Cheshire & Merseyside NHS
sexualhealthnetwork

# Service Standards Specification

# For

# Abortion Services within

# Cheshire & Merseyside

## Index

## Summary of Care Pathway

**1st Contact**

Self referral, or referral from General Practice or any contraception clinic or sexual health clinic by any health professional using a standard form and phoning referrals through an abortion action line referral

Referring doctor prompted to sign HSA1 Form (as 2 signatures needed)

Ideally offering STI testing and post abortion contraception.

**Assessment**

Dating of pregnancy
Counselling if required
Screening for sexually transmitted infections and treatment and / or referral for treatment
Offer abortion treatment options (medical versus surgical)
Pre abortion assessment (fitness for procedure)
Arrange date and time for procedure
Post abortion planning including LARC
Post abortion contraception consent

**Procedure**

Medical or surgical
Antibiotic prophylaxis
Rhesus and Anti D if necessary
Discharge planning and advice
Contraception, including long acting reversible contraception provided on date of procedure

## Abbreviations

| | |
|---|---|
| AWG | Abortion Working Group |
| ChaMPS | Cheshire & Merseyside Public Health Network |
| CMO | Chief Medical Officer |
| CMSHN | Cheshire & Merseyside Sexual Health Network |
| CSO | Chlamydia Screening Office |
| FFPRHC | The Faculty of Family Planning and Reproductive Health Care |
| LARC | Long Acting Reversible Contraception |
| LDP | Local Delivery Plan |
| LITs | Local Implementation Team |
| MVA | Manual vacuum aspiration |
| PSA | Public Service Agreement |
| STI | Sexually transmitted infection |
| SSHA | Health Advisers |

## Introduction

This document sets out the commissioning standards for the provision of abortion services to women in Cheshire and Merseyside. The abortion service will comply with the abortion Act 1967, as amended by the Human Fertilisation and Embryology Act 1990. Abortions refer to all those performed under the act, including for foetal abnormality and those performed to preserve the physical and psychological health of women with unintended pregnancy and the health of any existing children for:

Women registered with General Practitioners based in Cheshire and Merseyside Primary Care Trusts

Women who are not registered with a GP but reside within Cheshire and Merseyside and who are entitled to NHS treatments.

This specification has been drafted following review of the current service provision within Cheshire and Merseyside, including a SWOT analysis (strengths, weaknesses, opportunities, threats). The document takes into account the implications of 'Commissioning a patient led NHS' and the renewed government commitment to and pledges of resources for sexual health improvement in Public Health White Paper, 2004. A key underlying assumption of this document is that the Cheshire and Merseyside sexual health network abortions group will periodically review the standards to continuously improve the quality of the service and reflect current clinical practice. Implementation of these standards requires significant workforce development and good information management in order to deliver this component of integrated sexual health services.

## Supporting Guidance

National Strategy for Sexual Health and HIV, 2001

The Care of Women Requesting Induced Abortion (RCOG Guidelines) – September 2004

An investigation into the bpas response to requests for late abortions – September 2005

Development of National Evidence based Standards for HIV and sexual health services (MedFash standards) these are detailed in the appendix

National Institute for Clinical Excellence (NICE) guidelines on long acting reversible contraception (LARC), November 2005

Special Study Module on Abortion Care FFPRHC.org.uk

## Background

Abortion is one of the commonest gynaecological procedures in Great Britain. At least one-third of British women will have had an abortion by the time they reach the age of 45 years. One third of abortions in 2004 were repeat abortions.

The National Sexual Health and HIV Strategy, published in 2001, highlighted that there are wide variations in access to NHS abortion services and the methods available, and that there is evidence that women who choose to seek an abortion can wait up to four or five weeks in some areas of the country. The strategy's implementation action plan set a national standard for women who meet the legal requirements should have access to an abortion within three weeks of the first appointment with the referring doctor. Since then, the star ratings system has assessed trusts' performance by measuring the proportion of women having abortions under 10 weeks of pregnancy. Within Cheshire and Merseyside, star ratings data shows that there are significant variations in waiting times for abortions across the 15 PCTs.

## Aims of the Service Specification

To offer and provide a high quality service, at all stages of the patient journey, in terms of: acceptability, accessibility, effectiveness, efficiency and appropriateness to need as part of an integrated high quality sexual health service.

To provide abortions to women at the earliest gestation practicable (within the terms of the 1967 Abortion Act), through increasing provision of both early medical and surgical abortions.

