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) regarding the expiry 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 indicates that the 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 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 benefit.

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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References

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 for 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 was written were anonymous and the responses 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 sexual and reproductive 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 our first objective. We set out to look at whether nurses could do the Faculty Diploma (the DFFP as it was known 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 in 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 course is 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 any specific training in sexual and reproductive 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 with the lack of availability of days with lengthy assignments. In some instances, after 6 months two modules have been completed and the nurse is trained in contraception; however, the nurse is required to complete cervical cytology screening and yet another for management of sexually transmitted infections (STAs).

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 an important part 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 when the issue is raised to do 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 other recognised standardised course, it 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 Training, 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 training in sexually transmitted infections (STIs). However, this has implications for those who wish to become primary trainers for their medical colleagues.

Rosie Jackson
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Reference

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 the roles of the Sexual Health Nurse Recruitment.

In the days of the English National Board (ENB), as the authors quite rightly say, we knew the standards required. Currently we support FP staff 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 the placements 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.

Chris Stirney
Directorate Senior Nurse, Directorate of Sexual Health, Ashwood Centre, St Mary’s Hospital, Keighley, UK.

Reference

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 potentially discourage these Trainees, by the large increase in accreditation and re-accreditation fees. Primary care trust budgets seem 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 image 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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Reference

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 became involved with the rollout of non-medical prescribing. I was also the education lead on the Royal College of Nursing (RCN) Family Planning Forum Committee from 1986 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 teaching locations, and the loss of consistency. 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 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 pathway and mentor CASH students from Surrey University.

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Reference

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 Board 5 training 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 and not something the student nurse will find easy. 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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Reference

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 Board 5 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 and an examination undertaken and then 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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Reference

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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Reference

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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Reference

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 specialist skills. The RCN 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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Reference

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 DSFRH elements ensuring consistency across all clinicians working in this area. Working with 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 trained 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 on and do more.

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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Reference

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. Having a 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 primary medical services 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 ‘memorised’ most contraception methods. They are looking at running our own alternatives to this, not only to fulfil 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; personally I 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.

Carol Trotter, RGN, NDF Integrated Team Leader, Sexual & Reproductive Healthcare Partnership, Hull, UK.

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Reference

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 article in this Journal. This includes the subsequent lack of standardised training and a need for better recognition of post-registration qualification in sexual and reproductive health (SRH). With the variety of university courses in SRH, it is indeed difficult for employers and students to ensure that they have received appropriate and validated training in the field of SRH that 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 & Reproductive Healthcare acknowledged the contribution of nurses to the field of SRH by opening up membership to them. 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.

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 their 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 recommend 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

I would like to congratulate the authors on their excellent Personal View article 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 qualifications and diplomas being presented to successful candidates. Also nurses have struggled to be accepted in multidisciplinary teams and this is now well established.

In the 1960s and 1970s, 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 of SRH (RN). 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 set up again 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, and there is a lack of standardisation of core SRH theory and practice leaving themselves open to litigation. In the extraordinary situation of there being no national standards for SRH education, 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 recognised programmes to meet the needs of their communities and professional development, 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. 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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Reference

I would like to respond on behalf of the Scottish SRH Lead Nurse Forum to the Mehigan et al. article on nurse training in sexual and reproductive health (SRH) that appeared in the January 2010 issue of this Journal. I would endorse the view that standardisation of core SRH theory and practice education, which is evidence based and regularly reviewed by national bodies, is desirable ultimately in the best interests of patients and employers. This allows for a transfer of skills when practitioners move location within the UK.

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 other agencies (other 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.

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Reference

In response to the recent article1 on sexual and reproductive health (SRH) education for nurses, if I was to provide a higher education institute (HEI) perspective, I support the option proffered by 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.

Kathy Ellis, MR, RGN
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Reference
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), the NHS Career Framework for Health and the Scottish Credit and Qualifications Framework (SCQF).

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 modern 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.

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 ‘bagedged’ 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.

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.

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.

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 nurses to consider the possibility of nurses being able to qualify for the Diploma, which would then act as a benchmark.

Removing HEIs from the provision of assessment 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.

We favour multidisciplinary training in core SRH.

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References

RCN response
The Royal College of Nursing (RCN) would like to make the following points in response to the article 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 in conjunction with public health officials form the RCN 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 employers 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 these 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 nurses, and is a matter of personal choice.

However, in common with all membership organisations, the RCN offers membership benefits given to accredited events.

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 that all nurses, 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

Authors’ response to correspondence about Nurse training in Sexual and Reproductive Health

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 teaching framework for education in nursing in sexual and reproductive health in England.

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References

LETTERS TO THE EDITOR
Letters to the Editor are welcome and generally should not exceed 800 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 correspondence 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).