Service Standards for Workload in Sexual and Reproductive Health
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SERVICE STANDARDS FOR WORKLOAD IN SEXUAL & REPRODUCTIVE HEALTH

Changes introduced since review

- References to updated working time regulations
- Recommendation of job planning

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 safe and high quality consultations, enabling planning of standardised service delivery.

Guidance used to inform these standards includes:

- Department of Health, 2008. *Improving health and work: changing lives*
- Health and Safety Executive, 1998. *Working Times Regulations*
- The Medical Foundation for AIDS & Sexual Health (MEDFASH), 2005. *Recommended Standards for Sexual Health Services*
- NHS Quality Improvement Scotland, 2008. *Standards for Sexual Health Services*
- FSRH, 2013. *Service Standards for 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.
1. **Standard Statement on Meeting Population Needs**

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 (i.e. no appointment necessary) and appointment-only clinics. Clinic 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 methods (LARC) 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 that is sensitive to the religious and cultural needs of the population e.g. 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.\textsuperscript{9,10}

1.15 Additional time should be allocated for consultations for individuals with specific needs.

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. For example, 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.\textsuperscript{5}

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 time for a new consultation is 30 minutes

2.1 A Clinician (nurse or doctor) should be allocated 30 minutes for the following consultations11:

- A 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

2.2 Additional time may be needed where multiple activities are required e.g. 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 need to be addressed such as cervical cytology, sexual health screening, partner notification or when there is a need to address complex contraceptive problems.12

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

2.3 Extra time should be allocated to patients with special needs including the very young (those who need assessment of Fraser competency) and other groups as identified by individual services e.g. those with learning and communication needs, including those for whom English is not the first language requiring an interpreter, the visually impaired and for individuals with hearing impairment.6,8,13,14,15

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. Nurse led clinics should be supported by a doctor or senior nurse with the appropriate clinical skills.  

3.3 Services should have in place mechanisms to support all clinicians to continue professional development, through on-going training and other initiatives. Nurses should be supported in the use of patient group directions (PGDs) or a non-medical prescribing qualification. 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 Clinician Workload

Clinicians should expect to have a 20-minute break within a 6-hour clinical session.

4.1 Clinicians should expect to have a 20-minute break within a 6-hour clinical session.\(^3\)

4.2 Time should be allocated for telephone consultations. Time should be given 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 speciality 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.\(^{14}\)

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**

5.1 Allocated time within training clinics should be used for feedback and assessment with less emphasis on training. 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 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.\(^{15,16}\)

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

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


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