To enable abortion provision for later gestation within the legal limit and more complex cases.

To ensure equity of access, patient choice, improved patient experience and optimal clinical outcomes to assist in reducing the number of women requiring repeat abortions by increasing timely access to all long-term methods of contraception.

To contribute to reducing morbidity from sexually transmitted infections (STIs).

To provide a consistent approach to service provision throughout Cheshire and Merseyside that complements other sexual health services i.e. family planning, contraception, teenage pregnancy, genitourinary medicine and health promotion services.

To contribute to PCTs reaching their relevant targets relating to abortions (star ratings), Local Delivery Plan (LDP) sexual health targets and any other relevant targets.

**Relevant Local Delivery Plan data monitoring lines 2005-2008**

PSA 11a: to halve the under 18 conception rate by 2010, from 1998 baseline.
PSA 11b: 100% of patients attending GUM clinics are offered an appointment within 48 hours of contacting a service by 2008.
PSA 11c: decrease in rates of new diagnoses of gonorrhoea.
PSA 11d: increase in the percentage of people aged 15 to 24 accepting Chlamydia screening.

## Objectives of the Service Specification

1. To maximise NHS funded provision of abortions, by working in partnership with NHS and private sector to provide a choice of settings.

2. The consistent use of protocols to minimise local service idiosyncrasies, with business continuity planning.

3. Minimisation of time to procedure by appropriate signposting of services.

4. Assessment offered within 5 working days of first contact.

5. Diagnosis and dating of pregnancy at or before assessment.

6. Procedure before 10 weeks as standard.

7. Choice of local provision of early medical and surgical abortions

    a) The DoH rationale is that 'The earlier in pregnancy an abortion is performed the lower the risk of complications. If women can access services before they are nine weeks pregnant, they can potentially have a choice of an early medical or surgical abortion - medical abortion avoids the need for anaesthesia and surgery.'

    b) Manual vacuum aspiration can be provided as early as medicals, under local anaesthesia and with only one visit instead of two. The group is investigating the evidence on its cost effectiveness, as this is still a relatively new procedure in this country

8. Multidisciplinary continuous staff training working with

    a) Contraception Services
    b) Obstetrics and Gynaecology
    c) Genito-urinary Medicine (GUM)
    d) Sexual Health Promotion
    e) Primary Care

9. Patient centred service enabled by consistent and continuous care between health professionals, and effective and efficient communication with patients, using standardised paperwork.

10. Discussion of individual contraception plan and provision as early as possible. There should be a contraceptive plan made with the individual.
    This should be backed up with efficient referral to other contraceptive services within one week of procedure.

11. To improve the sexual health of women by offering of chlamydia screening at first presentation to health services, timely treatment and onward referral to other sexual health services if necessary.

12. Systems should enable audit of components of the service. (Relevant to local planning targets)

## 1. Service Standards

The confidential nature of the service should be stressed and provider contact numbers should be made available to patients so they can telephone to confirm their appointments and admission plans, if appropriate. Care should be taken to ensure that information is not shared with anyone else, including the woman's general practitioner, without her consent. The provider should maintain good working relationships to enable prompt communication of appointment time or location changes e.g. introduction of new clinics and any staffing issues causing delays to booked appointments

| Aim | How | Rationale | Action |
|---|---|---|---|
| Appropriate signposting of the referral system (referral pathway) and service provision to the public and professionals. | Self and clinical referral via telephone to Abortion Action phone line.<br>Signposting from both clinical and non-clinical settings including:<br><br>-Community Contraceptive Sexual Health Services<br>- Other sexual health services<br>- Primary care<br>- Obstetrics and Gynaecology<br>- Accident and Emergency<br>- Out of Hours service<br>- Pharmacy outlets<br>- School nurses<br>- Connexions<br>- Youth service<br>- Website aimed at users<br>-Standardised information leaflets (including downloadable from the web) | DH statistics published on NHS Contraceptive Services in England 2004/5 indicated that an increasing number of women are accessing emergency contraception via pharmacies | The provider is responsible for ensuring that all referrers are aware of the service provision in the locality via informing the AWG, who will inform the C&M SHN:<br>-Communications group<br>- Sexual Health Promotion group |

| Aim | How | Rationale | Action |
|---|---|---|---|
| Clear pathways for women patients who cannot be treated in either local NHS or non NHS settings | Suitability guidelines are provided by each provider | Equity of Service provision | Local / regional mapping of NHS funded abortion services |
| Comprehensive, consistent, accurate and unbiased information about abortion procedures (in accessible formats), regardless of setting | Clear communications detailing:<br>Information on the options and procedures available<br>Standardised information leaflets | MEDFASH standard | All referrers and providers |
| Clear pathways for under 16s | Safe Guarding Children Guidance and local policies and procedures | Safe Guarding Children Guidance | Referrers and providers in conjunction with local child protection |

