



**Faculty of Family Planning and Reproductive Health Care
of the Royal College of Obstetricians and Gynaecologists**

**SERVICE STANDARDS
FOR
SEXUAL HEALTH SERVICES**

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SERVICE STANDARDS FOR SEXUAL HEALTH SERVICES

This document addresses

Sexual health care as contraceptive/reproductive health service provision, including pregnancy planning, pregnancy choices, abortion, prevention and treatment of sexually transmitted infections (STIs), as well as sexual wellbeing and health promotion.

This Faculty document defines Service Standards for the contraceptive element in Sexual Health Services for all providers.

Introduction

Within UK countries there is considerable variation in how sexual health 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 Sexual Health Services in the community.

The Faculty of Family Planning and Reproductive Health Care (FFPRHC) acknowledges the great differences that exist between services; it is vital that the Faculty provides a national framework for **Essential (minimum)** standards, which can be applied, to all Sexual Health Services to ensure equitable service provision to all, irrespective of area of residence. In addition it also provides **Desirable (ideal)** standards that all services should work to, by development and reorganisation over the next decade. However the Faculty recognises that there will be very exceptional situations in remote geographical areas where these standards will need special adaptation.

- The National Strategy for Sexual Health and HIV¹ for England, and the Scottish Strategy, "Respect and responsibility"², acknowledge the wide differences in sexual health service provision across the country and sets out challenging aims to improve sexual health.
- The Medical Foundation for AIDS and Sexual Health (MedFASH) has published Recommended Standards for Sexual Health Services³, which apply to all settings providing NHS sexual health services. These include general practice, hospital and community-based clinics, pharmacies, and voluntary and independent sector organisations.
- The Faculty's Workforce Planning Committee surveys all community contraceptive and reproductive health services every year and publishes a bi-annual report⁴ - providing information on the workforce in services and makes projections on requirements for the future.
- The Faculty has contributed some elements to the standards of service provision mentioned in the Department of Health's Sexual Health and HIV Commissioning Toolkit for Primary Care Trusts and Local Authorities⁵.

This Faculty document on Service Standards brings together all elements mentioned in the above documents relating to service leadership, training, service provision, access and user focus. They are based on available evidence and best practice where evidence is lacking. MedFASH has produced 10 recommended standards on sexual health³, which also address key indicators and audit. The standards on contraception incorporate Faculty standards. The concept of 'levels' proposed in the National Strategy for Sexual Health and HIV¹ for England referred to in this document may not be replicated in other parts of the United Kingdom; however these Faculty recommendations are valid for other health care systems.

1. Standard Statement on Leadership

All Sexual Health Services should have appropriately trained adequate leadership to ensure quality of service provision, development, training and clinical governance.

Currently there is considerable variation in the background, training and experience of consultants/lead associate specialists/lead senior medical officers working in community based contraceptive and reproductive health services. This is due to the recent establishment of the specialty and the absence of appropriately structured training programmes in the past. It is expected that with the establishment of a joint subspecialty training programme in Sexual and Reproductive Health of the RCOG and FFPRHC, all services in future will become consultant led. These consultants will have the postgraduate qualification and structured training approved by the Faculty/College.

Essential (minimum):

- 1.1 All Sexual Health Services at levels 2 and 3 specified in the National Strategy for Sexual Health and HIV¹ for England, and equivalent services in the rest of the UK, should be **consultant-led** and have one full time consultant with **re-accredited** MFFP/FFFP in Family Planning and Sexual/Reproductive Health Care per population of 125,000 to ensure adequate quality of service provision, training, clinical governance and risk management across all three levels of service provision^{3, 4}.
- 1.2 Consultant leads should not work in isolation and should be supported by a team of Associate Specialists, Career Grade Trainees and other specialists in Contraception and Sexual Health.
- 1.3 Level 3 services should link with level 1 and 2 services to support quality of clinical service provision and clinical governance.

2. Standard Statement on Client Focus

Client need should be the key determinant of service development, provision, monitoring and evaluation in any service.

