Implementing the RCPCH guidance "*Safeguarding guidance for children and young people under 18 accessing early medical abortion services*"

Advice for Providers, Commissioners and Regulators, September 2022

Background

On 30.8.22 the RCPCH published guidance on safeguarding for young people accessing abortion services (Safeguarding guidance for children and young people under 18 accessing early medical abortion services – RCPCH Child Protection Portal). We welcome the aims of the guidance – ensuring that every CYP has access to EMA in a timely manner and that holistic and safeguarding needs are identified and acted upon.

A longer time-frame for the external commissioning of the RCPCH guideline would have been beneficial in ensuring that normal processes of guideline development could be effectively followed (e.g. RCPCH Process Manual for Development of Clinical Guidelines). For example, the RCPCH clinical reference group did not have an opportunity to review or agree the guideline before it was published.

As the bodies responsible for professional standards, quality and provision of pregnancy, sexual and reproductive health and abortion care in the UK, we welcome all resources that help keep women, girls and all people who can get pregnant safe. We are keen to ensure that these guidelines are implemented in such a way that they serve the best interests of young people who are pregnant.

The aim of this resource is to ensure clarity over the quality and standards expected of services. It is aimed at commissioners, regulators and abortion care providers and addresses four elements in need of clarification: the location of assessment, the nature of the clinical assessment of pregnancy gestation, the pathway for those aged under 13 years and data collection. This implementation guidance represents the views of many of the RCPCH guideline committee, including those who have expertise and experience in abortion care and safeguarding.

Existing Guidance

Providers, commissioners and regulators need to be aware of existing national guidance:

> NICE Guideline NG204 - Babies, children and young people's experience of healthcare.
> Recommendation 1.10.10 – "Use flexible methods where clinically appropriate, agreed with the child or young person to deliver healthcare services (for example, telephone or video calls, digital media such as websites and apps) as alternatives to in person face-to-face services to help overcome access difficulties, such as travelling to appointments or relying on parents for transport."

NICE Guideline NG140 - Abortion care.
Recommendation 1.1.9 – "Consider providing abortion assessments by phone or video call, for women who prefer this."

NSPCC Working virtually to support children and families. Report – 16 March 2022
"Conversations, therapeutic sessions and meetings held via phone or video call can seem less intimidating and intense than face-to-face meetings in an office or practitioners visiting someone's home. This might be because children and families feel safer and more comfortable with remote support in a familiar environment, which can help them feel more able to open up about their emotions, experiences and situations."

GMC - Ethical Guidance Summary 0-18 years.
Summary of good medical practice to ensure care is ethical, lawful and for the good of young people. Includes guidance on sexual health services, abortion and sexual activity. "A confidential sexual health service is essential for the welfare of children and young people. Concern about confidentiality is the biggest deterrent to young people asking for sexual health advice. That in turn presents dangers to young people's own health and to that of the community, particularly other young people."

Clarifications and points to support implementation

Location of Assessment

Services must be able to adapt to the needs and circumstances of the young person and to the evolving evidence-base, and to offer flexibility depending on an individual's needs and circumstances. There is currently no evidence that safeguarding is better delivered using any one model of care, but the experience of abortion and sexual health providers is that better safeguarding disclosure can be obtained through remote consultations[1].

We support the recommendation that all CYP seeking early medical abortion should be offered an in-person consultation at some point in the care pathway and that providers and commissioners should ensure that if this is desired, that any barriers to in-person attendance are mitigated. However, whilst recognising that younger CYP generally have greater needs for in-person assessment, the location of assessment for each individual case is best managed between the clinical team and young person.

REGULATORS OR COMMISSIONERS SHOULD NOT MANDATE LOCATION / MODE OF ASSESSMENT BASED ONLY ON THE AGE OF THE PREGNANT PERSON.

Nature of Clinical Assessment

The RCPCH guideline states that "the in-person consultation [must / will] facilitate a clinical assessment to confirm gestation and a more in-depth safeguarding risk assessment as appropriate". All abortion care pathways should include clinical assessment, which – depending on the

[1] The SAPHE study from the Universities of Bristol and Durham has presented its findings and is pending publication

circumstances – may involve menstrual and sexual history, clinical examination or ultrasound. Where safeguarding risks are identified, these must be investigated.

REGULATORS OR COMMISSIONERS SHOULD NOT MANDATE ULTRASOUND ASSESSMENT OF GESTATION BASED ON THE AGE OF THE PREGNANT PERSON.

Under 13y Pathway

The telemedicine for EMA service forms one aspect of the abortion care pathway in England, with safeguarding being a fundamental standard of care provision across the entire pathway and essential for all patients, regardless of their age.

Gynaecology units rarely have the skills or experience to offer abortion care to young people. In many areas, community settings with an experienced abortion provider will be more appropriate than an inpatient paediatric or gynaecology setting.

REGULATORS OR COMMISSIONERS SHOULD NOT MANDATE ATTENDANCE IN AN INPATIENT UNIT FOR THOSE UNDER 13.

Data Collection and Analysis

Local quality requirements should be clinically appropriate and realistically achievable. The technical guidance of the NHS Standard Contract notes that as a general rule, focussing on a small number of key indicators is likely to be more effective than requiring dozens of separate indicators to be monitored. It is important for commissioners to bear in mind the burden which Local Quality Requirements may create for providers, in terms of service management and data collection and reporting, especially for national providers who report to all CCGs, ICS or health boards.

NHSE notes [43.6] that in the current context where NHS finances are under considerable stress, it is essential that commissioners are rigorous in reviewing the information burden they place on providers, ensuring that they only require information which they will actually use in practice, that the benefit from having the information is in proportion to the costs the provider incurs in collating it and that the information is not already being submitted via a different route.

IN THE ABSENCE OF ANY EVIDENCE FOR CONCERN, RESOURCES ARE BETTER DIRECTED AT SERVICE PROVISION – INCLUDING SAFEGUARDING – THAN IN NEW DATA COLLECTION. EXISTING SYSTEMS OF GOVERNANCE, INCLUDING INCIDENT REPORTING, QUALITY AND SAFEGUARDING REPORTS SHOULD BE SHARED WITH PARTNER ORGANISATIONS FOR SHARED LEARNING AND QUALITY IMPROVEMENT.