## 2. Confirmation of Pregnancy

| Aim | How | Rationale | Action |
|---|---|---|---|
| To confirm pregnancy at earliest opportunity | Free near patient pregnancy testing at:<br>Contraceptive and Sexual Health Services<br>Primary Care<br>Walk in centres<br>The following settings can be negotiated locally<br>Young People's settings<br>Schools<br>Pharmacies | MEDFASH standards, Abortions group recommendation – late pregnancy tests can cause delay in referral | Mapping locally by commissioners |

## 3. Prompt Referral into Abortion Service

| Aim | How | Rationale | Action |
|---|---|---|---|
| Range of referrers<br>Increase opportunities for referral | Self referral<br>Nurse referral<br>GP referral<br>Sexual Health Service referral<br>Other referral e.g. youth workers | Access to Abortions group recommendation | LITs |
| Each area should have a dedicated telephone booking service, using a single telephone number | Referrals through this route should ensure that all details are forwarded to the provider once an appointment has been made by the clinician or individual woman | Access to Abortions group recommendation.<br>Already adopted across the region; St Helens, Knowsley, Liverpool, Wirral PCTs | LITs |
| HSA 1 form signed at earliest opportunity prompted by the booking service. | If appropriate, a referring doctor can pass on a signed HSA1 for the patient to take to her initial consultation. However the abortion provider will hold responsibility for arranging two signatures. | Access to Abortions group recommendation. | Provider |

## 4. Assessment

### a) Timeliness

| Aim | How | Rationale | Action |
|---|---|---|---|
| Maximise the opportunities for local, easily accessible and timely assessment. | The assessment will usually be within 5 working days of first contact | Access to Abortions group<br><br>RCOG standard as minimum<br>MedFASH | Local commissioners |
| Have adequate contingency plans to enable abortion before 10 weeks gestation | The provider should not cancel the assessment or procedure. If this cannot be avoided, the woman must be offered another appointment within 5 working days. The commissioning organisation must be informed of all such cancellations. | Reduce waiting times | Provider |
| Ideally be able to provide Mifepristone at assessment if requested by the clients. | Increasing number of approved clinical settings | Reduce number of appointments for individuals | Providers / LITs / Commissioners |

## b) Confirming and dating the pregnancy

| Aim | How | Rationale | Action |
|---|---|---|---|
| Pregnancy must be confirmed at the earliest stage possible | Using a valid and reliable pregnancy test | Easy access to avoid delays in diagnosing pregnancy and accessing care. | Referrer |
| Assessment of gestational age by physical examination and ultrasound examination, if clinically appropriate | All units should have early access to accurate ultrasound scanning.<br>This requires the appropriate equipment and suitably skilled staff to ensure continuity of access | RCOG 2004 Guidance:<br>"RECOMMENDATION 22<br>All services must have access to scanning, as it can be a necessary part of pre-abortion assessment, particularly where gestation is in doubt or where extra-uterine pregnancy is suspected. However, ultrasound scanning is not considered to be an essential prerequisite of abortion in all cases.<br>RECOMMENDATION 23 When ultrasound scanning is undertaken, it should be done in a setting and manner sensitive to the woman's situation. It is inappropriate for pre-abortion scanning to be undertaken in an antenatal department alongside women with wanted pregnancies. " | Provider<br>Commissioners<br>LITs |

## c) STI Screening

| Aim | How | Rationale | Action |
|---|---|---|---|
| Chlamydia and gonorrhoea screening | Sexual history taking and assessment<br>Urine testing, endocervical swab or self taken vaginal swab using TMA (the standardised test for Cheshire and Merseyside). Results should be available by the time of the procedure and treatment co-ordinated by the Chlamydia Screening Office (CSO) or the provider, depending on local arrangements. For those not tested before, testing should be offered at the time of the procedure<br>Contact tracing as per SSHA guidelines | CMO Guidance | C&M SH Network Care Pathways group<br><br>LIT |
| Raise awareness of other STIs | Signpost for testing if unable to provide at first contact. | MEDFASH standard | Referrer |

