

recommendation that intrauterine devices (IUDs) are safe to use after the manufacturer's expiry date. Guidance from the Medicines and Healthcare products Regulatory Agency (MHRA) on the safe use of medical devices advises checking before use whether a device is within its expiry or use-by date.²

Training material from Family Health International states that the expiration date printed on IUD packaging indicates the date when the sterile packaging expires, not the date when the IUD's effectiveness expires.³ Even in the resource-constrained settings for which this information is intended, it is advised that an IUD is used only if the sterile package has not expired.

Therefore, Dr Yadava's patient was probably not at increased risk of pregnancy but she may have been at increased risk of infection. In the event of inadvertent insertion of an expired IUD, the patient should be informed of the error and advised of the risks of retaining or replacing the IUD. If the IUD has only recently expired or if the IUD has been inserted without any infective complications, then the risks of replacing the IUD may outweigh the benefits.

Confusion has possibly arisen because in contraceptive literature the term 'expiry date' is often used to describe the limit of an IUD's recommended duration of use. This 'expiry date' can be exceeded in women who are over the age of 40 years at the time of insertion.⁴

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Correspondence about the recent article on "Nurse Training in Sexual and Reproductive Health"

The Journal has received a number of letters written in response to the Personal View article entitled "Nurse training in sexual and reproductive health" by Shelley Mehigan, Wendy Moore and Linda Hayes that appeared in the January 2010 issue of the Journal. The very fact that this article has attracted the greatest number of letters of any article published in the Journal in recent years is evidence of the article's timeliness and relevance to many of the Journal's readers. The individual letters received by the time this Journal issue went to press, and the response from Shelley Mehigan and Wendy Moore, are reproduced here in full.

Letters

I would like to thank the authors of the article¹ on nurse training in sexual and reproductive health in the January 2010 issue of this Journal for very clearly setting out the current situation regarding nurse training in this specialty and the history to the situation.

I agree with the authors that post-registration training in contraception and sexual health has been an area of concern for some years now. Certainly when I joined the Faculty Associate Members Working Group 3 years ago this was one of the main issues on our agenda. We set out to look at whether nurses could do the Faculty

Diploma (the DFFP as it was known as then) along with doctors. This was not possible as it is a medical diploma and qualification. This has come full circle and will be revisited. A lot of work has taken place within this group, including attempting to map current training provided across the country.

● **Recruitment.** As a Senior Nurse Manager in a service employing over 60 SRH nurses I find the lack of standardisation of training difficult when recruiting; to ascertain from applications whether the candidate has completed a recognised training or a skills course can be difficult, in addition 'recognised' courses can vary significantly. From the nurse's point of view there seem to be enthusiastic candidates who have not attended recognised contraception and sexual health courses but who are keen to move into the specialty and it seems some nurses are having difficulty in knowing exactly which training is required by employers and/or accessing the training.

● **Access to training.** From the nurse's position, to undertake a contraception and sexual health course at a Higher Education Institute (HEI) can take 3–9 months to complete. Managers are reluctant to give study leave to enable nurses to access the training, and nurses are struggling to balance the demands of their job with lengthy assignments. In some instances, after 6 months two modules have been completed and the nurse is trained in contraception; however, yet another module is required to complete cervical cytology screening and yet another for management of sexually transmitted infections (STIs).

● **Multidisciplinary training.** I believe that training in contraception and sexual health should be multidisciplinary. Nurses and doctors should be able to access the same training and undergo the same assessment; it would follow on that standard accreditation is required. The Faculty has welcomed Associate Members with the AMNG working group and with Associate Members represented on other committees. If the Faculty could extend accreditation to clinicians other than doctors this could address many of the issues, although this is currently not possible.

● **Standardised training.** The content of the training must be standardised and it is vital that training from all providers and HEIs is up to date, evidence-based and reviewed by practising experts in SRH. The course should cover contraception and sexual health to meet the needs of integrated services. Cytology training and updating is another area that would benefit from standardising across disciplines.

