Background note for stakeholders at consultation

What is the background to this work?
In April 2022, Parliament made the decision to legislate to permanently allow the remote delivery of early medical abortion (EMA) services in England and Wales, in line with the temporary arrangements introduced at the start of the COVID-19 pandemic. The Abortion Act will be amended to allow eligible girls and women in the first 10 weeks of pregnancy (nine weeks and six days) to take both pills required to induce an abortion at home. It is intended that the amendments to the legislation will commence at 00:01 on 30 August 2022.

Why is this work being developed?
In response to Parliament's decision to make home-use of EMA pills permanent in England and Wales, the Department of Health and Social Care (DHSC) are taking forward work to strengthen safeguarding for children and young people under 18 accessing EMA services. This is to ensure that under 18s are appropriately safeguarded when accessing EMA services, and to ensure there is consistency across the system in the implementation of robust safeguarding processes and procedures.

Whilst the new RCPCH safeguarding guidance will focus on children and young people under 18, DHSC and NHS England are currently exploring whether more needs to be done to strengthen safeguarding practices for vulnerable adults accessing EMA services. The UK Government has commissioned the Royal College of Paediatrics and Child Health (RCPCH) to lead on the development of this safeguarding guidance.

Who is this guidance for?
All RCPCH guidance is applicable to children and young people across the UK and sets out a standard of care that should be applied across the nations. The guidance is applicable to health organisations providing early medical abortions to children and young people under 18 years old across the UK.

How was the guidance developed?
The RCPCH convened a clinical reference group to provide professional clinical expertise to develop the first draft. This included clinicians trained in paediatrics, gynaecology, midwifery, nursing, sexual and reproductive health, and safeguarding. The RCPCH issued a call for evidence to health organisations and patient groups to understand current best practice. The RCPCH is engaging children and young people with experience of sexual health services to give their views on the work.

What happens next?
Following consultation with a wide range of stakeholders, including children and young people, a final document will be published on the RCPCH website on 30th August 2022, to dovetail with home-use of early medical abortion pills being made permanent in England and Wales.

DHSC will set out its expectations around implementation of the new guidance, including timeframes, alongside publication of the guidance. There is no expectation that the guidance will be fully implemented on 30th August 2022.

More information about the RCPCH is available here: https://www.rcpch.ac.uk/about-us

Safeguarding guidance for children and young people under 18 accessing early medical abortion services provided through telemedicine services

General principles

All health organisations providing early medical abortion (EMA) services for children and young people under 18-year-old (CYP) should follow these general principles when designing and providing services:

1. The best interests of CYP are paramount.
2. Policies and protocols should reflect the legal and professional frameworks in place throughout the four nations of the United Kingdom (UK).
3. CYP should have access to timely, high-quality, safe and effective EMA services.
4. EMA services should achieve equity by focusing on reducing health inequalities and championing diversity and inclusion principles.
5. All CYP have potential safeguarding needs; health professionals have a duty to undertake risk assessments to determine potential safeguarding needs for CYP and these risks should be acted upon.
6. CYP between the ages of 13 and 15 years old often have voluntary sex, which would not necessarily result in safeguarding concerns.
7. EMA services should be designed to respond to all the needs of CYP, with their views contributing to service planning and delivery.

Roles and responsibilities

Health organisations providing EMAs for CYP

The NHS is committed to promoting the safety, protection and welfare of all children. The safeguarding framework in England states, "All health providers including provider collaboratives are required under statute and regulation to have effective arrangements in place to safeguard and promote the welfare of children and adults at risk of harm and abuse in every service that they deliver. Providers must demonstrate safeguarding is embedded at every level in their organisation with effective governance processes evident."[1] Similar guidance and legislative frameworks are available in Scotland[2], Wales[3] and Northern Ireland. [4]

Section 11 of the Children Act (2004) places duties on a range of organisations, agencies and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children. [5]

Relationships between health organisations providing EMAs and other health services

There should be good working relationships and networks between providers of EMA services and wider health provision for CYP. This would include but is not limited to:

[1] https://www.england.nhs.uk/wp-content/uploads/2015/07/B0818_Safeguarding-children-young-people-and-adults-at-risk-in-the-NHS-Safeguarding-accountability-and-assuran.pdf
[2] https://www.gov.scot/publications/national-guidance-child-protection-scotland-2021/pages/2/
[3] https://www.safeguarding.wales/int/i1/i1.p1.html
[4] https://www.health-ni.gov.uk/publications/co-operating-safeguard-children-and-young-people-northern-ireland
[5] https://www.legislation.gov.uk/ukpga/2004/31/section/11

- Primary care
- Public health / school nursing / health visiting
- Family Nurse Partnership
- Community and acute paediatrics
- Emergency care settings
- Gynaecology services
- Sexual health and reproductive health services
- Sexual Assault Referral Centres
- Child and Adolescent Mental Health Services
- Named and Designated Health Professionals for Safeguarding Children and Named and Designated Health Professionals for Looked After Children

Wider health services should support the work of EMA services to promote the best interests of children and their safeguarding needs. By their nature, EMA services deliver time limited interventions. Some CYP may need longer term support for their health and wellbeing needs, which must be provided by partners in the wider health system.