## d) Decision Making

| Aim | How | Rationale | Action |
|---|---|---|---|
| To involve women in decisions about their treatment. | Clear explanation of options available (need standard leaflet, in a range of formats available e.g. CD ROM website | Patient choice | AWG to produce |
| Where a woman wishes to be accompanied by a partner or friend, arrangements should be in place to facilitate this. The partner may need support also and this should be available. | Adequate provision within local service | Patient choice | Provider |
| A female clinician should be made available at the assessment appointment for women who require this. This may involve a sideways referral to another provider but must not cause delays to the patient. | Adequate provision within local service | Patient choice | Provider |
| To provide abortions at late gestations within the North West Region | All localities should be able to offer referral for later gestation at an agreed centre in the North West Region | Abortions group recommendation. | Exact location to be agreed. To be resolved through joint commissioning with North West networks. |

| Aim | How | Rationale | Action |
|---|---|---|---|
| Option to continue with pregnancy | Women deciding not have an abortion should be referred for timely antenatal care. | Access appropriate antenatal care and advice | Provider |
| Provide information on all options available for contraception, including emergency contraception provision and long acting methods | Up to date information on contraceptive services and discussion of options. All women (including those who are found not to be pregnant) should be offered contraceptive advice, information and supplies. | Access to Abortions group<br>NICE LARC guidelines<br>MedFASH | All referrers and providers |

## Minimum service provision expected at all localities

| | | | |
|---|---|---|---|
| Medical or surgical abortions | All localities should be able to offer a choice of medical or surgical abortions | DoH, MedFASH | Provider |
| Earlier gestation | All localities should actively promote early abortion | Access to Abortions group recommendation | Provider |

## e) Counselling

| Aim | How | Rationale | Responsibility |
|---|---|---|---|
| Initial assessment | Psychological support. Initial consultations should include the opportunity to discuss options and feelings around abortion enabling women to reach their own decision as to whether to continue a pregnancy or to proceed with an abortion. | Access to Abortions group recommendation. | Provider |
| Counselling provided by appropriately qualified counsellors in a timely fashion | All localities should be able to offer pre and post provision, which can be accessed locally via service agreements with provider's e.g. young people's counselling organisations. | Access to Abortions group recommendation. | Provider |

## Pre abortion assessment

| Aim | How | Rationale | Responsibility |
|---|---|---|---|
| Doctor consent | Provider must ensure doctor available to sign the HSA1 form. Consent can be taken by an appropriately trained professional. | | Provider |
| Option for Mifepristone at first appointment | Provider to provide appropriately trained staff and means | Access to Abortions group | Provider |
| General medical examination to determine fitness for surgery and anaesthesia | Anyone appropriately trained to determine fitness for anaesthesia with appropriate back up on site | | Provider in agreement with Gynaecology & Anaesthetics department if NHS provision |
| STI Screening | Chlamydia Screening Programme for under 25s/ other agreed option for over 25s. | | |
| Blood tests for ABO, Rhesus group and antibodies, haemoglobin and haemoglobinopathy, if appropriate | | RCOG Guidance | Provider |

## f) Post abortion planning

| Aim | How | Rationale | Responsibility |
|---|---|---|---|
| Arrangements for post-operative care after day surgery and other follow-up arrangements should be agreed. | Provider to ensure. | RCOG Guidance<br>MedFASH standard | Provider |
| Contraception advice and provision should be offered on the day of the abortion | Provider to ensure. | FFPRHC<br>MedFASH standard<br>NICE LARC guideline<br>To reduce further unplanned pregnancies | Provider |

## 5. Abortion procedure

| Aim | How | Rationale | Responsibility |
|---|---|---|---|
| To provide the earliest possible procedure | Offer women a choice of appointments and settings from registered premises, including:<br>Primary Care<br>Community Contraceptive Clinics<br>Any appropriate sexual health services | To increase accessibility and choice | Provider |
| To provide, as appropriate, day care or inpatient care. | Day case or inpatient beds available, well trained, competent and empathetic staff | To offer choice and increase acceptability for clients | |
| To provide women with a full choice, as appropriate, of medical or surgical abortion at all gestations | | To offer choice and increase acceptability to clients, | |
| Medical TOP –Mifepristone at earliest opportunity | Identification and approval of suitable clinical locations | | |
| Surgical TOP – Availability of prompt local provision | RCOG guidelines on appropriate treatments for each gestation | | Would require further consultation with other stakeholders: |

