

# Service Standards for Workload 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 National Institute for Clinical Effectiveness (NICE) accredited evidence-based clinical guidance, including the UK Medical Eligibility Criteria (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 all individuals 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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of the Royal College of Obstetricians and Gynaecologists

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## SERVICE STANDARDS FOR WORKLOAD 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
- ▶ Updated references and links to relevant standards
- ▶ References are added as footnotes

### Introduction

Within the UK there is considerable variation in sexual and reproductive health service provision. This guidance aims to support the provision of safe, equitable, services and enable planning of standardised service delivery.

This standard should be used in conjunction with the following service standards to support best clinical practice:

- ▶ Quality Standard Contraceptive Services<sup>1</sup>
- ▶ Service Standards for Risk Management in Sexual and Reproductive Healthcare<sup>2</sup>
- ▶ Standards for Online and Remote Providers of Sexual and Reproductive Health Services<sup>3</sup>
- ▶ Service Standards for Consultations in Sexual and Reproductive Health Services<sup>4</sup>
- ▶ BASHH/FSRH Standards for Online and Remote Providers of Sexual and Reproductive Health Services<sup>5</sup>
- ▶ FSRH Key Principles for Intimate Clinical Assessments Undertaken Remotely in Response to Covid-19<sup>6</sup>
- ▶ FSRH Service Standard for Supporting Doctors' Appraisal and Revalidation in

<sup>1</sup> FSRH, 2014. [Quality Standard Contraceptive Services](#).

<sup>2</sup> FSRH, 2017. [Service Standards for Risk Management in Sexual and Reproductive Healthcare](#).

<sup>3</sup> FSRH & BASHH, 2019. [Standards for Online and Remote Providers of Sexual and Reproductive Health Services](#).

<sup>4</sup> FSRH, 2020. [Service Standards for Consultations](#).

<sup>5</sup> FSRH, 2019. [Service Standards for Online and Remote Providers of Sexual and Reproductive Health Services](#).

<sup>6</sup> FSRH, 2020. [Key Principles for Intimate Clinical Assessments Undertaken Remotely in Response to COVID-19](#).

SRH<sup>7</sup>

All sexual health providers should be able to audit their services against current standards.

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<sup>7</sup> FSRH, 2018. [\*Service Standards for Supporting Doctors' Appraisal and Revalidation in SRH.\*](#)  
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## 1 Standard Statement on Meeting Population Needs

### Services should meet the needs of the local population

- 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.<sup>8</sup>
- 1.2 Service users should be encouraged to provide feedback on their personal experience of care and to offer opinions about SRH services, both current and future.
- 1.3 Telephone triage and/or telephone/virtual consultation, followed by a booked face to face appointment if required, may be necessary in addition to, or as a replacement for 'walk-in/sit and wait' clinics.
- 1.4 Patients should be able to self-refer regardless of residential postcode. No referral from primary care should be necessary.
- 1.5 Services should have the facility to offer urgent / emergency appointments on the same working day.
- 1.6 Services should provide telephone advice on the same working day or within 24 hours depending on the availability of the local service.
- 1.7 Patients should be able to access non-urgent information, advice or services within two working days.
- 1.8 The waiting times for walk-in services, where these are deemed safe and appropriate, should be no longer than two hours.
- 1.9 Appointments for procedures for long-acting reversible contraception methods (LARC) should be offered within four weeks of initial contact if clinically appropriate.
- 1.10 Voicemail and message facilities should be considered according to local policy.
- 1.11 Services should meet national waiting time targets.
- 1.12 Services should address workload in a way that is sensitive to the religious and cultural needs of the population, e.g. female staff in certain clinics.
- 1.13 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.<sup>9</sup>
- 1.14 Additional time should be allocated for consultations for individuals with specific needs.
- 1.15 Commissioners and service leads should ensure a sexual and reproductive health

<sup>8</sup> Public Health England, 2018. [Commissioning local HIV sexual and reproductive health services.](#)

<sup>9</sup> General Medical Council, 2013. [Intimate examinations and chaperones.](#)

needs assessment has been undertaken within the last three years to determine the pattern of service provision. For example, this is likely to include the need for an equivalent of at least two full days per week of integrated sexual health clinic provision within 30 minutes travelling time per settlement of 10,000 population.<sup>8</sup>

- 1.16 A referral mechanism should be available for access to other local services.
- 1.17 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 time for a new face to face consultation is 30 minutes**

2.1 A clinician should be allocated 30 minutes for the following consultations<sup>10</sup>:

- ▶ 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

2.2 Additional time may be needed where multiple activities are required, e.g. when a new consultation is combined with implant removal or IUC insertion, or when other issues need to be addressed such as complex contraceptive problems, sexual health screening, cervical cytology, safeguarding and Fraser competency assessments, and partner notification.

Consultations involving procedures like ultrasound scanning, deep implant removal or complicated IUC insertion may also require additional time.

2.3 Extra time should be allocated to patients with learning and communication needs, including those requiring an interpreter, and individuals with hearing or visual impairments.

2.4 Time should be allotted for contemporaneous documentation of the consultation.

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<sup>10</sup> FSRH, 2016. [Service Standards for Sexual and Reproductive Healthcare](#).  
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### 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 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. Nurse-led clinics should be supported by a doctor or senior nurse with the appropriate clinical skills.<sup>6</sup>
- 3.3 Services should have mechanisms in place to support all clinicians to continue professional development, through on-going training and other initiatives.<sup>7</sup> Nurses should be supported in the use of patient group directions (PGDs) or a non-medical prescribing qualification.<sup>6</sup> Staff should have ready access to current service specified standard operating procedures and national treatment guidelines, e.g. those produced by FSRH and British Association for Sexual Health and HIV (BASHH). Internet facilities should be available.

## 4 Standard Statement on Individual Clinical Workload

**Clinicians will have a 20-minute break within a 6-hour clinical session**

- 4.1 Clinicians will have a 20-minute break within a 6-hour clinical session.<sup>11</sup>
- 4.2 Time should be allocated for telephone consultations and other remote consultations in accordance with relevant FSRH guidance.<sup>3,4,6</sup>
- 1.3. Time should be allocated for supporting other professionals (e.g. GPs, pharmacists) via telephone or email.
- 4.3 Time should be allocated for clinical administration, e.g. correspondence and onward referral.
- 4.4 Job 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.<sup>12</sup>
- 4.5 Time should be allocated within the working week for reflective practice, supervision 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.
- 4.7 Employers should ensure that support is available to those who feel that their workload is impacting their health and well-being.

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<sup>11</sup> Health and Safety Executive, 1998. [The Working Time Regulations](#).

<sup>12</sup> NHS Improvement, 2017. [A best practice guide for consultant job planning](#).  
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## 5 Standard Statement on Training and Assessment

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

- 5.1 Allocated time within training clinics should be used for feedback and assessment with less emphasis on theoretical teaching. Learners undertaking the [DFSRH/NDFSRH/LoC](#) should have acquired the relevant theoretical knowledge prior to clinical contact.
- 5.2 In clinics designated for training purposes, there should be sufficient time allocated to allow for assessment of prior experience, teaching and feedback. Without allowance for training time, 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.<sup>13</sup>
- 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.
- 5.5 Foundation doctors must have access to an on-site senior colleague at all times.<sup>14</sup>
- 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.

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<sup>13</sup> General Medical Council, 2016. [Promoting excellence: Standards for medical education and training](#)

<sup>14</sup> Nursing and Midwifery Council, 2019. [Quality assurance framework for nursing, midwifery and nursing associate education.](#)