● The new e-learning for the DFSRH will be accessible for all to learn in their own time and at their own pace. Assessment would be standard. The Course of 5 may be richer for having doctors and nurses training together. I believe the *clinical placement and clinical assessment* is a very important part of the SRH nurse training and I would not like to see it reduced. This part of the assessment is not undertaken by HEIs but by local SRH departments. Therefore this could continue whether or not the nurse is doing a university-accredited course. Locally we provide clinical placements of 12–14 weeks with usually one session a week. If this can be provided with longer sessions over a shorter time period then the clinical training could be completed in several weeks.

● Many post-registered nurses are not doing the contraception and sexual health training as part of a pathway to get a degree, but to achieve the competencies required to work in the area. For those nurses who choose to do it as part of a degree or masters, a standardised course should be available at HEIs but I would recommend that the course includes the same basic content as the standard training accessed by doctors and nurses (i.e. the e-learning, Course of 5 and clinical placement).

● **Accreditation** needs to be addressed urgently in view of the Royal College of Nursing (RCN) changes. We plan in future to provide accreditation as a Department of SRH to nurses trained in subdermal implants (SDIs). However, this has implications for those who wish to become primary trainers for their medical colleagues.

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- 1 Mehigan S, Moore W, Hayes L. Nurse training in sexual and reproductive health. *J Fam Plann Reprod Health Care* 2010; **36**: 5–6.

I am corresponding in response to the article¹ in the Journal on nurse training in SRH, and want to say that I totally agree with all of the points the authors raised in this article.

I am the lead nurse for sexual health in Northamptonshire Healthcare Foundation NHS Trust with 27 family planning (FP) nurses and 23 genitourinary medicine (GUM)/HIV nurses. Training, education and development of their roles is one of my key responsibilities.

In the days of the English National Board (ENB), as the authors quite rightly say, we knew the standards required. Currently we support FP students on courses at De Montfort University Leicester and are very satisfied with this course in terms of standards and support from tutors, and so on. However, there have been students from other areas where we have been less than impressed with the course offered.

I think the proposal to link in with the DFSRH standards is an excellent progression, particularly as nurses take on such an integral advanced role in this specialty. With advanced practice, I as a manager like to know that when a new member of staff has attended specific courses, it is at the level required to carry out the job competently and safely.

I welcome involvement in these new initiatives.

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Reference

- 1 Mehigan S, Moore W, Hayes L. Nurse training in sexual and reproductive health. *J Fam Plann Reprod Health Care* 2010; **36**: 5–6.

I was most interested to read the nurse training article¹ in the Journal.

I have a particular interest in nurse training as one of my roles at The Margaret Pyke Centre is Nurse Trainer for inserting and removing subdermal implants. I am also training to be a Faculty Nurse Trainer for Doctors in this specialty.

It seems to me that the Royal College of Nursing (RCN) are implementing policies that positively discourage Nurse Trainees, by the large increase in accreditation and re-accreditation fees. Primary care trust budgets seem to be so tight that they are not providing the money for the fees, so that the only way for a nurse to obtain accreditation is to pay for it herself. The nurses that I have trained have had difficulty in affording the fee of £35 (£75 for non-RCN members), so you can imagine the extra difficulty that a fee of £300 (£400 for non-members) is going to cause. It is definitely going to reduce the number of nurses coming forward for the programme. Furthermore, this disincentive to increasing the pool of competent people is contrary to the stated policy of promoting long-acting reversible contraception (LARC).

I shall be writing to the RCN to highlight this issue and ask them to reconsider the change. If they are not prepared to do so, are there other possible avenues to achieving a recognisable accreditation for nurses without a significant financial penalty?

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- 1 Mehigan S, Moore W, Hayes L. Nurse training in sexual and reproductive health. *J Fam Plann Reprod Health Care* 2010; **36**: 5–6.

I have just read the excellent article¹ in the January 2010 issue of the Journal on the subject of nurse training. The article clearly documents concerns I have had for several years relating to national standards for post-registration nurse education in contraception and sexual health.