## 6. Appropriate follow up

| Aim | How | Rationale | Responsibility |
|---|---|---|---|
| Follow up of non-attendees | Providers should contact referring doctor to ensure appropriate follow up obtained, particularly if the woman wishes to continue the pregnancy, she should be referred into antenatal services.<br>For under 16s, local Safeguarding Children procedures should be followed | To reduce delays in accessing antenatal care and any Child Protection issues are identified. | Provider |
| Appropriate information given to patient on discharge | Provider to provide information to the woman on discharge which explains:<br>likely course of recovery, including pain and bleeding<br>Symptoms indicating deviations from the normal course of recovery must be explained and the woman advised on when and how to seek medical help | To treat complications or answer queries quickly | Provider |
| Appropriate information given to medical follow up (GP/FPC) on discharge | Agreed follow up arrangements should be written in the case notes.<br>GP or referring clinician should be informed of the following using a standard form, if permission given by client:<br>Date of TOP<br>Method<br>Screening tests done<br>Antibiotic treatment<br>Other medical problems | | Provider |

| | | | |
|---|---|---|---|
| | Complications<br>Referral to other services for contraception and follow up | | |
| To provide reversible forms of contraception as appropriate | Women should be encouraged to have long acting forms of contraception or receive 3 months supply of contraception and be given information about local contraceptive services or young people's clinics<br>If a woman chooses an IUD the service should aim to insert this at the time of a surgical TOP.<br>If a woman chooses an implant the service should aim to insert this at the time of a medical or surgical TOP.<br>If these procedures cannot be done, the service should arrange an appointment for fitting after abortion. | see NICE LARC guidelines- also link for clients who need "extra care" e.g. domiciliary service | Access to Abortions Working Group<br>Media Group |
| Follow up of STI screening and positive results | Provider to ensure. | | Provider |
| Counselling as appropriate | Provider to ensure. | | Provider |
| User views on the design, delivery and evaluation of local service | Provider to ensure. | | Provider |

## 7. Audit

| Aim | How | Rationale | Responsibility |
|---|---|---|---|
| Clinical audit should be undertaken regularly | Professional and support staff should be involved in the audit of organisational care. Professional staff should undertake interdisciplinary clinical audit. The information gathered through user involvement methods should be taken into account when reviewing standards as part of clinical audit. | Access to Abortions group recommendation | Provider |
| Be aware of the location of service users | The postcode of residence of women accessing the service should be monitored. | Accessibility | Provider |
| The waiting time from first appointment to procedure should be monitored monthly. | Provider | Early awareness of delays, particularly those over 3 weeks. | Provider |
| Untoward events including all major complications should be audited together with deviations from planned care, such as overnight stays for day cases, abdominal surgery and repeat surgery. | Provider | Access to Abortions group recommendation | Provider |

## Appendix

*Supporting documents*

## Table 1 MEDFASH Standards

| **1. Women considering or seeking abortion should:** |
| --- |
| Have direct access to, or be referred for, an abortion assessment within five working days of initial contact with an abortion provider or other healthcare provider<br><br>Receive comprehensive, accurate and unbiased information - IN<br><br>Be able to access an abortion ideally within two weeks, but within a maximum of three weeks, of initial contact with healthcare providers<br><br>Be offered a choice of abortion methods clinically appropriate for their gestation and individual circumstances<br><br>Be offered screening for chlamydial infection, and treatment as necessary, with prophylactic treatment provided when results are not available prior to the procedure<br><br>Be able to access screening for other STIs, including HIV<br><br>Have individualised support and access to specialist counselling if needed at any time during or after the abortion process. |
| **2. Commissioners and services should ensure:** |
| Local NHS-funded abortion is provided to meet the needs of women resident in a PCT or network locality<br><br>Arrangements are in place to facilitate self-referral to abortion services |

Intervals between first contact and procedure should be achieved within time limits specified in the RCOG guidelines and *The national strategy for sexual health and HIV*

Local services are organised to enable abortions to be provided at as early a gestation as possible

When late abortions are needed, provision is available up to the maximum legal time limit
abortion services are able to provide immediate advice about, and initial supply of, the full range of reversible contraceptive methods, including condoms, and access to permanent methods, screening and prophylactic treatment for chlamydial infection are available for women having an abortion

Integrated care pathways are established to enable those requesting abortion also to have their other sexual health needs addressed, including those for ongoing contraception and for diagnosis and treatment of STIs

Arrangements are in place for those who need or request medical or psychological follow-up.

