

# Service Standards for Sexual and Reproductive Healthcare



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Faculty of Sexual & Reproductive Healthcare  
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## Contents

|  |           |
|--|-----------|
| <b>SERVICE STANDARDS FOR SEXUAL &amp; REPRODUCTIVE HEALTHCARE .....</b>  | <b>1</b>  |
| Changes introduced since review .....                                    | 1         |
| Introduction.....  | 1         |
| <b>Scope of the Document.....</b>  | <b>3</b>  |
| Overview .....   | 3         |
| <b>1. Standard Statement on Leadership.....</b>                          | <b>4</b>  |
| <b>2. Standard Statement on Service Provision .....</b>                  | <b>5</b>  |
| 2.1 Contraception .....  | 5         |
| 2.2 Pregnancy and abortion.....  | 5         |
| 2.3 Screening .....  | 6         |
| 2.4 Sexually transmitted infection (STI) services.....                   | 6         |
| 2.5 Psychosexual services .....  | 6         |
| 2.6 Other reproductive health services .....                             | 6         |
| 2.7 Services for patients with special needs .....                       | 6         |
| 2.8 Training and support in SRH.....                                     | 7         |
| 2.9 Sexual Health Networks (or Referral pathways between services) ..... | 7         |
| <b>3. Standard Statement on Patient Focus .....</b>                      | <b>8</b>  |
| <b>4. Standard Statement on User and Public Involvement .....</b>        | <b>9</b>  |
| <b>5. Standard Statement on Access .....</b>                             | <b>10</b> |
| <b>6. Standard Statement on Training.....</b>                            | <b>11</b> |
| <b>7. Standard Statement on Clinical Practice .....</b>                  | <b>12</b> |
| <b>8. Standard Statement on Confidentiality .....</b>                    | <b>13</b> |
| <b>9. Standard Statement on Record Keeping.....</b>                      | <b>14</b> |
| <b>10. Standard Statement on Nurse-Led Service Provision.....</b>        | <b>15</b> |
| <b>11. Standard Statement on Monitoring and Evaluation.....</b>          | <b>16</b> |
| <b>References .....</b>  | <b>17</b> |
| <b>Annex A.....</b>  | <b>22</b> |

## SERVICE STANDARDS FOR SEXUAL & REPRODUCTIVE HEALTHCARE

### Changes introduced since review

- ▶ Updated introduction in accordance with updated national guidelines
- ▶ Changes to commissioning arrangements
- ▶ Statement supporting non-consultant service leads in SRH
- ▶ Recommendation of annual friends and family test
- ▶ Updated references to FSRH qualifications

### Introduction

These Service Standards have been developed by the Faculty of Sexual and Reproductive Healthcare (FSRH) to support both providers and commissioners in providing safe, high-quality sexual and reproductive health services. They are based on current evidence of best practice. The Standards are recommended for use by all providers commissioned or contracted by the National Health Service (NHS) or Local Authorities who provide and manage all aspects of contraception and sexual health. It also covers services providing pregnancy planning, pregnancy choices, abortion, community gynaecology, sexual wellbeing and health promotion. There are some areas where the standards indicate that they are for specific service types such as Specialist Community SRH services.

The Standards have been developed to be applicable to all countries in the UK. Key documents from England, Scotland, Wales and Northern Ireland have been used to inform their production and they have been subject to consultation in the four countries. These standards can be applied irrespective of the commissioning system in operation.

This core document outlines **eleven** general service standard statements. Standards have also been produced by the Clinical Standards Committee of the FSRH in relation to specific issues e.g. [Medicines Management](#), [Resuscitation](#) and [Consultations in Sexual and Reproductive Health](#), which can be found on the [FSRH website](#). The Standards are auditable and have been developed by the committee by a process of review of all evidence of best practice. This process is repeated every 3 years with new evidence incorporated. After each Standard is reviewed it is placed onto the FSRH website for consultation. This is an ongoing process hence each document has a different review date.

There has been variation in the background of clinical leaders of community SRH services. All services should have appropriately trained leadership to ensure quality of service provision, service development, patient safety, training and clinical governance (**Standard Statement 1**). It is envisaged that all specialist SRH services should be consultant-led and should link with other contraceptive care providers, e.g. general practice, to provide support. Specialist services should

engage with local commissioners and have an active role in planning sexual health services in their area.