CYP benefit from care that is person-centred and co-ordinated within healthcare settings, across mental and physical health and across health and social care. Health professionals and organisations have a key role to play to support integrated care. CYP may need care that is provided by several different health and social care professionals, across different providers. Models of integrated care can enhance patient satisfaction, increase perceived quality of care, and enable better access to services.

Relationships with partners in the local authority, police, education and the third sector are also vital for delivering integrated care.

Professionals
Protecting CYP is the responsibility of all health professionals who must act according to national safeguarding guidance, and professional guidance.[6] [7] [8] [9] [10]

Capacity and consent

There are three separate considerations about capacity and consent for CYP:

1. The ability to consent for an EMA (medical consent)
2. The ability to agree to sexual activity
3. Duty on professionals to safeguard CYP

Ability to consent for an EMA

EMA services will assess whether a CYP is able to consent using national frameworks and their own internal guidance.

The person consenting to the EMA needs to be able to:

[6] https://www.gov.uk/government/publications/working-together-to-safeguard-children--2
[7] https://www.rcn.org.uk/Professional-Development/publications/pub-007366
[8] https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/protecting-children-and-young-people
[9] https://www.gov.scot/publications/national-guidance-child-protection-scotland-2021/
[10] https://www.health-ni.gov.uk/publications/co-operating-safeguard-children-and-young-people-northern-ireland

• understand the procedure

• remember what they have been told about the procedure

• be able to weigh up the potential benefits and drawbacks of the procedure

• communicate their views

They also need to be free from duress for consent for EMA to be valid.

There is a presumption that the young person from their 16th birthday will have the capacity to make decisions about their health, such as undergoing an EMA.[11] If there is any doubt about their capacity, the health professional will need to undertake a Mental Capacity Act[12] assessment, following national guidance and seek further advice within their organisation.

CYP under 16 years old may also have the capacity to make decisions about their health if they are deemed to be Gillick competent. This means that they are able to fulfil the criteria described in the bullet points above.

If a CYP under 16 years of age is not deemed to be Gillick competent, a person with parental responsibility may consent on their behalf if they are able to fulfil the described criteria above. In this situation the CYP needs to support this decision and every effort needs to be made by the clinician to ensure that the CYP understands as much as is possible, appropriate to their developmental level.

The Fraser guidelines that are applied for under 16-year-olds, sit alongside the assessment of Gillick competence[13] in respect of sexual health.

Practitioners using the Fraser guidelines should be satisfied of the following:

- the young person cannot be persuaded to inform their parents or carers that they are seeking this advice or treatment (or to allow the practitioner to inform their parents or carers).
- the young person understands the advice being given.
- the young person's physical or mental health or both are likely to suffer unless they receive the advice or treatment.
- it is in the young person's best interests to receive the advice, treatment or both without their parents' or carers' consent.
- the young person is very likely to continue having sex with or without contraceptive treatment.

In complex situations regarding consent, it is important to seek both professional and legal advice. This advice should be provided in a timely manner to ensure CYP can access the EMA service.

Ability to agree to sexual activity

The Sexual Offenses Act[14] defines when sexual intercourse constitutes either rape or unlawful sexual activity between individuals of all ages. It is important to note that sexual activity with CYP under 16 years old is unlawful, regardless of the age of the other party, as they are unable to consent in law to

[11] https://www.legislation.gov.uk/ukpga/1969/46
[12] https://www.legislation.gov.uk/ukpga/2005/9/contents
[13] Gillick v West Norfolk and Wisbech Area Health Authority and another [1985]
[14] https://www.legislation.gov.uk/ukpga/2003/42/contents

sexual intercourse. However, there are criteria included in the Act and the accompanying Crown Prosecution Service guidance[15] that helps professionals respond appropriately when they become aware that CYP under 16 years of age has had voluntary sexual intercourse.

In children under 13 years old, sexual intercourse is defined as statutory rape. This requires a referral to police and a social care response, in addition to ensuring access to an EMA.