I was involved in the provision of contraception and sexual health courses for over 20 years at City University and Surrey University before I become involved with the rollout of non-medical prescribing. I was also the education lead on the Royal College of Nursing (RCN) Family Planning Forum Executive Committee from 1998 to 2000, and would add that before the demise of the National Boards in 2002 we were concerned about the variation of training provision across different university providers. It was at this time that the Board Course No. 8103 came into being and the ENB R71 was developed by some providers as it was felt that the 8103 was not fit for their purpose. All this is now boring history but I suspect that some providers have for some time not drastically changed their CASH training! I fully support the need to rectify the confusing situation and revolutionise post-registration nurse training in this field.

Can I ask that when looking at levels of training, consideration be given to the Knowledge and Skills Framework, career progression and remuneration of nurses so that specialist nurses undertaking more advanced roles are suitably rewarded!

If I can provide any input into the development of this training please ask. Although I retired from my academic job at Surrey University in 2008, I still work part time in the CASH service in North Surrey and mentor CASH students from Surrey University.

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- 1 Mehigan S, Moore W, Hayes L. Nurse training in sexual and reproductive health. *J Fam Plann Reprod Health Care* 2010; **36**: 5–6.

Firstly, congratulations for publishing a very interesting article¹ on nurse training in the January 2010 issue of the Journal.

I wholeheartedly agree with the authors that there is no standard training for nurses to gain the CASH qualification, and standards from universities vary considerably across the country. It will be very interesting to see how the Band 5 trainee nurses at Margaret Pyke progress with the e-SRH modules and whether this will indeed provide a turning point for nurse education in CASH.

What I find a little more disturbing is the price hike by the Royal College of Nursing (RCN) for accreditation for subdermal implants and intrauterine devices: this is somewhat shocking in today's current economic climate. How are nurses expected to find this kind of money? I have actively encouraged training for appropriate primary care staff in these skills and encouraged them to seek accreditation but with many practice nurses not receiving Agenda for

Change pay and advised to do this training by their managers but not given financial backing by their employers (most practice nurses not employed by NHS) this has to be a grave mistake by the RCN. As CASH nurses trying to encourage the uptake of long-acting reversible contraception (LARC) and make it easily accessible this is yet another barrier.

I am well aware that the RCN has external accreditors and they are probably paid for the work they do, but £300 per member? I will have to seriously reconsider whether I renew my certificate when it expires later this year.

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I thought I would submit my comments on the article¹ in the January 2010 issue of the Journal on nurse training.

I am in agreement with the authors about the fact that we need to try to standardise the course in some way. I feel that it would be lovely if we could use the Faculty training in some way but I am aware that they do deal only with doctors.

I have thought that if all the universities could get together and decide to produce a examination paper that every student undertakes, then even if the lectures and practicals differed then the standardisation of the examination would be the same for all students and at least we would be able to say that an individual student has achieved a certain level.

I am aware that this may be impossible but it does seem like a good way forward.

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I absolutely agree with what the authors said in their recent article¹ on nurse training and I believe that they should continue to explore the option of the Faculty supporting nurse education and accrediting nurse training. This could be done by a separate but affiliated nurses group.

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I read the article¹ on nurse training in the January 2010 issue of the Journal with interest and I agree that things have become inconsistent since the demise of the English National Board (ENB).

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- 1 Mehigan S, Moore W, Hayes L. Nurse training in sexual and reproductive health. *J Fam Plann Reprod Health Care* 2010; **36**: 5–6.

Having read the article¹ on nurse training in SRH in the January 2010 issue of the Journal, I absolutely agree with the authors that there should

be standardised training not only for sexual health, but for all the other tasks and skills that nurses need to know these days. Coming out of university with a degree does not equip nurses with any specialised skills. Therefore having a course that 'adds on' to a degree and is the same anywhere in the UK has to be the way forward. E-learning is brilliant and would equip nurses, especially practice nurses, to at least be able to have some knowledge of family planning and STIs, even if they didn't want to do more in-depth study.