Services should provide comprehensive sexual and reproductive healthcare (**Standard Statement 2**). There should be access to all methods of contraception including emergency intrauterine device (IUD) insertion; pregnancy and abortion advice; screening of sexually transmitted infections and treatment where appropriate, partner notification, community gynaecology and psychosexual assessment. Where in-house services are not available, patients should be referred in a timely manner. Services should conform to the FSRH Service Standard [Workload in Services](#).

Services need to be patient focussed ensuring good communication, and provide clear patient information (**Standard Statement 3**). There should be patient pathways and services should adhere to FSRH Standards on [Consent](#) and [Confidentiality](#).

Services should demonstrate that user and public involvement has been fundamental to the planning, development, provision, monitoring and evaluation of a service (**Standard Statement 4**). User engagement should be encouraged on a regular basis, and evidence provided that it has been incorporated into the process. Services should provide open access with a mixture of booked appointments and 'walk-in' clinics (**Standard Statement 5**). There should be information available about the timing of services and there should be easy and non-discriminatory access for all.

All staff working in SRH services should be appropriately trained (**Standard Statement 6**). For doctors and nurses, the minimum standard should be the [Diploma of the Faculty of Sexual and Reproductive Healthcare \(DFSRH\)](#). For those performing intrauterine and subdermal procedures, [appropriate Letters of Competence](#) should be held and competency maintained. All other health professionals working in all levels of SRH services should be trained to the competencies laid down by their educational bodies e.g. FSRH, and administrative staff trained to deliver confidential and patient-focussed care.

SRH service provision should be evidence-based, which will include the use of national and local guidelines and policies (**Standard Statement 7**). This document outlines which standards should be used for different aspects of service provision. A comprehensive list of clinical standards produced by the Clinical Standards Committee can be found on the [FSRH website](#) and should be used to inform specific issues, for example [Resuscitation](#) and [Medicines Management](#).

All clients seeking SRH services should be confident that their right to confidentiality will be respected (**Standard Statement 8**). Record keeping should be of a high standard to provide maximum benefit in patient management and to facilitate audit and record the process of obtaining valid consent (**Standard Statement 9**). Services should work to the Service Standards for [Record Keeping](#).

Nurses working autonomously in providing SRH services should have their role supported and developed (**Standard Statement 10**). Finally, all services should continually monitor and evaluate themselves in order to maintain and improve performance (**Standard Statement 11**). A process of [Risk Management](#) should be evident to ensure that services provide safe, high-quality patient care.

## Scope of the Document

This document is intended to make recommendations with regard to service quality and can be used to maintain levels of excellence and to inform commissioners and all other providers as they plan SRH services for the future.

### Overview<sup>1</sup>

Within UK countries there is considerable variation in how SRH services are provided. These vary from distinctly separate general practice and community-based contraceptive provision with hospital-based abortion and genitourinary medicine services, to fully integrated SRH services in the community.

The FSRH acknowledges the great differences that exist between services and this document provides a framework of standards, which can be applied to all SRH services to enable equitable service provision. These include services within general practice, hospital- and community-based clinics and pharmacies, as well as voluntary and independent-sector organisations.

This document incorporates elements from the following key documents and is based on available evidence and best practice where evidence is lacking:

- ▶ FSRH, 2015. [Better care a better future: a new vision for sexual and reproductive healthcare in the UK](#)
- ▶ Department of Health, 2013 [A Framework for Sexual Health Improvement in England](#)
- ▶ Scottish Executive, 2015 [Respect and Responsibility: Strategy and Action Plan for Improving Sexual Health](#)
- ▶ Healthcare Improvement Scotland, 2008. [Sexual Health Services Standards](#)
- ▶ The Medical Foundation for AIDS & Sexual Health (MedFASH), 2005. [Recommended Standards for Sexual Health Services](#)
- ▶ Welsh Assembly Government, 2010. [Sexual Health and Wellbeing Action plan for Wales 2010 – 2015](#)
- ▶ Department of Health, [Social Services and Public Safety for Northern Ireland, 2008. Sexual Health Promotion: Strategy and Action Plan 2008-2013](#)
- ▶ BASHH, 2014. [Standards for the Management of STIs](#)
- ▶ Department of Health, 2012. [Public Health Outcomes Framework](#)
- ▶ FSRH, 2014. A Quality Standard for Contraceptive Services