CYP people between 13 and 15 years old may have voluntary sex which does not require referral to the police and a social care response, as guided by the Crown Prosecution Service guidance.[16] Relevant considerations include:

- The respective ages of the parties
- The existence and nature of any relationship
- Their level of maturity
- Whether there was a serious element of exploitation

In practice within health services, many CYP are seen and are assessed to fulfil the criteria for voluntary sexual activity under 16 years of age without the need for referral to either social care or police.

Duty on professionals to safeguard CYP

A child centred approach is fundamental to safeguarding.[17] This means building rapport and establishing trust with the CYP, maintaining professional curiosity, transparent and effective information sharing and an empathetic, professional response within clear boundaries.

There is a fundamental difference between the ability to consent to an EMA and/or voluntary sexual activity, and whether a CYP also requires a safeguarding intervention. For example:

- A CYP may not be able to consent to an EMA, but may still require one, and in this scenario, a safeguarding response is required.
- A CYP may not have consented to sexual intercourse / be deemed to lack capacity to consent to sexual intercourse, which would require a safeguarding response.
- A CYP may be able to consent both to voluntary sex, and an EMA, however there may be factors identified in the risk assessment that require an additional safeguarding response.

If a health professional has a safeguarding concern for a CYP, this requires an appropriate response, regardless of whether the CYP agrees to this. Wherever possible, this should be done collaboratively and supportively, giving the CYP appropriate choices and explanations for why the professional is needing to take these actions.

Interventions may be needed around sexual abuse or exploitation, or other adverse childhood experiences (ACEs), including physical abuse, emotional abuse and neglect. The contextual safeguarding needs of CYP are important to identify and respond to. CYP who have been sexually abused or exploited, or maltreated in other ways, may not recognise that this is happening, or may be frightened to disclose this information to professionals.

[15] https://www.cps.gov.uk/legal-guidance/rape-and-sexual-offences-overview-and-index-2021-updated-guidance

[16] https://www.cps.gov.uk/legal-guidance/rape-and-sexual-offences-chapter-13-sexual-offences-and-youths

[17] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf

CYP may not identify that they have vulnerabilities, and it is a professional's duty to be curious, including considering the factors or experiences of the CYP that may underpin other risk-taking behaviours and vulnerability. Therefore, robust risk assessment for all CYP under 18 years old is essential.

Risk assessments

Initial contact will include gathering basic demographic data and contact details. This will include questions about their safety, including whether they can speak freely over the telephone and offering the use of a safe word if the CYP can no longer communicate freely.

A comprehensive risk assessment must be undertaken by an appropriately trained health professional [refer to training & supervision section below].

Health professionals have a duty to document risk assessments for all CYP. These risk assessments must include information about the following factors:

- Telephone safety (can the CYP talk freely, use of safe word)
- Relationship (father of pregnancy)
- Attitude to pregnancy (is this their choice, have they had a pregnancy/termination before)
- Sexual history (number of sexual partners)
- Lifestyle (use of alcohol, drugs, sexual internet / social media activity)
- Family / support networks (parental awareness, or other support)
- School / college (do they attend)
- Previous or current social care involvement
- Any statements that would raise child protection concerns
- Consent to sex
- Gillick Competence
- Fraser guidelines
- Non-attendance or engagement for follow-up consultations

Further guidance for EMA providers to consider including in their risk assessments is in the appendix.

CYP's responses to the risk assessment questions may trigger more in-depth assessment about a particular issue using nationally accredited risk assessment tools such as Spotting the Signs,[18] Domestic Abuse, Stalking, and Honour Based Violence tool[19], Female Genital Mutilation,[20] psychosocial screening (for example a paediatric or adolescent HEADSS assessment). It may be appropriate for these more in-depth assessments to be done in person.

Effective risk assessments require collaborative relationships with CYP underpinned by active professional curiosity and analysis of the information provided.

[18] https://legacy.brook.org.uk/our-work/spotting-the-signs-cse-national-proforma#:~:text=Spotting%20the%20Signs%2C%20funded%20by,and%20social%20history%20taking%20frameworks.

[19] https://www.dashriskchecklist.co.uk/

[20] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/585083/FGM_safeguarding_and_risk_assessment.pdf

Appropriate safeguarding actions following risk assessment

In the majority of situations, there is time to reflect and discuss risk assessments in safeguarding supervision should this be necessary. In a small minority of cases, urgent action is appropriate which may necessitate calling 999 to request police support if the CYP is in imminent danger.

Undergoing an unplanned mid-trimester abortion caused by the provision of EMA constitutes harm, with potentially poor physical and mental health outcomes.

