NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health and social care directorate

Quality standards

Briefing paper

|  |
| --- |
| Quality standard topic: Abortion care  Output: Prioritised quality improvement areas for development.  Date of Quality Standards Advisory Committee meeting: 6th December 2019 |

# Contents

[1 Introduction 2](#_Toc25312410)

[2 Overview 2](#_Toc25312411)

[3 Summary of suggestions 7](#_Toc25312412)

[4 Suggested improvement areas 9](#_Toc25312413)

[Appendix 1: Review flowchart 35](#_Toc25312414)

[Appendix 2: Suggestions from stakeholder engagement exercise – registered stakeholders 36](#_Toc25312415)

1. Introduction

This briefing paper presents a structured overview of potential quality improvement areas for abortion care. It provides the committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

* 1. Structure

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the committee in considering potential statements and measures.

* 1. Development sources

The key development sources referenced in this briefing paper are:

* [Abortion care](https://www.nice.org.uk/guidance/ng140) NICE guideline NG140. Published September 2019.
* [Contraceptive services for under 25s](https://www.nice.org.uk/guidance/ph51) NICE guideline PH51. Published March 2014. Reviewed October 2017 and no update required.

[Sexually transmitted infections and under-18 conceptions: prevention](https://www.nice.org.uk/guidance/ph3) NICE guideline PH3. Published February 2007. Reviewed in December 2018 and update planned as part of a wider remit.

1. Overview
   1. Focus of quality standard

This quality standard will cover care for women of any age (including girls and young women under 18) who request an abortion.

This quality standard covers women and people who are pregnant. For simplicity of language the quality standard uses the term women throughout, but this should be taken to also include people who do not identify as women but who are pregnant.

* 1. Definition

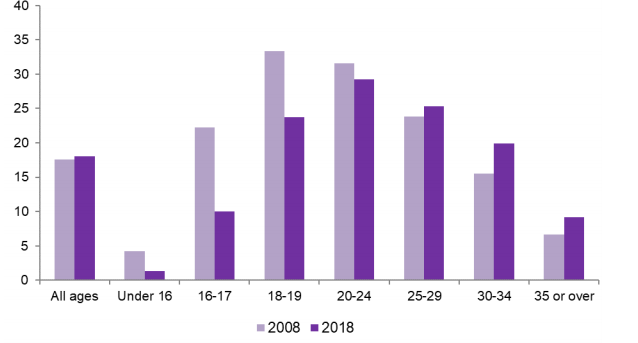
An abortion is the medical process of ending a pregnancy, so it doesn't result in the birth of a baby. Abortion is a simple, safe and commonly performed procedure. An abortion can be carried out medically (taking mifepristone followed by misoprostol) or surgically.

* 1. Incidence and prevalence

Abortion is a common procedure. In 2018, 200,608 women in England and Wales had an abortion. Almost all of these abortions were funded by the NHS, but 72% were performed by the independent sector.

The Department of Health and Social Care’s [2018 abortion statistics for England and Wales](https://www.gov.uk/government/collections/abortion-statistics-for-england-and-wales) indicates that the abortion rate increased from 16.7 per 1,000 women in 2017 to 17.4 per 1,000 women in 2018. The abortion rate in 2018 is lower than the peak in 2007 of 17.9 per 1,000 women. Trends in the abortion rate over the last 10 years vary by age, as shown in Figure 1. 39% of women who had an abortion in 2018 had one or more previous abortions.

### Figure 1: Abortion rate per 1,000 women by age, England and wales, 2008 and 2018



Most abortions are carried out because the pregnancy was unintended, and the majority of procedures (80% of abortions in England and Wales in 2018) are conducted in the first 10 weeks of pregnancy.

The trend in England and Wales over the past decade has been towards increasing use of medical abortion. In 2018, 71% of all abortions in England and Wales were medical, and this rises to 83% of abortions in the first 10 weeks of pregnancy.

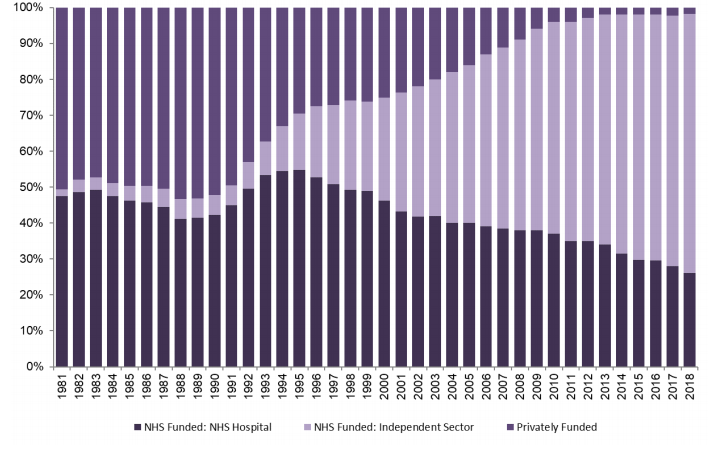
* 1. Current service delivery and management

Abortion in England, Scotland and Wales is primarily regulated by the Abortion Act 1967 (as amended by the Human Fertilisation and Embryology Act 1990) and regulations made under that Act – currently the [Abortion Regulations 1991](http://www.legislation.gov.uk/uksi/1991/499/contents/made) (SI 1991/499). The Abortion Act regulates when and where abortions can take place lawfully.

Abortion care services are commissioned by clinical commissioning groups. Providers are NHS hospital trusts and independent providers. Providers of abortion services must comply with the Health and Social Care Act 2008 and regulations made under that Act. In particular, providers must register with the Care Quality Commission (CQC). The CQC imposes specific requirements on providers that are not English NHS bodies (see [regulation 20 of the Care Quality Commission (Registration) Regulations 2009](https://www.cqc.org.uk/file/4981)).

In recent years, there have been changes in how and where abortion services are delivered (see Figure 2). This has resulted in variation in the type and choice of procedures available across the NHS, for example, in the offer of local anaesthesia and sedation for a surgical procedure. In addition, the procedure used for medical abortion has been refined and women in the first 10 weeks (up to 9 weeks and 6 days) may now self-administer misoprostol at home in England and Wales. Furthermore, methods for checking whether a medical abortion has been successful have also been simplified. Some of these developments could significantly reduce costs to the NHS and be more acceptable to women.

### Figure 2: Percentage of abortions by purchaser/provider, England and Wales, 1981 to 2018[[1]](#footnote-1)



Abortion services also provide other important sexual and reproductive health services to women, including contraceptive services.

Accessing abortion services may be difficult for women who live in remote areas, who are in the second trimester of pregnancy, or who have complex pre-existing conditions or difficult social circumstances. In particular, abortion care is challenging for women living in Northern Ireland who currently have to travel to other parts of the UK in order to access services.

* 1. Resource impact

We do not expect this quality standard to have a significant impact on resources. When the [Abortion care](https://www.nice.org.uk/guidance/NG140) guideline was developed, [a resource impact report and template](https://www.nice.org.uk/guidance/ng140/resources) was produced which noted that:

the savings resulting from implementing the whole guideline in England will be £6.6 million per year (or £11,800 per 100,000 population).

These savings are a result of the below recommendations:

* Commissioners should work with providers to ensure abortion services have the capacity and resources to deliver the range of services needed with minimal delay **(recommendation 1.1.5)**.
* Do not offer anti-D prophylaxis to women who are having medical abortion up to and including 10+0 weeks’ gestation **(recommendation 1.3.2)**.
* Consider abortion before there is definitive ultrasound evidence of an intrauterine pregnancy (a yolk sac) for women who do not have signs or symptoms of an ectopic pregnancy **(recommendation 1.7.1)**.

The Guideline Resource and Implementation Panel (GRIP) (this panel includes NICE, NHS England/Improvement, Health Education England and when appropriate Public Health England, Skills for Care and topic experts) received a report on this topic at its meetings on 20/06/19 and 12/09/2019. They concluded that an implementation statement to support the guideline was required which was published and can be found [here.](https://www.nice.org.uk/guidance/ng140/resources)

Abortion care services are commissioned by clinical commissioning groups. Providers are NHS hospital trusts and independent providers. Contraceptive services are commissioned by local authorities and provided by GP’s, community providers and NHS trusts.

1. Summary of suggestions
   1. Responses

In total 16 registered stakeholders responded to the 2-week engagement exercise 8/10/19 to 21/10/19. 13 of these registered stakeholders provided areas for quality improvement and 3 advised they had no comment to make. We also received comments from 6 specialist committee members. The responses have been merged and summarised in table 1 for further consideration by the committee.

Full details of all the suggestions provided are given in appendix 2 for information.

### Table 1 Summary of suggested quality improvement areas

| Suggested area for improvement | Stakeholders |
| --- | --- |
| Access and assessment   * Information * Self-referral * Assessment | * BC, RCM, SCM * RCGP, SCMs * SCMs |
| **Choice and referral**   * Choice of procedure * Referral pathways/collaborative working * Travel and accommodation | * BPAS, BSACP, DCUK, FSRH, NWAFT, NUPAS, SCMs, UHBT * BPAS, BSACP, HUHFT, NUPAS, RCOG, SCMs, UHBT * BPAS, BSACP, DCUK, FSRH, HUHFT, NWAFT, RCOG, SCMs |
| **Waiting times** | * BC, BPAS, BSACP, DCUK, FSRH, NWAFT, RCOG, SCMs |
| **Abortion procedures**   * Preventing infection * Early medical abortion * Anaesthesia for surgical abortion | * SCM, UHBT * BSACP, SCMs * BC, BSACP, SCM |
| **Access to contraception** | * BPAS, BSACP, DCUK, FSRH, HUHFT, NWAFT, NUPAS, RCOG, RCGP, SCMs, UHBT |
| **Follow-up care and support** | * RCOG, RCGP, RCM, SCM, UHBT |
| Additional areas   * Training for healthcare professionals * Commissioning * Women in prison * Standardising patient surveys | * BSACP, DCUK, FSRH, HUHFT, NWAFT, RCM, SCMs * BSACP, HUHFT, NUPAS * BC * MWCCG |
| Abbreviations:  BC, Birth Companions  BPAS, British Pregnancy Advisory Service  BSACP, British Society of Abortion Care Providers  DCUK, Doctors for Choice UK  FSRH, Faculty of Sexual and Reproductive Healthcare  HUHFT, Homerton University Hospital NHS Foundation Trust  MWCCG, NHS Merton & Wandsworth Clinical Commissioning Group  NUPAS, National Unplanned Pregnancy Advisory Services UK  NWAFT, North West Anglia Foundation Trust  RCGP, Royal College of General Practitioners  RCOG, Royal College of Obstetricians and Gynaecologists  RCM, Royal College of Midwives  SCM, Specialist Committee Member  UHBT, University Hospitals Birmingham NHS Trust | |

* 1. Identification of current practice evidence

Bibliographic databases were searched to identify examples of current practice in UK health and social care settings; 932 papers were identified for abortion care. In addition, 64 papers were suggested by stakeholders at topic engagement and 33 papers internally at project scoping.