## 1. Standard Statement on Leadership

**All sexual and reproductive health services should be led by appropriately trained clinical and managerial personnel to ensure quality of service provision, service development, training and clinical governance.**

Currently there is considerable variation in the background, training and experience of consultants/lead clinicians working in community-based SRH services. Since the establishment of the new medical specialty of Community Sexual & Reproductive Healthcare (CSRH) by the UK government in 2010, it is expected that new appointments to Level 3 services should be consultants in CSRH. These consultants will have the postgraduate qualification and structured training approved by the FSRH/the Royal College of Obstetricians and Gynaecologists (RCOG), the Academy of Royal Medical Colleges, and the General Medical Council (GMC). The FSRH acknowledges that many doctors currently leading SRH services were appointed prior to the recognition of this specialty and are not consultants. However, they should be regarded, respected and managed as if they were consultants.<sup>68</sup>

- 1.1 All SRH services at Level 3 as specified in the Framework for Sexual Health Improvement in England<sup>2</sup>, and equivalent services in the rest of the UK, should appoint consultants to new vacancies. It is recommended that one full-time CSRH consultant per population of 125 000, works as part of a multi- disciplinary team along-side other specialist consultants e.g. GUM and Psychiatry. The consultant should be accredited in SRH and hold Membership of the Faculty of Sexual and Reproductive Healthcare (MFSRH) to ensure adequate quality of service provision, training, clinical governance and risk management across all three levels of service provision.<sup>8</sup>
- 1.2 Consultant leads should not work in isolation and should be supported by consultant colleagues and a team of specialists in SRH to include associate specialists /specialty doctors, specialty trainees and nurses, and GP with a Special Interest (GPwSI). Where this is geographically not possible clinical networks should be developed.
- 1.3 Specialist services should collaborate with other services providing SRH to support quality of clinical service provision and provide clinical governance.<sup>2,4</sup>

## 2. Standard Statement on Service Provision

**Service provision should include a range of sexual and reproductive health services.**

### 2.1 Contraception

- 2.1.1 SRH services should provide unrestricted open access services with clear clinical pathways in line with national policies. They should be supported by clinical networks eg. Local Authorities, Clinical Commissioning Groups and Public Health England, Health Protection Scotland, NHS Scotland<sup>10, 11, 70</sup>
- 2.1.2 Access to and availability of the full range of contraceptive methods should be provided and include choice within products (e.g. a range of different combined hormonal contraceptives and intrauterine contraception) to maximise patient acceptability.<sup>11, 12</sup>
- 2.1.3 Services that do not offer male and female sterilisation should provide counselling, direct referral and signposting to appropriate providers.<sup>8</sup>
- 2.1.4 Services should provide emergency contraception, including timely access for postcoital IUD insertion.<sup>2, 10, 13</sup>
- 2.1.5 Provision should be made for the management of complex contraceptive problems, or onward referral as necessary.

### 2.2 Pregnancy and abortion

- 2.2.1 Services should provide counselling and information for pregnancy planning and preconception care.<sup>4, 10</sup>
- 2.2.2 Services should offer pregnancy testing with immediate results at point of care.<sup>4</sup>
- 2.2.3 Services should provide women attending with unplanned pregnancies support and advice in a non-judgmental and empathetic environment.<sup>2, 4</sup>
- 2.2.4 Services which do not carry out abortion procedures should offer women empathetic, unbiased information and timely referral, including the option of self-referral – this should meet the standards set out in the current RCOG abortion guidelines.<sup>14, 15</sup>
- 2.2.5 Abortion providers should advise and facilitate the supply of contraception, including LARC methods, as part of the episode of care. This may be provided by close liaison or integration with contraceptive services.<sup>14</sup>
- 2.2.6 Individual clinicians whose personal beliefs do not accept abortion have a right to exercise a conscientious objection to involvement in the care of women requesting this procedure. However, in exercising this right they must not treat patients unfairly, cause them distress or deny them timely access to this service from another practitioner.<sup>73</sup>

## 2.3 Screening

- 2.3.1 Cervical cytology screening should be available in line with national<sup>16</sup> and local guidelines.
- 2.3.2 According to local and national policies, services should offer screening for chlamydia infection with protocols in place for treatment and partner notification.<sup>16, 72</sup>