There are differing actions to consider in the following three age groups based on both legislative and national guidance frameworks, which reflect capacity, consent and developmental maturity. Providers of EMAs should aim for all CYP to be given an appointment for an in-person consultation at some point in the EMA care pathway. In some clinical scenarios, telemedicine can improve access to EMA services.

Under 13

a. CYP must have an initial risk assessment.
b. Same day appointment arranged with the provider
c. Health professional makes urgent referral to children's social care and police
d. Referral to an appropriate inpatient health setting with paediatric and gynaecological input. This will facilitate a clinical assessment; including an ultrasound scan to confirm gestation, and safeguarding action.
e. Consideration of how forensic evidence is collected, including products of conception
f. The inpatient health setting caring for the CYP must inform their Named Doctor for Safeguarding Children and the Designated Doctor for Safeguarding Children for the local authority area (and equivalents in Scotland, Wales and Northern Ireland)

Some 13-year-olds accessing EMAs, will have conceived the pregnancy under the age of 13 and therefore should be treated using the criteria above.

13 to 15

a. CYP must have an initial risk assessment.
b. An in-person consultation should be arranged for all CYP.
c. The in-person consultation must facilitate a clinical assessment including an ultrasound scan to confirm gestation and a more in-depth safeguarding children assessment as appropriate.
d. For CYP that decline the in-person consultation, despite arranging support for the CYP to attend in-person (e.g. providing transport, an alternative venue or professional), health professionals must act to ensure the CYP accesses their EMA and that their other safeguarding needs are also addressed.
e. CYP will be given safety netting advice and information about how to contact health professionals should they have concerns during their treatment.

16 & 17

a. CYP must have an initial risk assessment.
b. An in-person consultation should be arranged for all CYP.
c. The in-person consultation must facilitate a clinical assessment including an ultrasound scan to confirm gestation and a safeguarding children assessment.
d. For CYP that decline the in-person consultation, despite arranging support for the CYP to attend in-person (e.g. providing transport, an alternative venue or professional), health professionals must act to ensure the CYP accesses their EMA

and that their other safeguarding needs are also addressed. This will be guided by the initial risk assessment, which will take into account the difference in statute and guidance, and likely maturity at this age.

e. CYP will be given safety netting advice and information about how to contact health professionals should they have concerns during their treatment.

Where the health professional has identified the need to refer to other agencies (health, social care or police), and is unable to facilitate an appropriate and timely response, concerns must be escalated. Health organisations providing EMA will have an escalation pathway within their organisations. This pathway must be supported by local Named and Designated Health Professionals, or their equivalents, in the local health system where the CYP is resident.

Information sharing

Whilst acknowledging the need for CYP to be confident in the confidentiality of EMA services, robust information-sharing is at the heart of safe and effective safeguarding practice.[21] Collecting and sharing information about CYP supports effective risk assessment processes. The quality of information shared by CYP with health professionals will contribute to the risk assessment. (For example, if a health professional is concerned that a CYP is not being transparent about their safeguarding history.)

Health professionals should have access to the NHS Spine[22] (or equivalent in the devolved nations). In some instances where there are safeguarding concerns, this may help to confirm the CYP's name, date of birth and address.

Health organisations providing EMA in England should have access to the Child Protection Information Sharing (CP-IS) service to be aware when a CYP is on a child protection plan or looked after. This can then be factored into the safeguarding risk assessment. This group of CYP are more vulnerable and may require more support to access their EMA. Using the CP-IS will alert the CYP's social worker of their access to the EMA service.

Whilst acknowledging the importance of maintaining confidentiality within EMA services, CYP are particularly vulnerable and often require more holistic care than adults. Primary care are best placed to provide holistic care and long term support to CYP, should this be required. They also hold other information on the CYP that the EMA providers may be unaware of. This information, in totality, may require a proactive safeguarding response.

For CYP under 16 years old a letter should be sent to their GP to inform them of the EMA. This communication should be marked 'not for online access' in line with primary care guidance. The CYP should be informed that this information will be shared with their GP (if known).

16- and 17-year-olds should be informed of the advantages of sharing a letter with their GP, for example, as a route to accessing further support and guidance. Consent be sought from CYP of this age before sharing the letter.

For additional advice and guidance for complex scenarios, health professionals should seek advice, when necessary, from information guidance leads within their service, and check national guidance

[21] https://www.england.nhs.uk/wp-content/uploads/2015/07/B0818_Safeguarding-children-young-people-and-adults-at-risk-in-the-NHS-Safeguarding-accountability-and-assuran.pdf

[22] https://digital.nhs.uk/services/spine

for information sharing for child protection purposes, which is available in England,[23] Wales, [24] Northern Ireland [25] and Scotland.[26]

Clinical governance

Clinical governance is "a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish".[27] All health organisations providing EMA to CYP must have safeguarding children and young people guidance, which will include: detailed information on risk assessment and pathways; escalation processes for non-attendance; when and how to make safeguarding referrals outside of their organisation.