As a Practice Nurse Facilitator I am always being asked where nurses can find training and I have very little to offer.

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- 1 Mehigan S, Moore W, Hayes L. Nurse training in sexual and reproductive health. *J Fam Plann Reprod Health Care* 2010; **36**: 5–6.

Having read the recent article¹ on nurse training in this Journal, I am wholeheartedly behind the authors' efforts to both standardise and make accessible sexual and reproductive health (SRH) education. In this day and age I feel that e-learning is an entirely appropriate and cost-effective approach for core learning with the other three DFSRH elements ensuring consistency across all clinicians working in this area. Working with practice nurses I can clearly see benefits for this as follows:

1. Less time away from the workplace.
2. Recognition of the expertise and status of practice nurses working in this area which in many GP practices is a nurse-led service.
3. With more clinicians completing a standardised curriculum comes more accessibility to a pool of appropriately qualified mentors in practice to ensure proper succession planning and choice for accessing the clinical placements.
4. Safe and evidence-based practice that is equitable for patients.
5. Free access via e-learning for theory to support Level 1 sexual health service delivery will provide a taster for new nurses and other clinicians to ensure consistent delivery of the wider sexual health agenda and also ensure a standardised preparation for those who intend to go further.

With regard to the accreditation, I would favour the Faculty option with the university option second until the Faculty is able to take this on. Why would we want to share a training pathway and not see the output given equitable and consistent accreditation?

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I am responding to the article¹ on nurse training in the January 2010 issue of the Journal. I cannot begin to say how much I relate to the issues covered in this article and agree with the views expressed by its authors.

Here in Hull we have had real problems recruiting family planning (FP) nurses for several years and rely heavily on sessional bank nurses (whose main employment is elsewhere) to maintain a service. Similar problems recruiting suitably qualified FP doctors has meant that we have significantly developed the role of FP nurses to compensate – extended roles, patient group directions (PGDs), prescribing, and so on – which current university FP training has not really kept

pace with, and consequently we have had to develop our own training packages and competencies.

We are a service working towards full integration with genitourinary medicine (GUM) and have some 'one-stop' clinics at present. To do this we have trained all our GUM nurses to give emergency hormonal contraception and feel that the only way forward is to bring nurses into the service in GUM on Band 5 and second to do FP training once basic GUM competencies have been achieved. We have also very successfully 'fast tracked' one Band 6 nurse recruited from the substance misuse services to become a dual-trained sexual health nurse with her main remit in FP after failing to recruit FP trained nurses on several consecutive occasions.

We currently second nurses onto the Foundation in FP and Practical Aspects of FP (three semesters total) at the University of Hull but are looking at running our own alternatives to this, not only to fulfill our own needs but also to meet the requirements of primary care nurses (most of whom are not FP trained) who need to be trained up quickly to provide long-acting reversible contraception (LARC) methods in response to our high teen pregnancy rate. Our plan was to adapt the FSRH course as the authors mentioned in their article. I personally would be very grateful for any contacts that the authors have at either of the pilot sites – why reinvent the wheel?!

I would be more than happy to work on this with the authors, as I feel very strongly about this issue and would love to be involved in finding a solution that the whole country could benefit from.

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- 1 Mehigan S, Moore W, Hayes L. Nurse training in sexual and reproductive health. *J Fam Plann Reprod Health Care* 2010; **36**: 5–6.

The problems around post-registration training, since the demise of the National Boards in 2002, are succinctly summarised by Mehigan *et al.* in their recent article¹ in this Journal. This includes the subsequent lack of standardised training and a nationally recognised post-registration qualification in sexual and reproductive health (SRH). With the variety of university courses in SRH, it is indeed difficult for employers and service users to have confidence in knowing what the nurse has achieved in terms of theoretical and practical exposure within the discipline.

National accreditation of nurses' competence through the National Boards, with university courses built around recognised clinical curricula, enabled nurses to demonstrate their competence in SRH to employers and patients alike. The Faculty of Sexual and Reproductive Healthcare acknowledged the contribution of nurses to the field of SRH by opening up membership to them.