Essential (minimum):

- 2.1 Sexual Health Service providers should ensure clear information is available to clients regarding all services provided, in the form of leaflets and posters. Services should be advertised through easily available media such as Yellow pages/websites / general practice leaflets.
- 2.2 If the provider does not offer certain services, clear information on alternative sources for service provision locally, should be made available.
- 2.3 Services should be organised so that there are clear client pathways, e.g. use of triage.
- 2.4 Objective, evidence guided written information such as fpa leaflets should be readily available and accessible to assist clients in making informed choices about methods of contraception, sexual and reproductive health. There should be a choice of languages/formats appropriate to the client groups served by the provider, including those with sensory impairment.
- 2.5 Verbal counselling advice should be supported by appropriate written/pictorial/audiovisual information, which clients can take away.
- 2.6 Consultations should be conducted with due regard to the privacy of clients regardless of age, gender and sexual orientation.
- 2.7 Adequate time should be given for all consultations⁶. First visits, initial counselling and provision of all contraceptive methods, sexual health problems, 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.
- 2.8 Clients undergoing intimate examinations should be offered the presence of a chaperone, irrespective of the gender of the clinician^{7, 8}, whether doctor or nurse. There should be prominent notices displayed in the waiting and clinical rooms informing clients of their right to request a chaperone if desired.
- 2.9 The clients' compliments/comments/complaints procedure should be clearly displayed in the clinic/practice.
- 2.10 User involvement in planning services should be addressed^{3, 9}.

3. Standard Statement on Service Provision

**Service provision should include the following elements of sexual health care.
All services should be inclusive of all sections of society.**

Essential (minimum):

3.1 Contraception

- 3.1.1 Open access integrated clinical networks³ providing core contraceptive and Sexual Health Services should be provided.
- 3.1.2 Access to and availability of the full range of contraceptive methods should include choice within products, e.g. a range of different combined oral contraceptives and IUDs, to maximise client acceptability¹⁰.
- 3.1.3 Provision of counselling for and direct referral to male and female sterilisation.
- 3.1.4 Provision of emergency contraception should include timely referrals for post-coital IUD insertion between providers.

3.2 Pregnancy and abortion

- 3.2.1 Services should provide basic counselling/information for pregnancy planning and preconception care.
- 3.2.2 Services should offer access to pregnancy testing on site with results being available at the first visit.
- 3.2.3 Services should offer access to empathetic unplanned pregnancy information and decision support.
- 3.2.4 Referral to abortion services should be available without delay – this should meet the standards set out in the current RCOG abortion guidelines¹².

3.3 Screening

- 3.3.1 Cervical cytology screening should be available in line with national¹¹ and local guidelines.
- 3.3.2 Services should offer screening for Chlamydia infection with protocols for treatment and partner notification, or appropriate onward referral, according to national guidelines¹³.
- 3.3.3 Services should participate in the English National Chlamydia Screening Programme for under 25s¹³.

3.4 Sexually Transmitted Infection (STI) services

- 3.4.1 Services should offer advice and information on STIs, including HIV, with supporting leaflets and onward referral to appropriate services, as recommended by MedFASH guidelines³.

3.5 Psychosexual services

- 3.5.1 Services should offer access to psychosexual counselling or appropriate onward referral.

3.6 Other reproductive health services

3.6.1 Services should offer advice and information on medical gynaecological issues such as menopause, premenstrual syndrome, subfertility and menorrhagia with supporting leaflets, and onward referral to appropriate services.

3.7 Outreach services for clients with special needs

3.7.1 Appropriate arrangements should be in place to enable clients with special needs to access Sexual Health Services without undue delay eg appropriate young people's services (including young people in care of the local authority), access to interpreters, clinic facilities for people with physical disabilities, learning disabilities, victims of sexual assault, sex workers and substance misusers.

3.7.2 Outreach services should be provided for clients unable to access mainstream services.

3.8 Training and support

3.8.1 Specialist services (levels 2 & 3) should have structures in place to provide easily accessible clinical advice and support to professionals working in other services.

3.8.2 Specialist services should have structures in place to provide and support training in sexual health.

3.9 Communication

3.9.1 Effective and appropriate communication pathways should exist.

Desirable (ideal):

3.10 Abortion services should be integrated with contraceptive services.

3.11 Testing, treatment and partner notification for STIs for both men and women should be available through all contraceptive services.

3.12 Medical gynaecological services such as menopause, premenstrual syndrome, subfertility and menorrhagia should be integrated with contraceptive services.

3.13 Services for people with organic as well as psychological sexual dysfunction should be provided as part of an integrated Sexual & Reproductive Health service.

Note: 3.1.1 "Open access" refers to services to which clients can self-refer, irrespective of their area of residence. "Walk-in" refers to services which clients can access without an appointment.