Of these papers, 9 have been included in this report and are included in the current practice sections where relevant. Appendix 1 outlines the search process.

1. Suggested improvement areas
   1. Access and assessment
      1. Summary of suggestions

### Information

Stakeholders suggested that there is a lack of information about how to access abortion services and that it is important that information is available in a variety of formats and in different locations. This includes ensuring information is accessible to women who are vulnerable, including those in prison, who are homeless, not registered with a GP, and migrants. It was suggested that a lack of information can lead to late presentation and a greater risk of complications.

Stakeholders also suggested that women are not always given information about what to expect when having an abortion. This includes information for women who are having an abortion due to fetal abnormality in relation to diagnosis and dealing with fetal remains.

### Self-referral

It was suggested that it is important that women can self-refer to abortion services without having to see a healthcare professional first. Having to see a healthcare professional such as a GP can lead to a delay if it is difficult to get an appointment. Clinical Commissioning Groups (CCG’s) have different commissioning pathways and self-referral is not available everywhere. Having the option to self-refer gives women greater autonomy so that they can choose a service that best suits their needs.

### Assessment

There was a suggestion that abortion services should provide the option for women to choose to have assessments by phone or video call. This could reduce delays in accessing treatment, remove barriers to accessing services such as difficulty attending appointments, and help women to maintain privacy.

There were also suggestions about the use of ultrasound scans in assessments to determine gestational age for women who request an abortion:

* there is currently variation between providers in how to determine gestational age by ultrasound which leads to multiple rescanning of women and can cause confusion.

a potential development is that abortions could be delivered in the community via pharmacists or GP’s without a scan.

* + 1. Selected recommendations from development source

Table 2 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 2 to help inform the committee’s discussion.

### Table 2 Specific areas for quality improvement

|  |  |
| --- | --- |
| Suggested quality improvement area | Suggested source guidance recommendations |
| Information | NG140 Recommendations 1.1.1, 1.2.3 and 1.2.10 |
| Self-referral | NG140 Recommendations 1.1.2 |
| Assessment | NG140 Recommendation 1.1.1, 1.1.9, 1.1.10, 1.7.1 and 1.7.2 |

### Information

NICE NG140

Recommendation 1.1.1

Commissioners and providers should work together to:

* make information about abortion services (including how to access them) widely available

Recommendation 1.2.3

As early as possible, provide women with detailed information to help them prepare for the abortion. Cover:

* what it involves and what happens afterwards

how much pain and bleeding to expect.

Recommendation 1.2.10

Provide women with information about the different options for management and disposal of pregnancy remains.

### Self-referral

NICE NG140

Recommendation 1.1.2

Commissioners and providers should allow women to self-refer to abortion services.

### Assessment

NICE NG140

Recommendation 1.1.1

Commissioners and providers should work together to:

avoid the need for women to repeat key steps (such as returning to their GP for referral, or repeated assessments or investigations).

Recommendation 1.1.9

Consider providing abortion assessments by phone or video call, for women who prefer this.

Recommendation 1.1.10

Consider providing abortion services in a range of settings (including in the community and in hospitals), to meet the needs of the local population.

Recommendation 1.7.1

Consider abortion before there is definitive ultrasound evidence of an intrauterine pregnancy (a yolk sac) for women who do not have signs or symptoms of an ectopic pregnancy.

Recommendation 1.7.2

For women who are having an abortion before there is definitive ultrasound evidence of an intrauterine pregnancy (a yolk sac):

* explain that there is a small chance of an ectopic pregnancy
* explain that they may need to have follow-up appointments to ensure the pregnancy has been terminated and to monitor for ectopic pregnancy

provide 24‑hour emergency contact details, and advise them to get in contact immediately if they develop symptoms that could indicate an ectopic pregnancy (see symptoms and signs of ectopic pregnancy and initial assessment in the NICE guideline on ectopic pregnancy and miscarriage).

* + 1. Current UK practice

No published studies on current practice were highlighted for these suggested areas for quality improvement; these areas are based on stakeholder’s knowledge and experience.

* + 1. Resource impact

The estimated annual saving of implementing recommendation 1.7.1 for the population of England based on the uptake in the resource impact report is £1.1m per year in England for clinical commissioning groups.

* 1. Choice and referral
     1. Summary of suggestions

### Choice of procedure

It was suggested by stakeholders that it is important to ensure that women are offered a choice of abortion procedure up to the 23+6 week limit. Women should be able to access a medical or surgical procedure depending on their preference. In some areas surgical procedures are not available for abortion below 10 weeks. In addition, some women having an abortion at a later gestation may have no choice but to have a late medical rather than a surgical procedure because it is not available locally. It was suggested that people with co-morbidities and those who present later for abortion, including women having an abortion due to fetal anomaly, are more likely to be affected by a lack of choice. Women’s satisfaction with their abortion experience is increased if they are able to choose.

### Referral pathways/collaborative working

Stakeholders indicated that it is important that women can be quickly and easily referred to another service if their choice of procedure is not available from their provider. It was suggested that it is important to ensure that the full range of services are commissioned locally to avoid the need to travel. Currently, the development of collaborative care pathways between different providers is unusual. It was suggested that commissioners should do more to support collaboration and networking between providers. Stakeholders indicated that developing referral pathways for women with complex needs and co-morbidities should be a priority.

### Travel and accommodation

Stakeholders indicated that upfront (not refunded) travel and accommodation costs should be provided to women who need financial support in order to travel to access an abortion out of their area because the service is not available locally. Lack of funding causes delays and increases risks, particularly for vulnerable women. Lack of funding and delays can result in abortion no longer being an option. Although the NHS Healthcare Travel Costs Funding Scheme allows women to claim back costs after an abortion, some people find it impossible to pay the costs upfront. It is important to ensure that information is available about how to access any upfront funding.

* + 1. Selected recommendations from development source

Table 3 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 3 to help inform the committee’s discussion.

### Table 3 Specific areas for quality improvement

|  |  |
| --- | --- |
| Suggested quality improvement area | Selected source guidance recommendations |
| Choice of procedure | NG140 Recommendations 1.6.1, 1.6.2 |
| Referral pathways/collaborative working | NG140 Recommendations 1.1.1, 1.1.15, 1.1.16, 1.2.11 |
| Travel and accommodation | NG140 Recommendation 1.1.4 |

### Choice of procedure

NG140

Recommendation 1.6.1

Offer a choice between medical or surgical abortion up to and including 23+6 weeks' gestation. If any methods would not be clinically appropriate, explain why.

Recommendation 1.6.2

To help women decide between medical and surgical abortion, see the [NICE patient decision aids](https://www.nice.org.uk/guidance/ng140/resources/patient-decision-aids-and-user-guides-6906582256) on choosing medical or surgical abortion.

### Referral pathways/collaborative working

NG140

Recommendation 1.1.1

Commissioners and providers should work together to:

ensure that women are promptly referred onwards if a service cannot provide an abortion after a specific gestational age or by the woman's preferred method

Recommendation 1.1.15

Specialist centres should be available as locally as possible, to reduce delays and travel times for women with complex needs or significant comorbidities.

Recommendation 1.1.16

Providers should develop pathways for women with complex needs or significant comorbidities to:

* refer them to specialist centres if needed

minimise delays in accessing care.

Recommendation 1.2.11

If a woman who is having an abortion for fetal anomaly cannot have her preferred method of abortion in the maternity service, establish a clear referral pathway with ongoing communication between services so that she can:

* easily transfer to the abortion service
* receive ongoing support from the maternity service

get more information about the anomaly.

### Travel and accommodation

NICE NG140

Recommendation 1.1.4

Commissioners should consider upfront funding for travel and accommodation for women who:

* are eligible for the NHS Healthcare Travel Costs Scheme and/or

need to travel to a service that is not available locally.

Commissioners should make information available about any upfront funding to access services.

* + 1. Current UK practice

### Choice of procedure

The Department of Health and Social Care’s abortion statistics[[2]](#footnote-2) show that medical abortions accounted for 71% of total abortions in 2018. The proportion of medical abortions has almost doubled in the last 10 years from 37% in 2008, and since 2014, medical abortions have been the most common method of abortion. In 2018, 83% of abortions under 10 weeks were medical abortions compared with 46% in 2008. The report indicates that in autumn 2016, restrictions were placed on the provision of surgical abortions at some clinics resulting in some women who had, or would have, opted for a surgical abortion switching to a medical procedure. Although the proportion of medical abortions compared to surgical abortions had been increasing, this change of service provision in around 30 clinics resulted in a larger increase in the proportions of medical abortions from previous years.

The abortion statistics data tables[[3]](#footnote-3) show that in 2018, 66% of abortions carried out at 20+ weeks were surgical compared with 77% of those carried out at 15-19 weeks, 78% of those at 13-14 weeks and 84% of those at 10-12 weeks.

A survey of 120 women who accessed an abortion service at an NHS University Hospital in 2016-17[[4]](#footnote-4) found that 91% believed they had been able to choose their preferred abortion procedure. The survey excluded non-English speaking women, those pregnant as a result of sexual assault, or when the abortion was because of fetal anomaly. The most common reasons reported for women feeling that they had not been able to exercise choice were:

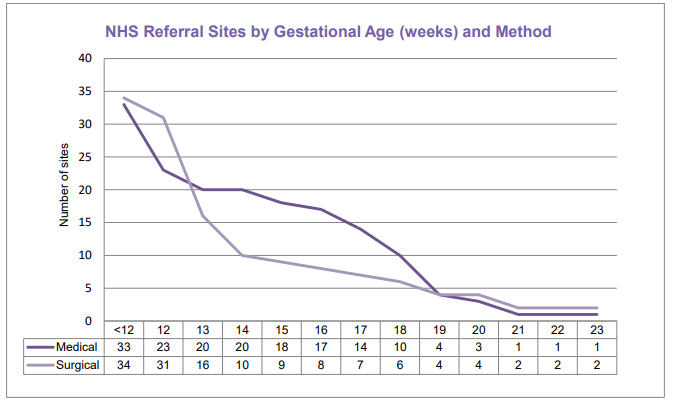
* Gestation was too far along for them to be given any other option (n=4)

An appointment for surgical abortion was not available before the cut-off gestation (n=6).