## 2.4 Sexually transmitted infection (STI) services

- 2.4.1 Services should offer advice and information (through a variety of media) on STIs, including HIV.<sup>4,10,11</sup>
- 2.4.2 Appropriate testing, treatment and partner notification for STIs for both men and women should be available through all SRH services, with onward timely referral to more specialist services when appropriate.<sup>4</sup>

## 2.5 Psychosexual services

- 2.5.1 Services should offer psychosexual counselling or appropriate onward referral.<sup>2,10</sup>
- 2.5.2 Services should offer people with organic sexual dysfunction treatment or appropriate onward referral.<sup>2</sup>

## 2.6 Other reproductive health services

- 2.6.1 Services should offer advice and information on medical gynaecological issues such as the peri-menopause and menopause, premenstrual syndrome, and menstrual dysfunction. Where this is not available patients should be offered timely onward referral.

## 2.7 Services for patients with special needs

- 2.7.1 Appropriate arrangements should be in place to enable patients with special needs to access SRH services without undue delay.<sup>4</sup> For example:

- ▶ Young people (including those in local authority care)
- ▶ People with communication difficulties
- ▶ People with physical or learning difficulties
- ▶ People who have been sexually assaulted
- ▶ Sex workers

- 2.7.2 Outreach services should be provided for patients unable to access mainstream services.<sup>10</sup>

## **2.8 Training and support in SRH**

2.8.1 Specialist services should have structures in place to provide easily accessible clinical advice and support to professionals working in other services, including those in primary care.<sup>2</sup>

2.8.2 Specialist services should have structures in place to provide and support training in sexual and reproductive healthcare in line with FSRH guidance <sup>4</sup>

## **2.9 Sexual Health Networks (or Referral pathways between services)**

2.9.1 Specialist services should be involved in establishing local Sexual Health Networks<sup>4,11</sup> and there should be clear referral pathways between services.

### 3. Standard Statement on Patient Focus

**Services need to be patient-focussed ensuring good communication, clear patient information and working to FSRH standards on consent and confidentiality**

- 3.1 SRH service providers should ensure clear information is available to patients regarding timing and location of all services provided, through a variety of media. Services should be advertised through easily available routes such as /websites/local press/leaflets.<sup>4,18</sup>
- 3.2 If the provider does not offer certain services, clear information on alternative sources for service provision locally should be made available.<sup>4,18</sup>
- 3.3 Services should be organised so that the user finds them easy to navigate.<sup>4</sup>
- 3.4 Objective, evidence-based resources such as those created by Family Planning Association (FPA) and NHS Choices should be available in a variety of media appropriate to the patient's preferences. There should be a choice of languages/formats appropriate to the patient groups served by the provider, including those with sensory impairment.<sup>4,18</sup>
- 3.5 Consultations should be conducted with due regard to the privacy of patients regardless of age, gender and sexual orientation.<sup>4,18</sup>
- 3.6 Adequate time should be given for all consultations.<sup>19</sup> First visits, initial counselling and provision of all contraceptive methods, STI treatment and partner notification, counselling for sterilisation/vasectomy and referral, pregnancy information, decision support and referral for abortion, will require more time compared to uncomplicated repeat visits for supply of hormonal contraception.
- 3.7 Patients undergoing intimate examinations should be offered the presence of a chaperone, irrespective of the gender of the clinician.<sup>20,21</sup> There should be prominent notices displayed in the waiting and clinical rooms informing patients of their right to request a chaperone if desired.
- 3.8 Services should accommodate the needs of young people as recommended in The Department of Health's *You're Welcome* document<sup>18</sup> and the Scottish initiative *Walk the Talk*.<sup>69</sup>

## 4. Standard Statement on User and Public Involvement

**Services should demonstrate that user and public involvement is fundamental to service development, provision, monitoring and evaluation.<sup>22-24</sup>**

- 4.1 An annual user and public involvement plan should be developed and supported by an annual friends and family test<sup>58</sup>
- 4.2 User engagement should be encouraged (e.g. with suggestion and comments boxes in clinics and regular user satisfaction surveys). An example of a validated patient satisfaction questionnaire is attached as Annex A.
- 4.3 The patients' compliments/comments/complaints procedure should be clearly displayed in clinical and waiting rooms.<sup>25</sup>
- 4.4 Services should respond appropriately to user feedback.
- 4.5 Public consultation is essential when service redesign or development is planned. This includes involving 'seldom heard' groups, and collaboration and partnership working with the voluntary and community sectors.