4. Standard Statement on Access

There should be easy and quick non-discriminatory access to Sexual Health Services for all.

Essential (minimum):

- 4.1 There should be effectively led local co-ordination of access to contraceptive services.
- 4.2 Sexual Health 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 services including emergency contraception.
- 4.3 There should be choice in terms of times and types of clinic/practice services for the population served (daytime/evening, walk-in/appointment).
- 4.4 Clinics should be in easily accessible/convenient locations and clearly signposted.
- 4.5 It should be possible for clients to access emergency contraceptive services (within the required timeframe). This should be provided on the same day during weekdays through walk-in provision or an appointment system. These should include a triage facility. In rural areas where specialist clinics may not be accessible locally throughout the week, development of appropriate alternative services should be addressed.
- 4.6 Arrangements for appropriate provision of emergency contraception as well as ongoing contraceptive supplies over weekends should be in place.
- 4.7 Advance provision of emergency hormonal contraception and instructions on use should be offered to clients who request it¹⁴.
- 4.8 Provision for clients with special needs should be ensured. (Refer 2.7.1.)
- 4.9 Walk-in clinics should have a maximum waiting time of two hours.
- 4.10 Services that operate an appointment system instead of walk-in clinics should provide appointments within 2 working days for non-specialist, non-urgent consultations^{3,6}.
- 4.11 Appointments for specialist services including permanent methods should be provided within 12 weeks of initial contact.

5. Standard Statement on Training

All staff working in Sexual Health Services should receive appropriate training and must maintain their skills.

Essential (minimum):

- 5.1 All doctors providing contraception within Sexual Health Services should hold a current Diploma in Family Planning of the FFPRHC (DFFP) or be trained to equivalent competencies and show evidence of maintaining their skills.
- 5.2 All doctors providing contraception within Sexual Health Services, who obtained their DFFP, or equivalent, prior to 2003, should undertake additional STI training and show evidence of maintaining appropriate skills.
- 5.3 All doctors offering IUD, IUS and contraceptive implant insertion should hold the DFFP and an up-to-date Letter of Competence Intrauterine Techniques (LoC IUT) / Letter of Competence Subdermal Contraceptive Implants (LoC SDI) of the FFPRHC or have achieved equivalent competencies and show evidence of maintaining their skills.
- 5.4 All nurses, pharmacists and other health professionals working in all levels of Sexual Health Services should be trained to the competencies laid down by their educational body^{15, 16, 17}.
- 5.5 All administrative staff involved in Sexual Health Services should receive appropriate training, including confidentiality, child protection and customer care.

Desirable (ideal):

- 5.6 All doctors, nurses and other health professionals working in Sexual Health Services should be trained to the competencies and training programmes **jointly** agreed by all their educational bodies including the Royal College of General Practitioners (RCGP), Royal College of Obstetricians and Gynaecologists (RCOG), FFPRHC, British Association for Sexual Health and HIV (BASHH), Society of Sexual Health Advisors, the Royal College of Nursing (RCN), Royal Pharmaceutical Society of Great Britain, the Pharmaceutical Society of Northern Ireland and supported by user representatives such as the fpa.
- 5.7 Dedicated young people's services should be staffed by those who have an understanding of adolescent development and experience of working with young people.
- 5.8 Staff working with vulnerable groups, e.g. young people, learning disabilities, should be appropriately trained.

6. Standard Statement on Clinical Practice

Sexual health service provision should be evidence-based, which will include use of national and local guidelines and policies or recognised body of opinion.

Essential (minimum):

Sexual Health Services should have the following local policies in place:

- 6.1 Evidence-based policies based on nationally recognised guidelines, e.g. FFPRHC Recommendations for Clinical Practice, NHS guidelines, including NICE and WHO Recommendations (as amended for UK practice where relevant) for provision of all contraceptive methods¹⁸.
- 6.2 Policies governing STI service provision that follow the guidelines outlined in the National Sexual Health Strategy/Commissioning Toolkit for STI services⁵ and are consistent with BASHH guidelines¹⁹.
- 6.3 Policies governing abortion that follow current RCOG Abortion Guidelines¹¹.
- 6.4 Policies relating to child protection²⁰ / vulnerable adults²¹ that follow national guidelines.
- 6.5 Policies that address the recommendations in the National Strategy for Sexual Health and HIV for England¹, its implementation plan²² and commissioning toolkit⁵ and the sexual health promotion toolkit²³ or its equivalent in other UK countries.
- 6.6 Policies which address MedFASH recommended standards for sexual health services³.
- 6.7 Locally applicable standards for administrative staff.
- 6.8 Appropriate IT services and provision for staff to access up-to-date guidance

Desirable (ideal):

- 6.9 Services should aim to achieve standardisation of delivery of care.