## *Special Groups*

### Under 16s

The legal age for young people to consent to have sex in England and Wales is 16 (Sexual Offences Act, 2003). However, the law is not intended to be used to prosecute consensual sexual activity between teenagers of similar age unless it involves abuse or exploitation. Young people (including those under 13) will continue to have the right to confidential sexual health advice. The aim of the law is to protect the rights and interests of young people whilst at the same time making it easier to prosecute those that force or coerce young people into sexual activity they don't want.

Although it is an offence for a man to have sex with a girl aged under 16 (17 in Northern Ireland) it is lawful for doctors to provide contraceptive advice and treatment without parental advice providing certain criteria is met.

Health professionals and other professionals working with young people must follow their local Safeguarding Children policies. This means carrying out a risk assessment when the young person presents to a service, assessing whether or not the young person is "Fraser Competent" and clearly documenting the decision making process (e.g. no further action, refer to Child Protection Team, Social Services or Police and whether or not this decision breaks confidentiality)

These criteria, known as the Fraser Guidelines, were laid down by Lord Fraser in the House of Lords' case and require the professional to be satisfied that[1]

- The young person will understand the professional's advice;
- The young person cannot be persuaded to inform their parents;
- The young person is likely to begin, or to continue having, sexual intercourse with or without contraceptive treatment;
- Unless the young person receives contraceptive treatment, their physical or mental health, or both, is likely to suffer;
- The young person receives contraceptive treatment, their physical or mental health, or both, is likely to suffer;
- The young person's best interests required them to receive contraceptive advice or treatment with or without parental consent.

Although the criteria specifically refer to contraception, the principles are deemed to apply to other treatments, including abortion. Doctors and health

[1] www.efc.org.uk/Pregnant/Confidentiality

professionals have a duty of care and a duty of confidentiality to all patients, including under 16s.

This [guidance] applies to the provision of advice and treatment on contraception, sexual and reproductive health, including abortion[2]

Under Section 14 of the Sexual Offences Act offering appropriate treatment regardless of age does not fall foul of the Act.

Doctors will encourage a young person to involve a parent or carer in the decision to have an abortion because most parents are able to be supportive. However, if the doctor agrees that it is in a patients' best interest to have an abortion without parental involvement and believe the young woman is competent to consent to this treatment it is possible to refer [or treat] her without consent. Additionally, parental accompaniment at the time of the abortion should not be a requirement for under 16 year olds. The Sex Offences Act 2003 does not affect the duty of care and confidentiality of health professionals to young people under 16[3] in Commissioners recognise the difficulties some young people have in dealing with an unintended pregnancy. This can often lead to delays in accessing support. Therefore providers are expected to fast-track (prioritise) referrals for under 18 year olds (young women aged 0 – 17 years). Providers should have a confidentiality policy which has specific reference to the policy for under 16 year olds.

**Under 13s**
Under the Sexual Offences Act 2003, children under the age of 13 are not considered to be able to give consent to sexual activity. In all cases where the sexually active young person is under 13, a full assessment must be undertaken. Each case must be assessed individually and consideration to make a Child protection referral must be made. When a girl under 13 is found to be pregnant a referral must be made and multi agency support package be formulated. All professionals (including abortion service providers) who look after pregnant under 13 year olds must adhere to their local safeguarding Children policy and work closely with their Child Protection Teams

**Women from black and minority ethnic groups**
The service should be compliant with the Race Relations Amendment Act 2000.

**Women who have English as a second language**
The provider should arrange and fund any translation or interpretation services required by women. Translation via family members should only be used in exceptional circumstances when nothing else is available.

[2] Best Practice Guidance for doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health, DH July 2004.
[3] Best Practice Guidance for doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health, DH July 2004.

**Women who have physical and / or learning disability**
Providers should be aware of the need for a health facilitator for women with learning disabilities. Premises should comply with the Disability Discrimination Act.

**Women who are geographically disadvantaged**
The service should be sited in an easily accessible location with good links to public transport.