## 5. Standard Statement on Access

**There should be easy and quick non-discriminatory access to sexual and reproductive health services for all.**

- 5.1 There should be effective local co-ordination of access to SRH services.<sup>2,4</sup>
- 5.2 Service providers should clearly advertise location, opening times, and services provided, and keep the FPA, NHS Direct and NHS 24 fully informed. They should have an answering machine outside opening hours to give information on opening times and where alternative services e.g. emergency contraception, can be accessed.<sup>4</sup>
- 5.3 There should be choice in terms of times (daytime/evening/weekend) and types of clinic/practice services for the population served (walk-in/appointment).<sup>4</sup>
- 5.4 Clinics should be in easily accessible/convenient locations and clearly signposted.<sup>4</sup>
- 5.5 It should be possible for patients to access emergency contraceptive services (within the required timeframe). This should be provided on the same day on weekdays. In rural areas where specialist clinics may not be accessible locally throughout the week, development of appropriate alternative services should be addressed.<sup>4,13</sup>
- 5.6 Arrangements for appropriate provision of emergency contraception as well as contraceptive supplies over weekends and public holidays should be in place e.g. with local pharmacies.<sup>11</sup>
- 5.7 Advance provision of emergency hormonal contraception and instructions on use should be offered to all patients where appropriate.<sup>13</sup>
- 5.8 Walk-in clinics should be adequately staffed to provide safe medical practice and ensure a maximum waiting time of 2 hours.<sup>10</sup>
- 5.9 Services should have mechanisms and systems in place to monitor patients who have been unable to access the service.

## 6. Standard Statement on Training

**All staff working in sexual and reproductive health services should receive appropriate training and must maintain their skills.**

- 6.1 All health professionals providing contraception within SRH services should hold a current [diploma in Sexual and Reproductive Healthcare \(NDFSRH or DFSRH\)](#) or be trained to equivalent competencies as stipulated by their educational bodies and show evidence of accreditation.<sup>27, 28, 63</sup>
- 6.2 All doctors and nurses offering IUD, intrauterine system (IUS) and contraceptive implant insertion should hold the Letter of Competence in [Intrauterine Techniques \(LoC IUT\)](#) and [Subdermal Contraceptive Implants \(LoC SDI\)](#) of the FSRH.<sup>29, 30</sup>
- 6.3 All health professionals holding the NDFSRH or DFSRH and Letters of Competence should be actively collecting evidence to support their re-accreditation.<sup>60</sup>
- 6.4 All health professionals, including pharmacists and Health Care Technicians working in SRH services should be trained to the competencies laid down by their educational body.<sup>31,32,33</sup>
- 6.5 All administrative staff involved in SRH services should receive appropriate training, including confidentiality, child protection and customer care.<sup>64</sup>
- 6.6 Dedicated young people's services, and those working with special needs and vulnerable groups, should be staffed by health professionals who have an understanding of adolescent development and experience of working with young and vulnerable people, including training in CSE and safeguarding.<sup>34,35,36, 61</sup>
- 6.7 All health professionals working in psychosexual services should be appropriately trained and re-accredited as per registered qualification. For example, [COSRT](#) and [IPM](#) registered.

## 7. Standard Statement on Clinical Practice

**Sexual and reproductive health service provision should be evidence-based, which will include the use of national and local guidelines and policies.**

SRH services should have the following local policies in place:

- 7.1 Policies governing SRH service provision and commissioning should follow the guidelines outlined in the Department of Health for England and Health Improvement Scotland (HIS) document<sup>2, 8, 11, 70</sup>
- 7.2 Clinical policies for the management of sexual infections and contraception provision should be based upon nationally recognised standards and guidelines, for example BASHH, FSRH, NICE and HIS<sup>37, 38, 70</sup>
- 7.3 Policies governing abortion that should follow current RCOG abortion guidelines<sup>14</sup>
- 7.4 Policies relating to child protection/safeguarding children<sup>34, 61</sup> and vulnerable adults<sup>36</sup> that follow national guidelines.
- 7.5 Policies that address the recommendations in the Framework for Sexual Health Improvement in England 2 its implementation plan and commissioning toolkit 10 and the sexual health promotion toolkit<sup>10</sup> or its equivalent in other UK countries<sup>5, 6, 9</sup>
- 7.6 Policies that address MEDFASH recommended standards for sexual health services.<sup>4</sup>
- 7.7 Locally applicable standards for administrative staff.
- 7.8 Appropriately managed IT services and provision for staff to access up-to-date guidance on using and storing electronic information<sup>62</sup>
- 7.9 Services should aim to achieve standardisation of delivery of care (e.g. record keeping) as described in FSRH standards.<sup>40</sup>
- 7.10 Services should work to FSRH standards on record keeping, medicines management, resuscitation and obtaining consent in sexual health services.<sup>40–43</sup>