7. Standard Statement on Confidentiality

All clients seeking Sexual Health Services should be certain that their right to confidentiality would be respected and maintained in line with GMC, NMC & other professional bodies' recommendations^{17,24, 25,26}.

Essential (minimum):

- 7.1 Services should prominently display their confidentiality statement at their premises.
- 7.2 Confidentiality training should be provided to all staff working in Sexual Health Services.
- 7.3 Staff providing these services should be familiar with the Fraser Guidelines, best practice guidance²⁷ and appropriate guidance in other UK countries^{28, 29}.
- 7.4 Clients 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 client wellbeing and/or safety.
- 7.5 Staff working with young people and vulnerable adults should be familiar with both local and national guidelines^{20, 21}.
- 7.6 Specific permission from the client should be sought prior to sharing any information with anyone outside the service except in issues relating to child protection when the client should be informed that sharing will happen. (Even in this case the consent of the young person to share information would be ideal)
- 7.7 Services should work to the Faculty Confidentiality Standards³⁰.

8. Standard Statement on Record Keeping

Record keeping in all services should be of a high standard, to provide maximum benefit in client management, to facilitate audit and record the process of obtaining valid consent³¹.

Essential (minimum):

- 8.1 Contemporaneous, legible and complete signed records of consultations must be maintained.
- 8.2 Adequate notes regarding the consultation and management plan should be made to help other clinicians following up the management of clients.
- 8.3 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 1.8.).
- 8.4 Clinical records must be kept confidential at all times and stored in a secure place.
- 8.5 All record systems whether written or computerised, must have processes in place that follow the Caldicott Guidelines³² and are compatible with the Data Protection and Freedom of Information Acts^{33, 34}.
- 8.6 In recognition of the work being developed by the Department of Health in England on a common data set for sexual health (CDSSH) all services should be working towards computerised systems.
- 8.7 All services should work to the Faculty Record Keeping Standards³¹.

9. Standard Statement on Nurse Led Service Provision

The role of nurses in sexual health service provision should be enhanced³⁵.

Essential (minimum):

- 9.1 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 nurse prescribing initiatives³⁶.
- 9.2 Nurses working in contraception should be supported to acquire competencies for intrauterine and subdermal implant techniques and other new technologies as they are developed¹⁵.
- 9.3 Services should fully develop the scope of nurses in service delivery including adequately supported fully nurse-led clinics providing the full range of sexual and reproductive health services, including, abortion, menopause and vasectomy counselling.
- 9.4 The role of health care assistants / clinical support workers should be developed.

10. Standard Statement on Monitoring & Evaluation

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

Essential (minimum):

- 10.1 All providers should regularly audit clinical service provision^{3, 37} in terms of quality as well as access, process and outcome issues from a consumer viewpoint. The results of audits should be acted upon to ensure appropriate improvements in service provision.
- 10.2 Commissioners for sexual health along with level 3 services for their population, should establish structures and processes for monitoring and evaluation of initiatives introduced to improve local sexual health care provision³. User involvement is essential in this process^{3, 9}.

Glossary

(Alphabetical Order)

BASHH	British Association for Sexual Health & HIV
DFFP	Diploma of the Faculty of Family Planning & Reproductive Health Care
FFFP	Fellow of the Faculty of Family Planning & Reproductive Health Care
FFPRHC	Faculty of Family Planning & Reproductive Health Care of the RCOG
fpa	Family Planning Association
GMC	General Medical Council
IUD	Intrauterine (contraceptive) device
IUS	Intrauterine (contraceptive) system
MedFASH	Medical Foundation for AIDS & Sexual Health
MFFP	Member of the Faculty of Family Planning & Reproductive Health Care
NICE	National Institute for Health and Clinical Excellence
NMC	Nursing & Midwifery Council
RCOG	Royal College of Obstetricians and Gynaecologists
STIs	Sexually Transmitted Infections
WHO	World Health Organisation

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