### Referral pathways/collaborative working

The British Pregnancy Advisory Service set up a Specialist Placement Service in 2007 to refer women with medically complex needs to NHS services. They reported[[5]](#footnote-5) an increase in demand for this service to 130 referrals per month in 2017, compared to 89 per month in 2015. The service was able to refer to 35 NHS services across England in 2018 which varied in the gestational age at which they accept women for care and what kind of abortion procedure they offer (see Figure 3). They reported that although the number of potential referral locations is highest in the first trimester the wait for these appointments can push women from needing a first trimester abortion to needing treatment in the second trimester. In addition, as gestation advances through the second trimester the number of potential referral locations decreases dramatically - and is most limited above 18 weeks gestation. There are only three NHS services which offer treatment up to the legal limit of 24 weeks on all grounds, all in London. The report raised concerns about the number of women who were unable to have an abortion because a placement could not be found for them - in 2016 and 2017 the service was unable to find treatment for 46 women.

### Figure 3: NHS Referral Sites for BPAS Specialist Placement Service



### Travel and accommodation

The BPAS report on medically complex women[[6]](#footnote-6) highlighted that because there are so few locations where this particular group of women can be treated, many have to travel significant distances to access services. As second trimester abortions are more complex and time-consuming, they may require an overnight stay. The report suggests that many women are unable to afford to travel away from home for extended periods, often because they have childcare responsibilities or do not have the financial resources to make the trip. The report gives examples of women who had to continue with their pregnancy because they were unable to travel.

a study of women in Great Britain (GB) who requested at-home medication abortion through an online telemedicine initiative between November 2016 and March 2017[[7]](#footnote-7) found that 9% (n=209) said ‘distance or lack of transport to clinic’ was their main reason for wanting to access abortion services outside the formal healthcare setting. The online telemedicine service is not available to women in GB, but women do try to access the service by completing the consultation form on the website. The study was carried out following a rise in requests from women in GB.

* + 1. Resource impact

This area was not included in the resource impact assessment for NG140. It was not identified as an area that would have a significant resource impact (>£1m in England each year).

* 1. Waiting times
     1. Summary of suggestions

Stakeholders highlighted the importance of limiting waiting times for abortion given that earlier abortions are safer and delays can increase the woman’s emotional and psychological distress. It was suggested that wait times for the assessment should be within 1 week of the referral and the abortion procedure should be carried out within 1 week of the assessment i.e. the total waiting time should not exceed 2 weeks. It was highlighted that long waiting times are a particular problem for women in prison.

Stakeholders emphasised that it is important to ensure that pressure on waiting times does not limit the woman’s choice of procedure. Individual needs should be taken into consideration when assessing waiting times as women may choose to wait longer to access a service that is closer to home or want more time to consider their decision. Stakeholders indicated, however, that there should not be a requirement for compulsory counselling or time for reflection. It is important to monitor if women are satisfied with the waiting time.

* + 1. Selected recommendations from development source

Table 4 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 4 to help inform the committee’s discussion.

### Table 4 Specific areas for quality improvement

|  |  |
| --- | --- |
| Suggested quality improvement area | Selected source guidance recommendations |
| Waiting times | NG140 Recommendations 1.1.5 to 1.1.8 |

### Waiting times

NICE NG140

Recommendation 1.1.5

Commissioners should work with providers to ensure abortion services have the capacity and resources to deliver the range of services needed with minimal delay.

Recommendation 1.1.6

Ensure minimal delay in the abortion process, and ideally:

* provide the assessment within 1 week of the request

provide the abortion within 1 week of the assessment

Recommendation 1.1.7

For women who would prefer to wait longer for an abortion, help them to make an informed decision by explaining the implications, including:

* the legal limit for abortions, as stated in the Abortion Act

that delaying the abortion will increase the risk of complications, although the overall risk is low.

Recommendation 1.1.8

Do not require women to have compulsory counselling or compulsory time for reflection before the abortion. Provide or refer women for support to make a decision if they request this.

* + 1. Current UK practice

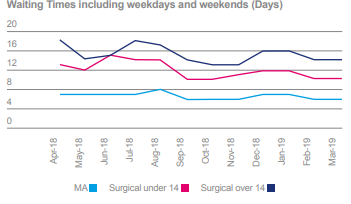
Freedom of information requests to clinical commissioning groups in England in 2017[[8]](#footnote-8) indicated that 76% of CCGs in England recorded longer waiting times for abortions in 2016 than they did in 2013 (39 out of 51). In relation to waiting times for abortion procedures in 2016:

* 41 out of 64 CCGs/Trusts exceeded the suggested waiting time of 10 working (or 14 calendar) days for surgical abortion (64%)

16 out of 61 CCGs/Trusts exceeded the suggested waiting time of 10 working (or 14 calendar) days for medical abortion (26%).

Marie Stopes provided 67,702 medical and surgical abortions in 2018 and their 2018-19 quality account[[9]](#footnote-9) indicates progress on the target to reduce waiting times to 10 days or less across all gestations (see Figure 4). The report indicates that reported wait times reflect patient choice rather than the next available appointment. Variations in different regions were noted and reducing waiting times for surgical abortions has been carried forward as a priority for 2019-20.

### Figure 4: Marie Stopes waiting times for abortion procedures



Waiting times were also highlighted as a priority in the British Pregnancy Advisory Service (BPAS) Quality Report for 2018/19[[10]](#footnote-10). BPAS provides over a third of all abortion treatment in the UK. The report indicates that dissatisfaction with waiting between the initial contact and treatment reduced to 15% in 2018/19 compared to 18% in 2017. The report suggests that improvements have been counteracted by increased caseload. Clients are also opting to wait for a ‘consultation and same day treatment appointment’, which has meant that ‘wait to consultation’ has not improved but the overall waiting time from first point of contact to treatment, has reduced significantly. 74.6% of women who expressed a view about waiting times, felt that time to consultation was acceptable and 85.4% felt the waiting time to treatment was acceptable. During 2019/20, reducing waiting times remains a high priority for BPAS.

a study of women in Great Britain (GB) who requested at-home medication abortion through an online telemedicine initiative between November 2016 and March 2017[[11]](#footnote-11) found that 30% (n=209) said ‘waiting times and multiple appointments’ was their main reason for wanting to access abortion services outside the formal healthcare setting. The online telemedicine service is not available to women in GB, but women do try to access the service by completing the consultation form on the website. The study was carried out following a rise in requests from women in GB.

* + 1. Resource impact

The estimated annual saving of implementing recommendation 1.1.5 for the population of England based on the uptake in the resource impact report is £4.2m per year in England for clinical commissioning groups.

* 1. Abortion procedures
     1. Summary of suggestions

### Preventing infection

Stakeholders suggested that women who are having an abortion have an increased risk of having a sexually transmitted infection (STI). There was therefore a concern that testing for STIs, including HIV, among women who are having an abortion is generally low. In addition, it was suggested that it is unclear how STI risk should affect the decision to offer antibiotic prophylaxis given that STI testing results are likely to be unknown at the time of the abortion. It was also suggested that the regime for antibiotic prophylaxis to prevent infection following a surgical abortion is unclear.

### Early medical abortion

It was suggested that there is currently local variation in the options available for early medical abortion, with a lack of availability of specific options in some areas, including:

* same day dispensing
* simultaneous administration
* administration at home

nurse support.

There was a concern that abortion providers use different regimens of misoprostol for early medical abortions which may be associated with a risk of retained products of conception and ongoing viable pregnancy at increasing gestational age. It was emphasised that it is important to ensure the most effective regimen is used to reduce these risks.

It was also suggested that there is a need for effective pain management for women having an early medical abortion.

Finally, there was a suggestion that a developmental area could be increasing the gestation age for home use medical abortion.

### Anaesthesia for surgical abortion

There was a suggestion that women should have a choice of anaesthesia for surgical abortion including local anaesthesia alone, conscious sedation with local anaesthesia, deep sedation or general anaesthesia. There was also a specific concern that women in prison who are having a surgical abortion are not being given information to allow them to fast in advance of the anaesthetic, leading to appointments having to be rearranged.

* + 1. Selected recommendations from development source

Table 5 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 5 to help inform the committee’s discussion.

### Table 5 Specific areas for quality improvement

|  |  |
| --- | --- |
| Suggested quality improvement area | Selected source guidance recommendations |
| Preventing infection | NG140 Recommendations 1.4.1 to 1.4.3  PH3 Recommendation 1 |
| Early medical abortion | NG140 Recommendations 1.8.1, 1.8.2, 1.9.1, 1.9.2 |
| Anaesthesia for surgical abortion | NG140 Recommendation 1.13.1 |

### Preventing infection

NICE NG140

Recommendation 1.4.1

For guidance on testing for sexually transmitted infections for women who are having an abortion, see the NICE guideline on preventing sexually transmitted infections and under-18 conceptions.

Recommendation 1.4.2

Do not routinely offer antibiotic prophylaxis to women who are having a medical abortion.

Recommendation 1.4.3

Offer antibiotic prophylaxis to women who are having surgical abortion.

NICE PH3

Recommendation 1

Identify individuals at high risk of STIs using their sexual history. Opportunities for risk assessment may arise during consultations on contraception, pregnancy or abortion, and when carrying out a cervical smear test, offering an STI test or providing travel immunisation. Risk assessment could also be carried out during routine care or when a new patient registers.

Have one to one structured discussions with individuals at high risk of STIs (if trained in sexual health), or arrange for these discussions to take place with a trained practitioner.

### Early medical abortion

NICE NG140

Recommendation 1.8.1

For women who are having a medical abortion and will be taking the mifepristone up to and including 9+6 weeks' gestation, offer the option of expulsion at home after they have taken the misoprostol. Misoprostol can be taken at home or in the clinic or hospital.

Recommendation 1.8.2

For women who are having a medical abortion and will be taking the mifepristone at 10+0 weeks' gestation, offer the option of expulsion at home after they have taken the misoprostol. Misoprostol can be taken in the clinic or hospital.

Recommendation 1.9.1

Offer interval treatment (usually 24 to 48 hours) with mifepristone and misoprostol to women who are having a medical abortion up to and including 10+0 weeks' gestation.