I support the option proffered by the authors, namely exploring the possibility of the Faculty supporting and accrediting nurse training. The universities would once again be able to develop their courses around recognised curricula. I suspect many of them will welcome the return of standardisation in post-registration SRH education, reducing any ambivalence they may have about developing new courses.

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- 1 Mehigan S, Moore W, Hayes L. Nurse training in sexual and reproductive health. *J Fam Plann Reprod Health Care* 2010; **36**: 5–6.

Thank you to the three correspondents in the Personal View article¹ on nurse training in sexual and reproductive health.

The extraordinary situation of there being no national standards for nurse training in England needs to be highlighted and emphasised whenever possible in the hope that someone, somewhere will see fit to reinstate an English National Board (ENB) equivalent.

With regard to training in sexual health, I feel that the Faculty has a great opportunity to positively move this situation forward. Having been a member of the Nurses' Working Group for a number of years, I am only too well aware that changes within the Faculty are extremely difficult but feel not impossible.

Multidisciplinary work is now the norm and it seems that merging nurse training with that of the doctors has to be the most reasonable way forward. The two professions are very different with different training needs but there is a point where the merging of core sexual and reproductive health training could be perfectly possible and definitely pragmatic with health care as it is at the moment.

Another point highlighted in this article is the Royal College of Nursing (RCN) raising the price of accreditation to a degree that suggests a nurse has the take home pay of a banker. What is their justification for this? Clearly it will be the individual nurse paying this rather than her primary care trust, which anyway are all pleading poverty. Presumably many nurses will vote with their feet and prefer not to accredit themselves at the very moment that the National Institute for Health and Clinical Excellence (NICE) guidelines are promoting long-acting reversible contraception (LARC); procedures requiring training and accreditation. Is it possible for another organisation to set up an accreditation process?

After 40 years in this area of work I feel that there have been many opportunities for nurse self-development that have not only been good for the individual but also the patients and the organisations for which we nurses work. The issue of standards is crucial, and the fact that the nurses' union is the only body looking at them is concerning.

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Reference

- 1 Mehigan S, Moore W, Hayes L. Nurse training in sexual and reproductive health. *J Fam Plann Reprod Health Care* 2010; **36**: 5–6.

I would like to congratulate the authors on their excellent Personal View article¹ on nurse training in sexual and reproductive health (SRH) that appeared in the January 2010 issue of this Journal.

SRH nursing appears to have gone full circle. During the last 33 years many courses have been open to doctors, nurses, midwives and health visitors, with examinations and diplomas being presented to successful candidates. Also nurses have struggled to be accepted in multidisciplinary teams and this is now well established.

Globally since the late 1960s, nurses/midwives with the appropriate recognised training have extended their roles in order to meet the needs of their communities and professional development. This has been supported by their medical colleagues.

I totally agree there is a lack of national recognised post-registration training in advanced knowledge and clinical skills of SRH.

The Faculty is globally recognised for academic expertise and development of standards of care and training. Surely now it is time for the Faculty to yet again approach the Chairman and Council of the Royal College of Obstetricians

and Gynaecologists (RCOG) to make a special case to pioneer accrediting post-registration nurses in SRH?

The Royal College of Nursing (RCN) is not the appropriate professional body to accredit some courses and study days at an over-rated price for members/non-members.

Today families have to move around the country to seek employment. Surely potential employees have the right to a set of National Standards in SRH for their clients/patients. This should be a question for the Department of Health.

I have spent the last 30 years contributing to this field, and feel very strongly that it must not be just pushed under the carpet by a small number of medical and nursing colleagues.

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- 1 Mehigan S, Moore W, Hayes L. Nurse training in sexual and reproductive health. *J Fam Plann Reprod Health Care* 2010; **36**: 5–6.

In response to the recent article¹ on sexual and reproductive health (SRH) education for nurses, I would like to provide a higher education institute (HEI) perspective. As an educator and course deliverer, I would welcome professional bodies developing National Standards for SRH education and training, identifying roles and the core competencies for such roles.

