care and to offer opinions about services managing STIs, both current and future.

1.3 Services should be open access, provide a selection of walk-in (ie no appointment necessary) and appointment-only clinics. The mix will be determined by the needs of the local population in conjunction with the availability of other sexual health services.

1.4 Open access should be defined in terms of both clinic provision and access to services. Patients should be able to self-refer regardless of residential postcode.

1.5 Information should be visible and easily accessible to patients. There should be access to current electronic and web-based information.

1.6 Services should have the facility to offer urgent / emergency appointments on the same working day.⁶

1.7 Services should provide telephone advice on the same working day or within 24 hours depending on the availability of the local service.

1.8 Patients should be able to access non-urgent information, advice or services within 2 working days.⁶

1.9 The waiting times for walk-in services, should be no longer than 2 hours.⁶

1.10 Appointments for procedures for long-acting reversible contraception (LARC) methods should be offered within 4 weeks of initial contact if clinically appropriate.

1.11 There should be the facility to leave voicemail and messages should be retrieved and acted upon according to local policy.⁵

1.12 Services should meet national waiting time targets.

1.13 Services should address workload in a way, which is sensitive to the religious and cultural needs of the population eg. female staff in certain clinics.

1.14 All patients should be given the option to have an impartial observer to act as a chaperone for all intimate examinations. This is not dependent upon the gender of the clinician and is recommended for all clinical interactions of an intimate nature. Error! Bookmark not defined.⁹¹⁰
1.15 Additional time should be allocated for consultations for individuals with specific communication needs, including those for whom English is not the first language the visually impaired and for individuals with hearing impairment.

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

1.17 A referral mechanism should be available for access to other local services e.g. to hub-and-spoke clinics.

1.18 Patients should have access to services at various locations and at times of the day including evenings to suit their individual needs. Service users should be consulted when considering the location and clinic times.
2. Standard Statement on Length of Consultation

The minimum recommended consultation time for a routine new appointment is 20 minutes and the minimum recommended time for a routine follow-up appointment is 10 minutes.

2.1 A Clinician (nurse or doctor) should be allocated 20 minutes for the following consultations:

A new consultation including:

- First prescription of hormonal contraception including a new method
- IUD/IUS insertion
- Sub-dermal implant insertion or removal
- Pregnancy advisory services
- Male or female sterilisation counselling
- Request for emergency contraception

Additional time may be needed where multiple activities are required eg. a new consultation is combined with implant removal and IUC insertion. Consultations involving special procedures like ultrasound scan, deep implant removal or complicated IUC insertion may require additional time depending on the complexity of the individual case. Extra time is also needed when multiple issues such as cervical cytology, sexual health screening or partner notification is undertaken or when there is a need to address complex contraceptive problems.

Screening for and reporting safeguarding children issues are potentially time consuming, frequently necessitating a longer consultation.

2.2 A minimum of 10 minutes should be allocated to a clinician (nurse or doctor) for a routine follow-up appointment.

2.3 Extra time should be allocated to patients with special needs eg. very young (those who need assessment of Fraser competency) and those groups with special needs as identified by individual services e.g. those requiring an interpreter.

2.4 Time should be allotted for contemporaneous documentation of the consultation.
3. Standard Statement on Skill Mix

Services, but not necessarily individual clinics, should be staffed by doctors, nurses and healthcare assistants with a variety of skills working as a clinical team.

3.1 Services should ensure that an appropriate skill mix of clinical staff is employed to maximise each clinician’s potential and to provide a high standard of care for patients in a professional and organised clinical setting with adequate support.

3.2 Services should have appropriate senior staff input. Independent nurse clinics should be appropriately supported by the presence of a doctor or senior nurse with appropriate clinical skills.

3.3 Services should have in place mechanisms to support all clinicians to continue appropriate professional development, through on-going training and other initiatives. Nurses should be supported in the use of patient group directions (PGDs), or non-medical prescribing qualification. Staff should have ready access to current service specified standard operating procedures and national treatment guidelines eg. FSRH and BASHH. Internet facilities should be available.
4. Standard Statement on Individual Clinician Workload

Clinicians should work for no more than 6 hours in the clinic setting with patients without a break for a minimum of 20 minutes.

4.1 Clinicians should work for no more than 6 hours in the clinic setting with patients without a break (a minimum of 20 minutes).\textsuperscript{3}

4.2 Time should be allocated for telephone consultations as clinically appropriate.

4.3 Time should be allotted for clinical administration e.g. Correspondence and onward referral.

4.4 Job plans for consultants and 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.\textsuperscript{14}

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

4.6 Time should be allocated for clinicians to prepare for and meet with commissioners of services to ensure appropriate clinical input into service development.
5. **Standard Statement on Training and Assessment**

In clinics designated for training and assessment purposes, the minimum recommended consultation time for a routine new appointment is 30 minutes and for a routine follow up appointment the minimum recommended consultation time is 15 minutes.

5.1 Learners undertaking the DFSRH/NDFSRH/LoC should have acquired knowledge and relevant clinical skills prior to clinical contact. Allocated time within the training clinics should be used for feedback and assessment with less emphasis on training.

5.2 In clinics designated for training purposes there should be sufficient time allocated to allow for assessment of prior experience, teaching if appropriate and feedback. 30 minutes should be allocated for a routine new consultation and 15 minutes should be allocated for a routine follow up consultation.

5.3 Trainers should have time within their job plan that allows them to fulfil their educational responsibilities and develop their skills in medical education.\(^{15}\)

5.4 Services should design rotas to ensure doctors and nurses in training and medical and nursing students have appropriate workloads, learning opportunities and clinical supervision by suitably qualified members of staff. Foundation doctors must have access to an on-site senior colleague at all times.\(^{15}\)^{16}

5.6 Service user feedback should be supported and time allocated to review this with trainees.

5.7 There should be ongoing encouragement of appropriately trained staff to become mentors/trainers.