Recommendation 1.9.2

For women who are having a medical abortion up to and including 9+0 weeks' gestation, give them the choice of having mifepristone and vaginal misoprostol at the same time, but explain that:

* the risk of ongoing pregnancy may be higher, and it may increase with gestation
* it may take longer for the bleeding and pain to start

it is important for them to complete the same follow-up programme that is recommended for all medical abortions up to and including 10+0 weeks (recommendations 1.14.1 and 1.14.2).

### Anaesthesia for surgical abortion

NICE NG140

Recommendation 1.13.1

For women who are having surgical abortion, consider local anaesthesia alone, conscious sedation with local anaesthesia, deep sedation or general anaesthesia. To help women make an informed choice, discuss the options with them and explain that:

* having local anaesthesia alone means they will be able to spend less time in hospital
* intravenous sedation plus local anaesthesia will help if they are anxious about the procedure

with deep sedation or general anaesthesia they will not usually be aware during the procedure.

* + 1. Current UK practice

### Preventing infection

The 2018 abortion statistics report[[12]](#footnote-12) indicates that 90% of women having abortions in 2018 were offered chlamydia screening, up from 73% in 2008.

A 2016 survey of clinical commissioning groups[[13]](#footnote-13) found that less than half (42%) of those that responded (n=103) stipulated that HIV testing should be offered to all women having an abortion. A further 9% requested that providers work towards this, 26% requested signposting to HIV testing and 20% had no specific arrangements in place for HIV testing in abortion services. All 10 CCGs in extremely high HIV prevalence areas (where diagnosed HIV is >5/1000) commissioned HIV testing in abortion services, 54% (14/26) of CCGs in high prevalence areas (diagnosed HIV is 2-5/1000) and 45% (30/67) of CCGs in low prevalence areas (diagnosed HIV is <2/1000) did so.

### Early medical abortion

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder’s knowledge and experience.

### Anaesthesia for surgical abortion

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder’s knowledge and experience.

* + 1. Resource impact

This area was not included in the resource impact assessment for NG140. It was not identified as an area that would have a significant resource impact (>£1m in England each year).

* 1. Access to contraception
     1. Summary of suggestions

Stakeholders emphasised that advice on contraception and access to all methods of contraception should be easily available to women who are having an abortion. It was suggested that future contraception should be discussed at the pre-abortion assessment visit and women should be able to access their preferred contraceptive method (e.g. long-acting reversible contraception (LARC)) at the time of or immediately following the abortion. Women who are referred to a community service for this advice may have to wait for an appointment and are less likely to use contraception following the abortion than those who access contraception as part of their abortion care.

Currently, abortion providers may find it difficult to provide all forms of contraception due to local funding limitations and staff skills and training. Funding limitations can mean that women having an abortion have a reduced choice of contraceptive methods. Providing access to contraception through abortion services is associated with higher continuation rates and can help to avoid future unplanned pregnancies.

There was a concern that contraception uptake rates (e.g. LARC) are used by commissioners to monitor performance but may not be appropriate given that the focus should be on providing choice.

* + 1. Selected recommendations from development source

Table 6 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 6 to help inform the committee’s discussion.

### Table 6 Specific areas for quality improvement

|  |  |
| --- | --- |
| Suggested quality improvement area | Selected source guidance recommendations |
| Access to contraception | NG140 Recommendations 1.2.6, 1.15.1, 1.15.3 to 1.15.5  PH51 Recommendation 7 |

### Access to contraception

NICE NG140

Recommendation 1.2.6

Ask women if they want information on contraception, and if so provide information about the options available to them (see improving access to contraception).

Recommendation 1.15.1

Commissioners and providers should ensure that the full range of reversible contraceptive options (depot medroxyprogesterone acetate [DMPA], contraceptive implant, intrauterine methods, oral contraceptives, contraceptive patches, vaginal rings or barrier contraception) is available for women on the same day as their surgical or medical abortion.

Recommendation 1.15.3

Providers should ensure they can provide the contraceptive implant, and that women who choose this method are offered it on:

* the day of the surgical abortion or

the day they take mifepristone (for medical abortions).

Recommendation 1.15.4

Providers should ensure they can provide intrauterine methods of contraception, and that women who choose this method are offered this:

* at the same time as the surgical abortion or

as soon as possible after expulsion of the pregnancy (for medical abortions).

Recommendation 1.15.5

For women who are having a medical abortion and who choose DMPA intramuscular injection for contraception:

* consider providing it at the same appointment when they take the mifepristone

explain that having the injection at this stage may increase the risk of ongoing pregnancy, although overall the risk is low.

NICE PH51

Recommendation 7

* Before – and as soon as possible after – an abortion, discuss contraception and explain the full range of contraceptive methods available. Help young women and their partners identify and obtain the most effective method that best meets their needs. Dispel the myth that there is no need for contraception after an abortion and explain that women are fertile immediately following an abortion.
* Provide contraception to prevent another unintended pregnancy or refer them to contraceptive services for advice and contraception. If appropriate, offer counselling.

If the young woman does not want to be referred on, offer to contact her after her abortion to give advice on the most effective and suitable method of contraception for her, using a communication method of her choice (for example, text messages). Also consider using outreach or home services to provide information and contraceptives.

* + 1. Statements in existing quality standards

NICE QS129 Contraception statement 3

Women who request an abortion discuss contraception with a healthcare practitioner and are offered a choice of all methods when they are assessed for abortion and before discharge.

* + 1. Current UK practice

A survey of 430 women booked for an abortion at a Marie Stopes International (MSI) centre in 2012-13[[14]](#footnote-14) indicated that 86% reported using a method of contraception at 4 weeks post-abortion. 79% obtained the method from MSI and 7% from a different provider. All women reported being provided with contraceptive advice during their consultation and at the time of their abortion, however, 21% were discharged after their abortion without a method of contraception. These women either did not want to start using a method immediately after their abortion, their preferred method was not available, they were undecided what method to start, or they preferred to see a different service provider for contraception.

A greater proportion of women who had a surgical abortion compared to those who had a medical abortion left the MSI centre with a method of contraception (85% vs. 69%). The difference between method of abortion and contraceptive uptake was still significant at four weeks post-abortion (surgical: 88% vs. medical: 80%). More women who had a surgical abortion started to use a long acting reversible contraception (LARC) method (70% vs. 50% respectively). Women who had a medical abortion were more likely to choose to start using the pill (48%).

The Marie Stopes Quality Account for 2018/19[[15]](#footnote-15) indicates that improving the uptake of Long Acting Reversible Contraception (LARC) for those women who have requested it remains a quality related objective for the organisation in 2019/20.

* + 1. Resource impact

This area was not included in the resource impact assessment for NG140. It was not identified as an area that would have a significant resource impact (>£1m in England each year).

* 1. Follow-up care and support
     1. Summary of suggestions

Stakeholders suggested that it is important that women know how to access support following an abortion, including:

* clinical support if complications arise
* psychological support and counselling
* bereavement care and support following an abortion because of fetal anomaly

continuation of contraception.

It was suggested that it is important that information about an abortion is shared with the woman’s GP so that on-going care and support can be provided. If a woman is not able to access clinical follow-up support from their abortion provider, it is important that clear pathways are in place to primary and secondary care and sexual health services.

* + 1. Selected recommendations from development source

Table 7 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 7 to help inform the committee’s discussion.

### Table 7 Specific areas for quality improvement

|  |  |
| --- | --- |
| Suggested quality improvement area | Selected source guidance recommendations |
| Follow-up care and support | NG140 Recommendations 1.14.3 to 1.14.6 |

### Follow-up care and support

NICE NG140

Recommendation 1.14.3

Explain to women:

* what aftercare and follow-up to expect
* what to do if they have any problems after the abortion, including how to get help out of hours

that it is common to feel a range of emotions after the abortion.

Recommendation 1.14.4

Advise women to seek support if they need it, and how to access it (if relevant). This could include:

* support from family and friends or pastoral support
* peer support, or support groups for women who have had an abortion

counselling or psychological interventions.

Recommendation 1.14.5

Providers should be able to provide emotional support after abortions. They should tell women this support is available if they need it.

Recommendation 1.14.6

Providers should provide or refer women for counselling if requested.

* + 1. Current UK practice

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder’s knowledge and experience.

* + 1. Resource impact

This area was not included in the resource impact assessment for NG140. It was not identified as an area that would have a significant resource impact (>£1m in England each year).

* 1. Additional areas

### Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise. However, they were felt to be either unsuitable for development as quality statements, outside the remit of this particular quality standard referral or need further discussion by the committee to establish potential for statement development.

There will be an opportunity for the committee to discuss these areas at the end of the session on 6th December.

### Training for healthcare professionals

Stakeholders suggested that healthcare professionals such as GPs, student doctors, nurses and midwives should gain practical experience of abortion services and training in abortion procedures during their medical training. As most abortion care is carried out by independent providers it can be difficult to arrange training in the NHS. Improved access to training will reduce the stigma of abortion and improve the sustainability of the workforce.

Quality statements focus on actions that demonstrate high quality care or support, not the training that enables the actions to take place. The committee should consider which parts of care and support would be improved by increased training. Training may be referred to in the audience descriptors and structure measures.

### Commissioning

There were concerns that the current approach to the commissioning of abortion care has created an unsustainable system. It was reported that the tariffs used by commissioners for abortion care do not reflect the complexity of different types of abortion or the additional requirements for women with complex needs. Contracts have been offered where payments are significantly lower than the national tariff and are ‘below-cost’ which has created an unstable system with many NHS Trusts opting to stop offering abortion services. It was suggested that commissioners should aim to create a ‘mixed economy’ of providers including independent and NHS providers with networking and collaboration to provide high-quality abortion care.

Quality statements focus on actions that demonstrate high quality care or support, not the commissioning of services to deliver those actions. The committee should consider which parts of care and support would be improved by better commissioning. The quality standard will include an audience descriptor describing what commissioners should do for each statement.

### Women in prison

There were concerns that women in prison do not have equal access to abortion services and receive poor treatment, including: judgemental attitudes from prison staff; being placed in restraints during consultations and procedures; and access to support.

A quality standard on the physical health of people in prisons was published in September 2017. Any specific considerations for women in prison in relation to this quality standard can be identified in the equality and diversity considerations.

### Standardising patient surveys

There was a suggestion that there is a need to standardise the questions used in patient experience surveys for women having an abortion to improve benchmarking for providers.

Quality statements focus on actions that demonstrate high quality care or support. The measures for the quality statements may include patient experience and therefore the data sources could help to ensure consistency.

© NICE 2019. All rights reserved. Subject to [Notice of rights](https://www.nice.org.uk/terms-and-conditions#notice-of-rights).