If commissioners were required to fund only professionally badged courses, HEIs and other training providers would be forced to develop education and training programmes to meet these standards in order to attract students. HEIs must also find alternative ways of delivering such courses to increase access for training.

One key driver for commissioners and service deliverers would be that if staff were undertaking roles without such core competencies stated within their professional bodies' National Standards then they may be leaving themselves open to litigation. In following the model cited in the article would be an example of best practice, offering an opportunity to standardise SRH education and training, allowing HEIs the opportunity to accredit such courses.

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- 1 Mehigan S, Moore W, Hayes L. Nurse training in sexual and reproductive health. *J Fam Plann Reprod Health Care* 2010; **36**: 5–6.

I would like to respond on behalf of the Scottish SRH Lead Nurse Forum to the Mehigan *et al.* article¹ on nurse training in sexual and reproductive health (SRH) that appeared in the January 2010 issue of the Journal.

1. We would endorse the view that standardisation of core SRH theory and practice education, which is evidence based and regularly reviewed by SRH experts, is desirable and ultimately in the best interests of patients and employers. This allows for a transfer of skills when practitioners move location within the UK.
2. We would endorse the view that evidence of formal accreditation for learning is important as a means of quality assurance and governance. Currently in Scotland all accreditation is provided by Higher Education Institutes (HEIs). Employers would expect to fill posts with candidates who could provide evidence of accreditation in SRH from an HEI or, if a novice in SRH, candidates who are prepared to undertake HEI SRH modules.

3. In 2008 the Scottish SRH Lead Nurse Forum (representing each of the Scottish regions) formed a collaboration with the leads for SRH in each of the Scottish HEIs with a view to producing a Career and Education Framework for sexual health nursing. This work was supported and published by NHS Education Scotland (NES) in 2009. The Career and Education Framework is based on the Knowledge and Skills Framework (KSF),² the NHS Career Framework for Health³ and the Scottish Credit and Qualifications Framework (SCQF).⁴

4. The intention in 2010 is to review current course content in order to provide recipients and employers with a standard content and level of delivery aimed at equipping nurses to work within modernised and integrated sexual health services. Clearly the Faculty's standards will be taken into account as we determine this. We are also considering future demand and capacity. We intend to agree how many courses are needed (including new modules/courses), what formats, content and level, and who is best equipped to provide these in future to ensure sufficient and high-quality access across Scotland with choice for practitioners and employers.

5. Since the Faculty e-learning material has only just been launched there has not been time to assess where it will fit in the overall picture of SRH training and education for both specialist and non-specialist nurses. It does need to be clearly 'badged' in terms of accreditation if it is not to get lost among some of the other online training resources aimed, in particular, at practice nurses. We plan to assess it against the NES Competency Record Book for sexual health nursing.⁵

6. We look forward to the outcome of the current pilot exercises in The Margaret Pyke Centre and Reading. Our general feeling is that it would be retrograde to suggest that nurses undertake courses of this magnitude without formal accreditation from a UK body.

7. Currently in Scotland there is still a small cohort of nurses who use 'credit points' obtained from HEI sexual health modules to count towards the achievement of a degree. As the profession becomes wholly degree educated this will no longer be an issue.

8. There is concern that there has been too little consideration of the implications for assessed practice for nurses if we were to adopt the e-FSRH theory component without having access to the full accredited DFSRH. We would encourage the Faculty to consider the possibility of nurses being able to qualify for the Diploma, which would then act as a benchmark.

9. Removing HEIs from the provision of assessed practice puts the onus on employers to manage this along with all governance aspects of training staff who are not employed within the organisation (e.g. registration checks). This is not impossible but very difficult for areas with low staff numbers.

10. We favour multidisciplinary training in core SRH.

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RCN response

The Royal College of Nursing (RCN) would like to make the following points in response to the article¹ on nurse training in sexual and reproductive health by Shelley Mehigan *et al.* published in the January 2010 issue of the Journal.