Clinical governance systems will enable audit and monitoring, information about quality and safety performance and patient safety. There will be systems to debrief staff and learn from practice, and safeguarding incidents. Service planners and commissioners must ensure that all health organisations share information with EMA providers relating to any adverse events that results from their provision of care.

Data collection and analysis is a key component of clinical governance. Data must be stratified by the three age groups outlined in this guidance (under 13 years, 13 to 15 years, and 16 and 17 year), and must include:

- The numbers of CYP accessing the service
- Exception reporting for those CYP not seen in-person during the care pathway
- Adverse incidents
- Number of referrals to:
    - children's social care (including information on the risk categories that triggered the referral)
    - police
    - other health providers

This information will support a continuous evaluation of the quality of safeguarding components of EMA services for CYP.

Health organisations providing EMAs for CYP must publish an annual safeguarding report.

Training & supervision

Health professionals undertaking risk assessments for CYP must be Level 3 trained [ref: ICD] health professional, who has in addition, had training and experience in the specific complexities related to sexual health in CYP. Specifically, they need to have an understanding of domestic abuse, adult safeguarding, child sexual abuse and exploitation, trafficking and honour-based violence and Female Genital Mutilation (FGM). Health professionals also require training around specific episodes where lessons may be learned, either as a result of good practice or adverse incidents.

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[23] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1062969/Information_sharing_advice_practitioners_safeguarding_services.pdf

[24] https://gov.wales/sharing-information-safeguard-children

[25] https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-guidance-on-info-sharing-child-protection-purposes.pdf

[26] https://ihub.scot/media/1512/a-guide-to-getting-it-right-for-every-child.pdf

[27] https://www.england.nhs.uk/mat-transformation/matrons-handbook/governance-patient-safety-and-quality/

Health organisations providing EMAs to CYP must have systems in place to facilitate timely case management advice for those health professionals concerned about the outcome of the risk assessment and next steps in case management.

Clinical supervision supports staff and encourages professional development with the aim of improving patient care. This is particularly important to support health professionals working in complex clinical areas. Health organisations providing EMA services need to provide both individual clinical supervision and group supervision to their clinical staff. It is also necessary for healthcare providers to debrief staff after adverse events and serious incidents.

Safeguarding leads within health organisations providing EMA may benefit from receiving clinical supervision from a Designated Safeguarding Children health professional within their region.

Appendix

Telephone safety

- Is anyone else in the house or room with you?
- Do you feel safe to talk today?
- Will it be safe for you to pass the pregnancy at home?
- Are you able to receive a small package to your home address?

Relationship (father of pregnancy)

- Status of current relationship
- Age of partner
- Were you happy to have sex with this person?
- Is the father of this pregnancy aware of your decision to terminate?
- How long have you known them?
- What age were you when you first had sex?
- Any Suggestion of Coercion

Attitude to pregnancy

- Is accessing this early medical abortion your choice?
- Have you had any previous pregnancies?
- Have you had any previous terminations?

Sexual history

- How many sexual partners have you had in the last 12 months?
- How many sexual partners have you ever had?

Lifestyle

- Do you ever use alcohol or drugs?
- Do you ever use alcohol or drugs before you have sex?
- Have you ever sent or received a message of sexual nature?
- Does anyone have any pictures of you of a sexual nature?

Family

- Parental awareness
- Who do you live with?
- Does anyone you live with know you're having sex?
- How are things at home

School / college

- Do you attend school/college regularly?

Previous or current social care involvement

Any statements that would raise child protection concerns

- Domestic Abuse
- Mental health
- FGM
- Substance/Alcohol Misuse
- Learning Disability
- Trafficking / modern slavery
- Honour based violence
- Any mental health problems

Consent to sex

- Have you ever been made to feel scared or uncomfortable by the person you have been having sex with?
- Have you ever been made to do something sexual that you didn't want to do?
- Do you feel you could say no to sex?
- Has anyone given you anything like gifts, money or alcohol/drug in exchange of having sex with them?

- Is anyone else around when you have sex?

Gillick Competence

- An understanding of the proposed treatment
- The consequences of the treatment, including alternatives.
- Can retain and weigh up the risks and benefits to arrive at an informed decision
- Remember and communicate their decision to the health professional

Fraser Competence

Non-attendance or engagement for follow-up consultations