# Appendix 1: Review flowchart

Records identified through topic engagement  
[n =64]

Records identified through IS scoping search  
[n = 33]

Records identified through ViP searching  
[n =932]

Records excluded  
[n = 1015]

Records screened  
[n =1029]

Citation searching or snowballing

[n= 1]

Full-text papers excluded  
[n =6]

Full-text papers assessed   
[n =15]

Current practice examples included in the briefing paper  
[n = 9]

# Appendix 2: Suggestions from stakeholder engagement exercise – registered stakeholders

| ID | | Stakeholder | | Suggested key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Access and assessment – Information** | | | | | | | |
| 1 | Birth Companions | | **Abortion services during prison custody** | | Birth Companions and bpas have significant concerns about women’s access to and experience of abortion services while in prison custody in England.  Women in prison have a right to healthcare provision equal to that accessed by women in the community. Yet despite this, both Birth Companions and bpas see and hear of inequalities and poor practice in abortion care for prisoners. | The level of information and quality of services provided to pregnant women experiencing an unplanned or unwanted pregnancy, or a pregnancy they feel unable to continue, is inconsistent across the prison estate. While some prisons demonstrate best practice through the provision of specialist services offering advice and counselling, or by signposting women to phone advice lines; others provide little or no such support. As a result, women’s access to information, advice, guidance and support to make informed decisions is restricted and their rights are affected. This is even more concerning given the proportion of pregnant women in custody who only learn of their pregnancy on their arrival to prison. | We believe the following changes need to be prioritised to improve abortion care during prison custody:  1.Women’s legal rights to abortion, and to dignity and privacy while they access abortion must be protected and upheld. Prisons should ensure they have clear care pathways in place for pregnant women, which include specific, detailed requirements on the provision of information and support relating to abortions and clear standards of care throughout the process. |
| 2 | Royal College of Midwives | | Key area for quality improvement 1  **Provision of adequate information – improving access to services** | | There is evidence that there is a lack of information available about how to access services including vulnerable population e.g. undocumented migrant women, homeless who are not registered with GP.  In addition, there is a considerable amount of misinformation online that may be impacting women’s choices i.e. that abortion leads to breast cancer or mental health problems. | Inability to access adequate information can lead to late presentation. The earlier in pregnancy an abortion is performed the lower the risk of complications. Easy access to appropriate information would represent lower risk for women, as well as a cost benefit. | Kung, S. et al. (2018). Access to abortion under the heath exception: A comparative analysis in three countries. <https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-018-0548-x>  World Health Organisation (2014) Clinical practice handbook for safe abortion <https://www.who.int/reproductivehealth/publications/unsafe_abortion/clinical-practice-safe-abortion/en/>  Doctors of the World (2017) DOTW Department of Health and Social Care formal review of The National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2017  <https://www.doctorsoftheworld.org.uk/wp-content/uploads/import-from-old-site/files/DoTW_Response_to_DH_formal_review.pdf>  Humanism (2019) Abortion Factsheet <https://humanism.org.uk/2019/01/31/abortion-factsheet-launched-to-challenge-spread-of-junk-science-in-schools/> |
| 3 | Royal College of Midwives | | Key area for quality improvement 2  **Provision of adequate information – interacting with services** | | There is evidence that women often do not receive adequate information when interacting with services. | Women need to know what to expect when viewing the pregnancy and what to expect after the abortion procedure. Women who are having an abortion for fatal fetal abnormality also need information about the diagnosis and the procedures relating to fetal remains.  Failure to provide adequate information could lead negative experiences which may cause delays in presentation in the future. | Purcell, C. et al. (2017) Self-management of first trimester medical termination of pregnancy: a qualitative study of women's experiences. <https://www.ncbi.nlm.nih.gov/pubmed/28421651> |
| 4 | | SCM5 | | Key area for quality improvement 1  **Access to reliable information** | To provide abortion services for all women who need them, information must be available in a variety of forms and locations. To reach women who are vulnerable, there is a need for clear information in public areas such as GP’s surgeries. Services such as helplines and websites could signpost to local services and inform women about self referral. | As a lay member, I do not know about provision across the country, but am aware that women will have varying needs in different locations eg. urban or rural areas. Cultural differences will also affect women’s access to information. Awareness of these differences should help lead to widely available information. | No supporting information is offered here. Most points were discussed during committee meetings or in conversation with professionals. |
| **Access and assessment – Self-referral** | | | | | | | |
| 5 | | Royal College General Practitioners | | Key area for quality improvement 3  Number of women who self-refer for termination aiming to improve access to termination by providing a uniform self-referral process for all women who need it | Many women decide to have a termination of pregnancy without consulting their GP and some CCGs allow women to self-refer directly to abortion providers e.g. BPAS. In other areas, women are made to wait for a GP appointment, to see a GP who will then fill in a referral form. Since all care (including the termination form A and B) is provided at the provider, this additional step (seeing the GP) can delay access to termination services by weeks if GP appointments are difficult to obtain. | Different CCG commissioning pathways cross the UK lead to different waiting times for women | NICE NG140 suggests self-referral should be available and minimal delay in the process of referral 1.1.2  Avoid repeat steps by returning to the GP for a referral (1.1.1) |
| 6 | | SCM4 | | Key area for quality improvement 3  **Commissioners and providers should allow women to self-refer to abortion**  **services** | Routine self-referral removes potential barriers and gives women greater autonomy. By removing barriers and facilitating timely access, it also fits with Key area for quality improvement 1, above. | Self-referral is far more common now but there are still pockets where women seeking abortion care have to ‘jump through hoops’. ‘Gatekeepers’ are unnecessary for abortion care and only serve to impede access. |  |
| 7 | | SCM5 | | Key area for quality improvement 2  **Access to abortion services** | Women may prefer to use a local service for ease of access and reduced time needed for travel or they may prefer the anonymity of a service further away. It is important they are given the options so they can make the decision that is best for their needs. Self referral is very important for some vulnerable groups. | Again , this will be affected by location. In a remote area, women may find it offputting to see their GP as they are not sure about confidentiality. An opportunity to find out their options would be very important and this could be widely provided with self referral. |  |
| 8 | | SCM6 | | Key area for quality improvement 1  **Direct Access** | A pathway that includes a requirement/ perceived requirement for a referral through a GP, sexual health clinic, or other HCP creates barriers and delays to accessing care. | We know that facilitating a termination at the earliest possible gestation, for those women making an informed choice to have an abortion and where the requirements of the law are met, leads to less harm for the women concerned.  Levels of direct access vary widely between providers and by geographical area – with figures ranging from as high as 80% to as low as 20% (self-referral rate). |  |
| **Access and assessment- Assessment** | | | | | | | |
| 9 | | SCM2 | | Making it easier to access services - | Because it reduces delays in being seen and treated. It reduces the need for repeated time of work for appointments. Women can choose the time that they want the consultation prior to face to face treatment. Reduced times in clinics. | Individual providers use different ways to access their services and this can mean that some women are disadvantaged. Women should have a choice on how they wish to access a service | Abortion Care  www.nice.org.uk/guidance/ng140 |
| 10 | | SCM2 | | Ultrasound | No consensus between providers on the best gestational age determinant on ultrasound at any given time | Individual providers use different determinants for dating a pregnancy which leads to multiple rescanning of women. This leads to different gestational ages being given and confusion for the woman seeking the abortion | Pam Loughna1, Lyn Chitty2, Tony Evans3 & Trish Chudleigh4 Fetal size and dating: charts  recommended for clinical obstetric  practice  1Academic Division of Obstetrics and Gynaecology, Nottingham University Hospitals NHS Trust, 2Genetics and Fetal Medicine, Institute of  Child Health and University College London Hospitals NHS foundation Trust, London, 3Medical Physics, University of Leeds, Leeds and  4The Rosie Hospital, Cambridge, UK  Trish Chudleigh1, Pam Loughna2 and Tony Evans3 A practical solution to combining dating and screening for  Down’s syndrome  1The Rosie Hospital, Cambridge University Hospitals NHS Trust, Cambridge, UK; 2Academic Division of Obstetrics and Gynaecology,  Nottingham University Hospitals NHS Trust, Nottingham, UK; 3Division of Medical Physics, LIGHT Institute, University of Leeds, Leeds, UK  Corresponding author: Dr Trish Chudleigh. Email: trish.chudleigh@addenbrookes.nhs.uk  Ultrasound 2011; 19: 154–157. DOI: 10.1258/ult.2011.011028  **ISUOG Practice Guidelines: ultrasound assessment of fetal**  **biometry and growth**  Ultrasound Obstet Gynecol 2019; 53: 715–723 |
| 11 | | SCM3 | | Additional developmental areas of emergent practice:   * Remote assessment (e.g. telemedicine) * Delivering abortion without scan – e.g. directly via pharmacists or GPs (e.g. Ireland model) | Current service structure is restricted owing to the 1967 Abortion Act. Decriminalisation is expected during the lifetime of this guidance which would permit more woman-centred care, but even without that some innovations could be delivered | Delivery of better woman-centred pathways, more cost effective and less invasive | NICE 1.1.9-11, IOG/ICGP Interim Clinical Guidance and Guidelines document on Termination of Pregnancy |
| 12 | | SCM4 | | Key area for quality improvement 2  **Consider providing abortion assessments by phone or video call, for women who prefer this.** | Women value convenience very highly when accessing abortion services. Provision of a variety of platforms by which women can access those services enhances convenience and removes potential barriers to access. | Smart technology is ubiquitous now. There are still many women who have to travel significant distances to access abortion care. Young people and vulnerable women, for example those in violent relationships, may find it extremely difficult to attend face to face appointments, and to maintain confidentiality. Having a choice of platforms by which women can engage with providers improves access, privacy and potentially safety for women. As access is improved, one would expect to see a continuing decrease in the gestational age at which women present to care providers which is an additional benefit. |  |
| **Choice and referral - Choice of procedure** | | | | | | | |
| 13 | | British Pregnancy Advisory Service | | Ensuring availability of choice of method up to the 23+6 week limit | This is a new recommendation in the NICE guideline which is likely to require serious consideration of how services are provided, particularly by sole NHS providers.  It is recognised in the guideline that women should be able to opt for different types of treatment given their comparable risk profile but different qualitative experience.  This should include as standard:   * Provision of expulsion at home up to an including 10+0 weeks * Provision of EMAH within the legal constraints   Provision of surgical services up to 24 weeks. | Given that this is a new requirement, there is a high likelihood that without a quality standard, many CCGs will not prioritise provision of alternatives – meaning that women particularly at later gestations are left with a lack of choice and, particularly in the case of TOPFA, forced into undergoing late medical procedures rather than a surgical provision which they may prefer. This quality standard would ensure that commissioners were clear when issuing contracts that collaborative provision at different gestations and with different client priorities.  Expulsion at home up to and including 10+0 weeks  Including medical up to 10 weeks.  Surgical up to 24 weeks from NHS providers | Contract details from CCGs and evidence base of recommendations in NICE guideline. |