The article states that "the RCN removed the specialist sexual health adviser post which was a detrimental and backward step". We fundamentally disagree with this view. The RCN places a firm emphasis on public health. Sexual health nurses have seats on the public health forum and this is working well, with clear programmes of work being developed around sexual health issues. We believe this model provides a broader perspective than simply having one Sexual Health Adviser.

Second, RCN accreditation is provided to external organisations seeking accreditation for events, resources and courses. The fee is in two bandings: a lower rate for National Health Service (NHS) Trusts and not-for-profit organisations, and a higher rate for for-profit companies. There is no differential made between applicants who are RCN members and those who are not.

Evaluation of our accreditation service shows that the reason organisers from various organisations apply for accreditation is that they wish to associate their names with the RCN's high standards and commitment to professional development. We have evidence to show that employers who know that RCN-accredited events are educationally robust, focused on nursing practice and evidence-based are more likely to release their staff to attend RCN-accredited events.

There is a difference in the cost of accreditation for members and non-members seeking to be accredited for fitting IUTs/IUSs and SDIs. Membership of the RCN is open to all nurses, and is a matter of personal choice. However, in common with all membership organisations, the RCN offers membership benefits such as this reduced fee.

In terms of education, it is accepted that there is a lack of consistency in the content of many professional programmes since the National Boards ceased to exist. To address this, and to contribute to quality of care in practice, the RCN has developed a number of standards and competency frameworks to provide an evidence-based benchmark in order that programmes, or an individual's experience, might be mapped against the evidence and current best practice. The processes used by the RCN Accreditation Unit are robust and supported by experts in the relevant fields of practice.

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Reference

- 1 Mehigan S, Moore W, Hayes L. Nurse training in sexual and reproductive health. *J Fam Plann Reprod Health Care* 2010; **36**: 5–6.

Authors' response to correspondence about Nurse Training in SRH

We would like to thank all those who responded to our article.¹ As Journal readers will see, most respondents are in agreement with our concerns and are supportive of the suggestions we made as to how nurse training in SRH might be delivered in the future. In addition to the written responses we have heard from a number of people who have expressed the same views verbally.

In specific response to the letter from the Royal College of Nursing (RCN),² we were surprised to read their comment about the current situation being better than "simply having one Sexual Health Adviser". The sexual health (and previous family planning forum) was one of the longest established and most active forums within the RCN, with up to seven representative members on the steering group supported by an adviser who was qualified and experienced in the field. We are aware of instances now of members being unable to get answers from people with sexual health knowledge or qualifications to concerns about which they have contacted the public health team. We would repeat our concern, namely that since most Level 1 sexual health care is delivered in general practice, and many practice nurses are members of the Medical Defence Union (MDU) in preference to the RCN, this has implications for the cost incurred for accreditation.

We are delighted that the National Support Team for Sexual Health and Sexual Health Policy Team at the Department of Health (DH) has recently appointed Anita Weston (formerly Nurse Adviser for Sexual Health at the DH) to undertake a 4-month project on 'Nurse Education in Sexual Health'. The aim of this project is to bring together the various pieces of work and educational initiatives that a number of organisations in the field have developed, and to consider an overall nationally recognised and standardised educational pathway for nursing in sexual and reproductive health in England.

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- 1 Mehigan S, Moore W, Hayes L. Nurse training in sexual and reproductive health. *J Fam Plann Reprod Health Care* 2010; **36**: 5–6.
- 2 Davies J. RCN response [Letter]. *J Fam Plann Reprod Health Care* 2010; **36**: 111.

LETTERS TO THE EDITOR

Letters to the Editor are welcome and generally should not exceed 600 words or cite more than five references. For comments on material published in the most recent issue of the Journal, correspondence should be received within 4 weeks of dispatch of that Journal to be in time for inclusion in the next issue. When submitting letters correspondents should include their job title, a maximum of two qualifications and their address(es). A statement on competing interests should also be submitted for all letters. Letters may be submitted to the Editor or the Journal Editorial Office (details on page 50).