## 8. Standard Statement on Confidentiality

**All users seeking sexual and reproductive health services should be made aware that their right to confidentiality will be respected and maintained in line with GMC, NMC and other professional bodies' recommendations.**<sup>44-46</sup>

- 8.1 Services should prominently display their confidentiality statement at their premises.<sup>44- 46, 50</sup>
- 8.2 Confidentiality training should be provided to all staff.<sup>48, 50</sup>
- 8.3 Staff providing SRH services to young people and vulnerable adults should be familiar with the law in their country, and local and national policies, with regard to confidentiality and specifically Fraser Guidelines in England and the Age of Legal Capacity Act in Scotland. Staff should regularly attend safeguarding training.<sup>34, 35,44,45,46, 48, 50, 71</sup>
- 8.4 Patients should have the assurance of confidentiality with regard to their consultations regardless of age, gender, sexual orientation, religion or ethnicity unless the clinician has concerns about wellbeing and/or safety of the patient or others.<sup>44,45</sup>
- 8.5 Staff should be aware of both local and national policies for sharing patient information<sup>59</sup>
- 8.6 Services should work to the FSRH [Confidentiality Standards](#).<sup>50</sup>

## 9. Standard Statement on Record Keeping

**Record keeping in all services should be of a high standard, to provide maximum benefit in patient management, to facilitate audit and record the process of obtaining valid consent.<sup>45</sup>**

- 9.1 All services should work to the FSRH [Record Keeping Standards](#).<sup>40</sup>
- 9.2 The offer of a chaperone during an intimate examination should be documented. If it is accepted or declined, this should also be clearly recorded in the notes including the name of the chaperone (see also 2.8.).<sup>20, 41</sup>
- 9.3 In line with new guidance, services should screen for and record cases of Child Sexual Exploitation (CSE) and Female Genital Mutilation (FGM) and submit reports as per local and national policy.<sup>61,67</sup>
- 9.4 Clinical records must be kept confidential at all times. For those using paper notes these should be stored in a secure place as per your local guidelines.<sup>40</sup> Adequate protection of electronic patient records (EPR) should also be enforced.<sup>59</sup>
- 9.5 All record systems, whether written or computerised, must have processes in place that follow the Caldicott Guidelines<sup>51</sup> and are compatible with the Data Protection and Freedom of Information Acts.<sup>52, 53</sup> All staff working in SRH should be familiar with and receive regular information governance and data protection training.
- 9.6 In recognition of the work being developed by the Department of Health in England on a common Sexual and Reproductive Health Activity Dataset (SRHAD) and similar work in the other UK countries, all services should be working towards computerised systems.<sup>54</sup> Data should be submitted to commissioners and the appropriate body in a timely and appropriate manner.
- 9.7 Contemporaneous, legible and signed records of consultations must be maintained. Each entry in electronic records should include the name of the clinician (who will be logged on to the system as a registered user).<sup>40</sup>

## 10. Standard Statement on Nurse-Led Service Provision

**The role of nurses in sexual and reproductive health service provision should be enhanced.<sup>39</sup>**

- 10.1 Services should have mechanisms in place to support nurses to supply and administer, or prescribe all methods of contraception, either through adequately supported patient group directions and/or non-medical prescribing.<sup>55, 63</sup>
- 10.2 Nurses with Advanced Practice Roles in SRH services should be supported by a recognised programme of leadership and development according to their local and national policies to ensure robust quality and governance necessary for revalidation.
- 10.3 Experienced nurses working in contraception should, when appropriate, be supported to acquire competencies for intrauterine and sub dermal implant techniques and other new technologies as they are developed. They should be supported when appropriate to attain the [NDFSRH](#) and PGA MedEd (SRH), in order to be eligible to become Faculty Registered Trainers (FRTs).<sup>63</sup>
- 10.4 Services should develop the scope of nurses in service delivery including adequately supported nurse-led clinics providing the full range of SRH services, including counselling for abortion, menopause and vasectomy.<sup>63</sup> Services should be encouraged to develop a mentoring programme for all their staff with regular one-to-one training and annual appraisal.<sup>65</sup>
- 10.5 Other health care practitioners who work alongside and support nurses (ie. Health Advisors and Health Care Assistants) should have a job description and be encouraged by the service to develop their roles, including active participation in audit and service development.