| 14 | | British Society of Abortion Care Providers (BSACP) | | Key area for quality improvement 2 | **The NHS should aim to reduce the geographical variation and inequality that currently exists in access to a** **choice of both method of abortion and post abortion contraception offered.**  **Ensure a woman can have medical or surgical abortion by treatment within the service to which she initially presents or following a seamless transfer of her care.**  NICE recommendations:  1.6.1Offer a choice between medical or surgical abortion up to and including 23+6 weeks' gestation[[1](https://www.nice.org.uk/guidance/ng140/chapter/Recommendations#ftn.footnote_1)]. If any methods would not be clinically appropriate, explain why. | There is geographical variation in availability of abortion methods. For example, in some areas of the country surgical options are not offered/ not available for abortion below 10 weeks.  Practically this would need to be addressed in stages, initially prioritising below 10 weeks.  Those women for whom either method is medically suitable deserve to have a choice. They should also have choice around the type of anaesthesia for surgical procedures.  Whilst we understand the committee’s argument “that it is not feasible for surgical abortions to be available from all services or in all locations and that some services may lack the expertise or resources to perform abortions after a specific gestational age”, we feel that a woman should be able **to seamlessly transfer** and receive her choice of method if this cannot be provided at her initial place of care.  Availability of procedure can influence choice (i.e. women will often "choose" a method which is not genuinely their preferred option on the basis that they may wish to avoid delay). |  |
| 15 | | Doctors for Choice UK | | Key area for quality improvement 2  Choice of method of abortion for all pregnant people needing an abortion | Choice is a key theme of NICE guidelines and a central tennet of medical ethics. | Because of the variation in choice offered by providers nationally.  People with co-morbidities and other people who present later for abortions, including young people and vulnerable and marginalised people are disproportionately affected by lack of choice.  Sometimes this can even lead to them being required to continue their unwanted pregnancies. | NICE recommendations  1.6.1 Offer a choice between medical or surgical abortion up to and including 23+6 weeks' gestation[[1](https://www.nice.org.uk/guidance/ng140/chapter/Recommendations#ftn.footnote_1)]. If any methods would not be clinically appropriate, explain why.  1.2.11 If a woman who is having an abortion for fetal anomaly cannot have her preferred method of abortion in the maternity service, establish a clear referral pathway with ongoing communication between services so that she can: easily transfer to the abortion service receive ongoing support from the maternity service get more information about the anomaly.  <https://www.bpas.org/media/2074/briefing-medically-complex-women-and-abortion-care.pdf> |
| 16 | | Faculty of Sexual and Reproductive Healthcare (FSRH) | | **Key area for quality improvement 1**  **Supporting genuine patient choice of method of abortion** | Women requesting an abortion have the right to decide the best course of treatment for themselves if medically appropriate, just like is the case with other medical procedures. The NICE guideline on abortion care is clear that women should be offered a choice between medical or surgical abortion up to 23+6 weeks and receive further information on whether it is clinically appropriate. The NICE guideline makes a clear recommendation that commissioners and providers should allow women to self-refer to abortion services. It also states that commissioners and providers should work together to ensure that women are promptly referred onwards if a service cannot provide an abortion by the woman's preferred method or after a specific gestational age. | Funding of NHS abortion services differs in various parts of the country. It is the responsibility of the commissioner to ensure that eligible women have access to abortion care, irrespective of the funding arrangements or any other criteria that could restrict access. There is widespread variation in type and choice of procedure offered to patients as well as variation in quality across the NHS and independent sector. Clinical Commissioning Groups (CCGs) often lack the specialist knowledge needed to commission abortion services appropriately.  Availability of procedure can influence choice. The availability of medical abortions in England and Wales as a method of abortion is likely to have contributed to the increase in the overall percentage of abortions performed at under ten weeks gestation (73% in 2008 compared with 80% in 2018). A full range of services should be commissioned to include a choice of medical and surgical procedures as part of a pathway of care. Individual local referral pathways should be used to support this, to include a clear process for managing women presenting at late gestation.  Additionally, most hospitals in Britain only offer medical termination of pregnancy for a foetal anomaly (TOPFA) due to a lack of current skills in the workforce to provide surgical TOPFA in second trimester; however, it has been demonstrated that a surgical abortion in the first and second trimesters is safe and acceptable, and preferable for many, to a medical induction for most women, including those seeking TOPFA. The lack of choice of method can have negative impact on women's experiences of TOPFA care. See Callaby, H., Fisher, J. & Lohr, P.A. 2019. Surgical termination of pregnancy for fetal anomaly: what role can an independent abortion service provider play? J Obstet Gynaecol. 2019 Aug; 39(6):799-804. <https://www.ncbi.nlm.nih.gov/pubmed/30999795>  Finally, patient participation and exercising their right to choose can improve quality of care. Evidence suggests that satisfaction with abortion care is higher when women choose the procedure than after being randomized to receive either medical or surgical treatment, the difference persisting over a two-year follow-up. Studies assessing the strength of preference for abortion procedure show that most women who express a preference feel strongly about their choice, rating the provision of choice as extremely or very important. | [NICE 2019. *Abortion care. NICE guideline*](https://www.nice.org.uk/guidance/ng140).  DHSC & ONS 2019. [*Abortion Statistics, England and Wales: 2018. Summary information from the abortion notification forms returned to the Chief Medical Officers of England and Wales*](https://www.gov.uk/government/collections/abortion-statistics-for-england-and-wales).  RCOG 2011. [*The Care of Women Requesting Induced Abortion*](https://www.rcog.org.uk/globalassets/documents/guidelines/abortion-guideline_web_1.pdf)(Evidence-based Guideline Number 7).  RCOG 2017. [*The Royal College of Obstetricians and Gynaecologists submission to the APPG on Population, Development and Reproductive Health*](http://www.appg-popdevrh.org.uk/RCOG%20Submission%20APPG%20PDRH%20Abortion%20UK.pdf)*. Call for evidence on Abortion in the Developing World and UK*.  Callaby, H., Fisher, J. & Lohr, P.A. 2019. [Surgical termination of pregnancy for fetal anomaly: what role can an independent abortion service provider play?](https://www.ncbi.nlm.nih.gov/pubmed/30999795) *J Obstet Gynaecol*. 2019 Aug; 39(6):799-804.  Moreau, C., Trussell, J., Desfreres, J. & Bajos, N. [Medical versus surgical abortion: the importance of women’s choice](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3703632/). *Contraception*. 2011 Sep; 84(3): 224–229.  Heller R, Purcell C, Mackay L, Caird L, Cameron ST. ‘[Barriers to accessing termination of pregnancy in a remote and rural setting: a qualitative study’](https://www.ncbi.nlm.nih.gov/pubmed/27145987). *BJOG*. 2016 Sep;123 (10):1684-91. |
| 17 | | North West Anglia Foundation Trust | | Key area for quality improvement 5 | Patients should be provided with a choice of procedure at all gestations. If the local service is unable to provide this effective referral pathways should ensure timely treatment. | Medical and surgical abortions are equally safe and so patients should be provided with a free choice. This shouldn’t be dependent on local/NHS provision. | NICE |
| 18 | | NUPAS- National Unplanned Pregnancy Advisory Services UK | | Key area for quality improvement 2  **Choice of Termination Procedure to be available for all** | Clients presenting up to 10 weeks gestation should be able to access all the methods of termination of pregnancy, in all termination services | Currently the choice of termination of pregnancy may be restricted in some centres, and clients do not get the opportunity of making informed choice about their treatment options. Again the underlying issue may be funding and staff skills unavailability |  |
| 19 | | SCM1 | | Key area for quality improvement 4  **Ensure all women can have the abortion method of their choice (if clinically suitable) without the need to travel** | NICE recommendations:  1.6.1 state offer a choice of medical and surgical abortion  1.8.1 & 1.8.2 state that women who have an EMA up to 10 weeks gestation should have the option of completing the abortion process at home | There is wide geographical variation in services who offer all methods of abortion up to 23 weeks and 6 days.  Whilst recognising that not all services can offer all methods (especially in more advancing gestations), women should not be disadvantaged if their local service does not offer the method of their choice (if clinical appropriate). Seamless transfer of patients to services that can accommodate them is essential. | Requirement by NHS England Specialised Commissioning to undertake scoping exercise of services in preparation for commissioning Specialist Placement Centres |
| 20 | | SCM3 | | Providers should ensure that they can offer women, either themselves or through seamless pathways with other providers:   * A choice between medical or surgical abortion up to and including 23+6 weeks’ gestation | Choice and reducing delays were key themes of the NICE guidelines. Not all providers can offer all choices in all locations (there are advantages to community settings, nurse-delivered clinics and remote consultations for example), but they should have collaborative pathways so that women can access their choice without delay where it is not available where she presents. | There is marked variation in choice offered between providers. The development of care pathways & collaboration between different providers is rare. Reducing delay is essential for quality as it is safer, ensures the woman has more options, a better experience, and it is cheaper for the NHS (each day of delay costs £1.6m). | NICE 1.1.1, 1.1.6-8, 1.1.16, 1.6.1, 1.13.1 |
| 21 | | SCM4 | | Key area for quality improvement 4  **Offer a choice between medical or surgical abortion up to and including 23+6 weeks' gestation** | Because there are still too many women who have no choice but a medical abortion in the second trimester and yet where women do have a choice, they overwhelmingly choose surgical. There is evidence that women’s satisfaction with their abortion experience is increased where the woman is able to choose the abortion method. | Exercising choice in method improves women’s experience of abortion care.  This is easily measurable as a standard, and speaks directly to commissioners funding providers adequately to provide choice to their populations. |  |
| 22 | | Umbrella Sexual Health Service/ University Hospitals Birmingham NHS Trust | | Key area for quality improvement 3  Choice of procedure | Women anecdotally may opt for EMA based on provision at first appointment. | It would be helpful to understand if women would be more likely to opt for surgical TOP (especially MVA under local anaesthetic) if this was also offered on the day. | NICE decision aid for abortion before 14 weeks |
| **Choice and referral - Referral pathways/collaborative working** | | | | | | | |
| 23 | | British Pregnancy Advisory Service | | Building networks of collaborative working that support cross-organisation provision | Abortion care is essential care that relies on a relatively small and dedicated workforce – most of which is nurse- and midwife-led. Because of the relatively small number of staff and clinics involved, supply-side shocks can have a sizeable impact on the ability of clients to access care.  Collaborative working would not only enable better sharing of best practice experience, but also enable clients to access a more uniform service across the country. | BPAS has worked extensively in recent years, without funding, to provide a single bookings service for women with complex medical comorbidities attempting to access abortion care. This requires significant cross-provider working and has enabled more women to be seen in specialised environments.  However, there is nothing comparable for women in less dire circumstances and this can result in individual women having issues with access to care and aftercare eg. Where they are on the border of a CCG but unable to be treated in their nearest clinic owing to contract reasons. |  |
| 24 | | Homerton University Hospital NHS Foundation Trust | | Key area for quality improvement 2 | The NHS should aim to reduce the geographical variation that currently means many women diagnosed with fetal anomaly do not have an option of surgical abortion.  NICE recommendations  1.6.1 Offer a choice between medical or surgical abortion up to and including 23+6 weeks' gestation[[1](https://www.nice.org.uk/guidance/ng140/chapter/Recommendations" \l "ftn.footnote_1)]. If any methods would not be clinically appropriate, explain why.  1.2.11 If a woman who is having an abortion for [fetal anomaly](https://www.nice.org.uk/guidance/ng140/chapter/recommendations#fetal-anomaly) cannot have her preferred method of abortion in the maternity service, establish a clear referral pathway with ongoing communication between services so that she can: easily transfer to the abortion service receive ongoing support from the maternity service get more information about the anomaly. | We understand the committee’s argument “that it is not feasible for surgical abortions to be available from all services or in all locations and that some services may lack the expertise or resources to perform abortions after a specific gestational age”, but we feel that a woman should be able **to seamlessly transfer** and receive her choice of method if this cannot be provided at her initial place of care.  Commissioners need to support collaboration and networking between fetal medicine units to sharing of skills and where necessary seamless transfer of care for individuals. |  |
| 25 | | NUPAS- National Unplanned Pregnancy Advisory Services UK | | Key area for quality improvement 4  **Robust pathways for referral of people with complex co morbidities** | Clients having background complex medical/surgical problems are often victims of having to wait for a much longer time till appropriate termination services are identified for them  This magnifies the already distressing situation they are in ,and prolongation of the pregnancy period may adversely affect both their physical and mental health | NHS England recently published data showing at least 20-30% of termination done nationwide are for clients with complex co morbidities  Working in one of the three independent sector providers of termination services in UK , we are faced with the regular task of trying to find appropriate referral centres for these clients  This is due to lack of efficient referral systems and lack of prioritisation of abortion services in NHS hospitals |  |
| 26 | | RCOG | | Key area for quality improvement 2  Abortion for women with a previous caesarean section | Specific separate guidance should be available for this group due to rupture risk with standard doses of misoprostol, also AIP risk in surgical TOP | Complications of abortion - previous CS group are over-represented |  |
| 27 | | SCM3 | | Commissioners should ensure their local services have sufficient resources to deliver the range of services needed:   * Where contracts are awarded to providers at below national tariff rates (i.e. prices determine through NHS reference costs), ensure that this does not reduce choice, quality or training opportunities, that it does not exclude other providers and that the variation is registered with NHSE * Encourage a seamless network approach so that women can access the range of options for procedure and anaesthesia without delay even if her preferred option is not available at her local provider (e.g. in a community setting, where there are complex co-morbidities or late gestation) * Ensure commissioning arrangements encourage collaboration and do not exclude a range of providers from offering these networks (e.g. independent and NHS Trusts) | A culture of commissioning services out to independent providers through restrictive tenders has resulted in fragmentation and competition, with many NHS Trusts no longer offering services. This was raised as a key issue by stakeholders in the scope of the NICE guideline, and for example has meant that women with complex needs or later gestations have prolonged waits and must travel to distant providers as local Trusts have not been commissioned. Whilst commissioners have a legal duty to report local variations in commissioning to NHSE/I, to date none have done so despite 70% of abortions being delivered by independent providers outside of payment by results. This has made it impossible to monitor quality or to ensure other responsibilities such as training are delivered across the NHS. | There is marked variation in service provision with a “race to the bottom” for quality owing to the need to compete and submit the lowest tender. This has resulted in reduced choice, poor provision for later gestations, complex cases and often no facility for training of NHS staff. Both independent providers and NHS Trusts have complementary strengths, but standards must require them to act collaboratively using integrated care pathways | NICE 1.1.5, 1.1.15-16, including rationale and text in evidence review A. |
| 28 | | SCM6 | | Additional developmental areas of emergent practice   1. Facilitating complex abortions (for women with comorbidities and/ or of late gestation) 2. Facilitating access | Such abortions need to be carried-out by an experienced theatre team within a DGH setting.  Delay to access can lead to women having a termination at a later gestation, potentially prolonging their need to have an abortion and increasing the complexity/ degree of intervention required to deliver successful care. | I believe (from professional conversations) that around 2,000-3,000 of circa 198,000 abortions per year would be considered ‘clinically complex’. That is to say – the women concerned have co-morbidities that could likely/ potentially cause complications during the procedure and/ or present at a late gestation of say 20+ weeks.  Most providers will receive few referrals concerning such women, but historically have had to refer to a single digit number of clinicians/ providers who are able to carry-out such work. This has previously been left without guidance and to the hands of circa 200 individual commissioning organisations.  NHS England has begun to develop a network of provider organisations able to deliver such work; and who are committing to expand their scope of practice.  During this mobilisation period, and indeed when fully established, we will want to ensure that women and / or referrers have good, barrier-free access to such provision.  A key barrier to access is funding for public transport; particularly for women requiring surgical interventions; women presenting at later gestation; and women from rural areas and those struggling financially.  The guideline makes key recommendations for commissioners to consider how they could better facilitate access and it will be important to monitor the impact of that. |  |
| 29 | | Umbrella Sexual Health Service/ University Hospitals Birmingham NHS Trust | | Key area for quality improvement 1  Pathways for women with complex needs or significant comorbidities | Current delays in provision of TOP for these women, many of whom require avoidance of delay (increases comorbidity relevance and likelihood of not attending) | Current delays in provision of TOP for these women due to:  Lack of relevant medical information available if woman self-refers to TOP provider +/- declines GP being informed  PLUS  Lack of local providers of TOP for these women (often unsuitable for ISPs) | NICE guidance 2019 |
| **Accessing abortion services - Travel and accommodation** | | | | | | | |
| 30 | | British Pregnancy Advisory Service | | Providing up-front funding for clients requiring travel and/or accommodation to access appropriate care | Owing to the specialised nature of later procedures, it is unlikely that all women will have a local service up to the legal limit and thus many women will be required to travel. Lack of up-front funding causes delays, particularly for vulnerable women, and with the delay the risk of experiencing a negative side-effect increases. | As a charitable provider, BPAS is asked to provide upfront funding to women even where our contract does not have the provision for us to recharge the commissioning body, which is the case approximately 50% of the time.  We are aware that this ability to fund upfront is not the case with many NHS services where women may be forced to travel sizeable distances to access even early treatments, and that women do put off attending services, particularly when later in pregnancy, to enable them to save up money for travel tickets or accommodation. |  |
| 31 | | British Society of Abortion Care Providers (BSACP) | | Key area for quality improvement 5 | **Upfront (not refund) travel and accommodation costs should be made available for those women who must travel to get abortion care.**  NICE recommendation:  1.1.4 Commissioners should consider upfront funding for travel and accommodation for women who: are eligible for the NHS Healthcare Travel Costs Scheme **and/or** need to travel to a service that is not available locally. Commissioners should make information available about any upfront funding to access services. | Poverty can cause delay in getting abortion care and abortion is time-sensitive. Women living in poverty will often be unable to meet upfront travel costs and a system of refund is ineffective at addressing the problem. Delay will result in increased risk and can sometimes result in abortion no longer being an option. It is unacceptable and perpetuates inequality if lack of funds to travel delays or prevents access. The healthcare cost of abortion versus maternity care also means there is an economic argument to support upfront NHS Healthcare Travel Costs. | BPAS Specialist Placement Service (which deals with women with co-morbidity requiring hospital-based care) have experience of many cases where the lack of funds led to delay, sometimes even beyond 24 weeks so that abortion was no longer an option.  <https://www.bpas.org/media/2074/briefing-medically-complex-women-and-abortion-care.pdf> |
| 32 | | Doctors for Choice UK | | Key area for quality improvement 4  Upfront funding for people needing to travel to access abortion care | Travel (and accommodation) costs are a significant barrier to accessing abortion care for some.  Lack of funds for travel and accommodation if needed (e.g. for second trimester surgical procedures) can result in later abortions with increased morbidity, distress and cost. | This issue disproportionally affects people with co-morbidities, those living in remote/rural areas, those on low income and vulnerable and marginalised people.  The NHS Healthcare Travel Costs Funding Scheme allows people with a low income to claim back travel costs after an abortion. But some people find it impossible to pay upfront which may lead to them having to continue with an unwanted pregnancy. | NICE recommendations 1.1.4 Commissioners should consider upfront funding for travel and accommodation for women who are eligible for the NHS Healthcare Travel Costs Scheme **and/or** need to travel to a service that is not available locally. |
| 33 | | Faculty of Sexual and Reproductive Healthcare (FSRH) | | **Key area for quality improvement 5**  **Upfront (not refund) travel and accommodation costs** | As a way of improving access to services, the NICE guideline recommends commissioners to consider *upfront* funding for travel and accommodation for women who are eligible for the NHS Healthcare Travel Costs Scheme and/or need to travel to a service that is not available locally. Commissioners should also make information available about any upfront funding to access services. | Abortion rates follow patterns of income deprivation. Abortion rates increase as levels of deprivation increase. The rate in the most deprived decile in the Index of Multiple Deprivation (IMD) is 25.2. This is over twice the rate in the least deprived decile of 11.6. The trend of abortion rates increasing as levels of deprivation increase remains consistent when the abortion data is studied at both regional and national level. Hence, many women do not have the financial resources to cover immediate, prohibitive costs associated with travel and accommodation for abortion care, making a refund an unviable option.  The NICE guideline recommendation is clear that commissioners and providers should make it easier for women to access abortion services, ensuring that specialist centres are accessible *as locally as possible* to reduce delays. When the healthcare system fails to provide this service locally, the burden should not fall on women.  Additionally, the NHS Healthcare Travel Costs Scheme has conditionalities attached to it, such as that the woman or partner must receive benefits or meet the eligibility criteria for the NHS Low Income Scheme; and that the woman must have a referral from a healthcare professional to a specialist. Whilst it is important that provision is made, in the NICE guideline, for women to access abortion care via this scheme, we believe that the “need to travel to a service that is not available locally” as specified in the guideline should always be a priority criterion, even if the woman does not qualify for the NHS Healthcare Travel Costs Scheme. | NHS. [Healthcare Travel Costs Scheme (HTCS)](https://www.nhs.uk/using-the-nhs/help-with-health-costs/healthcare-travel-costs-scheme-htcs/)  DHSC & ONS 2019. [*Abortion Statistics, England and Wales: 2018. Summary information from the abortion notification forms returned to the Chief Medical Officers of England and Wales*](https://www.gov.uk/government/collections/abortion-statistics-for-england-and-wales) |