## 11. Standard Statement on Monitoring and Evaluation

**All services should continually monitor and evaluate themselves in order to maintain and improve performance.**

- 11.1 All providers should have a programme in place to regularly audit clinical service provision<sup>4, 56</sup> in terms of quality as well as access, process and outcome issues from a consumer viewpoint. This should include auditing complaints and near misses. The results of audits should be acted upon to ensure appropriate improvements in service provision.
- 11.2 Commissioners and local authority providers for sexual health, together with specialist services, should establish structures and processes for the monitoring and evaluation of initiatives introduced to improve local sexual healthcare provision<sup>4</sup>. These should include the identification of any inequality gaps<sup>66</sup> which may exist within their local services through needs assessment. User involvement is essential in this process.<sup>4, 10</sup>
- 11.3 All services should provide quarterly reports (e.g. SRHAD) to the appropriate body in a timely manner.<sup>54</sup>
- 11.4 Services should work to FSRH standards for risk management.<sup>57</sup>

## References

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## Annex A

**Patient Experience Survey**  
**Contraception and Sexual Health Service**  
**'We need your views to help improve our service'**

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We are keen to learn from your experiences of our services. Please help us by taking the time to answer the following simple questions:

1. What is the first part of your postcode? (e.g. M40)
2. Are you the patient / carer / parent / guardian / friend (*Please circle*)?
3. Which clinic did you attend?  Walk-in  Appointment
4. On what day have you attended (*please circle*)?  
Monday / Tuesday / Wednesday / Thursday / Friday / Saturday
5. How did you hear about the clinic (*please circle*)?  
GP / Internet / Poster / Service Information Leaflet / Friend / School Nurse / Walk-in centre / Other

6. What did you think about the following? *(Please tick one box for each question)*

|   | Excellent                | Good                     | Fair                     | Poor                     |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| Clinic opening times                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Time taken to book in at reception            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Level of privacy and dignity at reception     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Respect and courtesy shown by reception staff | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

7. How long have you waited to see a doctor/nurse today?

|                       |                          |               |                          |
|-----------------------|--------------------------|---------------|--------------------------|
| Less than 30 minutes  | <input type="checkbox"/> | 30–60 minutes | <input type="checkbox"/> |
| Between 1 and 2 hours | <input type="checkbox"/> | Over 2 hours  | <input type="checkbox"/> |

8. Thinking about your consultation with the doctor / nurse today, how do you rate the following?  
*(please tick one box per question)*

|   | Excellent                | Good                     | Fair                     | Poor                     |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| The doctor / nurse introducing themselves to you          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Whether the 'confidentiality policy' was explained to you | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

|   |                          |                          |                          |                          |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| How well you were listened to   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Your involvement in decisions about your care   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Your questions being answered well enough   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| How private and confidential your appointment felt  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| The respect and courtesy shown by the doctor / nurse                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| How safe you felt during your appointment   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Information you received about the service  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Information you received about your treatment   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| How satisfied you were after your visit   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If you are aged under 25 years, how friendly the environment felt from your point of view | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**9. Have you any other comments about this service?**

Please let us know how you felt about your visit, both good and bad, in the box below.

**All information shared with us will be used anonymously, stored confidentially and not shared with any external third party. This survey can be produced in other languages on request. We can also provide the information in other formats such as Braille and audio CD.**

**If you are interested in being part of a service user group to help us develop and improve our service further (e.g. input into service leaflets) please leave your name and contact details below. We will contact you with more information.**

|   |  |
|---|--|
| Name  |  |
| Address   |  |
| Phone   |  |
| How would you prefer we contact you?  |  |
| <input type="checkbox"/> Phone <input type="checkbox"/> Letter <input type="checkbox"/> Email |  |
| Email address   |  |

If you would like help or advice for any general community health issues you can telephone the Patient Advice and Liaison Service (PALS) on.....  
 or email to ..... Or write to the PALS team  
 at:.....