| 34 | | Homerton University Hospital NHS Foundation Trust | | Key area for quality improvement 3 | **Upfront (not refund) travel and accommodation costs should be made available for those women who must travel to get abortion care.**  NICE recommendation 1.1.4 Commissioners should consider upfront funding for travel and accommodation for women who: are eligible for the NHS Healthcare Travel Costs Scheme **and/or** need to travel to a service that is not available locally. Commissioners should make information available about any upfront funding to access services. | Women living in poverty will often be unable to meet upfront travel costs and a system of refund is ineffective at addressing the problem. The costs of maternity care are also significantly more than abortion care and so there is an economic argument to support upfront NHS Travel costs. | Homerton receives referrals form the independent sector providers BPAS and MSI (and others) to provide second trimester surgical abortion to women who need care in an NHS setting due to co-morbidity.  We hear the stories directly from women who are in contact with us and struggling to find the funds to travel from across to the UK to London and to pay for the required overnight accommodation in local B&B/hotels. A refund system cannot give them the immediate recourse to money that some require.  BPAS Specialist Placement Service (who place women with co-morbidity requiring hospital care) have also reported cases where the lack of funds led to delay, sometimes such that abortion was no longer an option in the report form 2018 which can be found at;  <https://www.bpas.org/media/2074/briefing-medically-complex-women-and-abortion-care.pdf> |
| 35 | | North West Anglia Foundation Trust | | Key area for quality improvement 1 | Commissioners should ensure that women are not denied access to abortion based on inability to fund travel or accommodation costs. These should provided up-front. | All women need equal access to abortion which not based on ability to pay | NICE guidance |
| 36 | | RCOG | | Key area for quality improvement 4 | Travel and accommodation should be provided upfront for women who require this support. | Evidence of poor access to abortion services, especially when a woman requests a surgical procedure, which can involve long travel. |  |
| 37 | | SCM1 | | Key area for quality improvement 1  **Upfront (not refunded) travel & accommodation costs for women who have to travel out of area for an abortion** | NICE recommendation 1.1.4 states that commissioners should consider upfront funding for travel and accommodation for women who are eligible for NHS healthcare travel costs scheme and/ or need to travel to a service that is not available locally | Women that have to travel for an abortion because their local area does not provide often present at later gestations, have more complex health needs and are often the most vulnerable women. Adding the burden of travel costs to someone that nay be living in abject poverty often results in them continuing with pregnancy that do not want, cannot cope with psychology and financially. This is turn puts an increased burden on the health and social care system | BPAS specialist placement report  [www.bpas.org/media/2074/briefing-medically-complex-women-and-abportion-care.pdf](http://www.bpas.org/media/2074/briefing-medically-complex-women-and-abportion-care.pdf) |
| 38 | | SCM3 | | Provide upfront funding for travel costs to women where needed, especially where a service is not available locally | Women having an abortion often have to travel at very short notice and may have difficulty arranging funds before the appointment. There is marked variation in provision, and evidence in NICE showed travel costs were a significant barrier to access, resulting in later presentation with increased morbidity, distress and cost. | Vulnerable women are disproportionally affected, especially those with co-morbidities, later gestations, living in remote areas and with low income. Funding for travel is already available for women with low income under the NHS Healthcare Travel Costs Scheme, but this policy requires that women pay upfront and claim back costs after the abortion which may be unachievable and involve systems that women may not be able to navigate. | NICE 1.1.4 |
| **Waiting times** | | | | | | | |
| 39 | | Birth Companions | | **Abortion services during prison custody** | Birth Companions and bpas have significant concerns about women’s access to and experience of abortion services while in prison custody in England.  Women in prison have a right to healthcare provision equal to that accessed by women in the community. Yet despite this, both Birth Companions and bpas see and hear of inequalities and poor practice in abortion care for prisoners. | **Women are not being consistently supported to access abortion services in a timely way** across the estate. We have heard of a number of incidents where women who have requested abortions have had to wait for long periods of time before their request is processed. This has a number of implications. While legal abortion is safe, it is safer the earlier it is performed. After 12 weeks, access to medical abortion (the most commonly used method of abortion in the UK) is limited, with surgical abortion the only option in some areas of the country. This limits women’s choice of procedure.  We are also aware of episodes in which prisons have not given sufficient priority to enabling women to access terminations, resulting in women being released from custody before their appointment for an abortion. For a number of understandable reasons, women may find it very difficult to navigate services on their own following release, and as a result some will be unable to attend.  In some cases, delays in prison may mean women pass the 24 week threshold for abortions, and are therefore forced to continue a pregnancy against their wishes. A dating scan is crucial to a woman being able to access an abortion, but the importance of these appointments is not always understood and scans can be cancelled due to staff shortages. |  |
| 40 | | British Pregnancy Advisory Service | | Ensuring access to treatment within an time period acceptable to a client | Abortion is a safe procedure that has the lowest number of complications the earlier it is performed. Increasingly, women present to abortion care very early in pregnancy and thus waiting times are the key issue in relation to delay. This is particularly true of women with complex medical co-morbidities where availability of treatment, particularly at later gestations, is currently limited.  It is important that this area focuses on the acceptability of waiting times to individuals – as a provider we often have women who opt to wait longer than the ideal waiting time in order to access care closer to home (where a clinic may only be open one day a week), or to give them more time to consider their decision. | We are aware of areas where waiting times are longer than the NICE guidance indicates as acceptable. A measure of this would place an onus not only on providers but also on commissioners to ensure that funding is appropriately targeted to ensure the best possible care. | A number of national news stories have included figures based on FOI requests to individual CCGs which indicate long waiting periods in some areas. |
| 41 | | British Society of Abortion Care Providers (BSACP) | | Key area for quality improvement 4 | **Commissioners should monitor wait times so that referral to abortion does not exceed 2 weeks.**  NICE recommendation:  1.1.6 Ensure minimal delay in the abortion process, and ideally: provide the assessment within 1 week of the request provide the abortion within 1 week of the assessment. | Abortion care is time-sensitive. Delay will result in increased risk and can result in significant distress.  We would not want a rigid target nor excessive data collection processes in monitoring but services should be commissioned to meet these guideline requirements on waiting times, with frequent audits to ascertain this is being met and that women are satisfied with time to assessment and treatment.  Further, we want to stress the value of minimising the barriers that delay women making that first contact/abortion request. Having a co-ordinated information source would help a woman to quickly and successfully self-refer. At the moment there is no single source of information. Women in England may have to ring multiple services before they find the correct one, whereas in Ireland/Eire they have a “My Options” website and freephone call centre - <https://www2.hse.ie/unplanned-pregnancy/> – and this allows every woman to have one place she can go to identify her nearest provider. |  |
| 42 | | Doctors for Choice UK | | Key area for quality improvement 5  Abortion wait times | Reducing delays is a key theme of NICE guidelines. | Reducing delay is essential for safety, quality and choice.  Reducing delays will also save the NHS money (each day of delay costs £1.6m). | NICE recommendation  1.1.6 Ensure minimal delay in the abortion process, and ideally: provide the assessment within 1 week of the request provide the abortion within 1 week of the assessment |
| 43 | | Faculty of Sexual and Reproductive Healthcare (FSRH) | | **Key area for quality improvement 2**  **Waiting times for assessment and treatment** | The earlier an abortion is performed, the safer it is. The Department of Health & Social Care (DHSC) supports the principle that women choosing to end a pregnancy who are legally entitled to an abortion should have access to the procedure as soon as possible.    The NICE abortion care guideline clearly states that commissioners and providers should work together to ensure abortion services have the capacity and resources to deliver the range of services needed with minimal delay, and ideally provide the assessment within 1 week of the request and provide the abortion within 1 week of the assessment. Same day services should be provided when possible. Therefore, abortion services should be commissioned to meet these guideline requirements on waiting times, with frequent audits to ascertain this goal is being achieved and women are satisfied with time to assessment and treatment.  It is crucial to note that the NICE guideline tells commissioners and providers not to require women to have compulsory counselling or compulsory time for reflection before the abortion; they should rather provide or refer women for support to make a decision if women request this. | In 2018, 80% of abortions were performed under 10 weeks, increasing from 73% in 2008. This is also an increase of 3% since 2017. The proportion of abortions performed between 10-12 weeks in 2018 was 11%. This proportion has decreased since 2008 from 17%. This was probably in large part due to an emphasis on monitoring / “performance management” of waiting times through commissioning arrangements.  As evidenced in Evidence Review A pertaining to evidence submitted as part of the consultation to develop the NICE guidelines, there is good evidence that there are long waiting times and delays when accessing abortion services, and that decreasing waiting times is a key way of improving care for women.  Waiting times are often negatively impacted by delayed referral – particularly where services at different gestations are provided by different providers. See BPAS response to NICE guideline. <https://www.nice.org.uk/guidance/ng140/documents/consultation-comments-and-responses-2> | DHSC & ONS 2019. [*Abortion Statistics, England and Wales: 2018. Summary information from the abortion notification forms returned to the Chief Medical Officers of England and Wales*](https://www.gov.uk/government/collections/abortion-statistics-for-england-and-wales)  Bartlett, L.A., Berg, C.J., Shulman, H.B., Zane, S.B., Green. C.A., Whitehead, S. & Atrash, H.K. 2004. [Risk factors for legal induced abortion-related mortality in the United States](https://www.ncbi.nlm.nih.gov/pubmed/15051566). *Obstet Gynecol*. 2004 Apr;103(4):729-37.  NICE 2019. *[Termination of Pregnancy [A] Accessibility and sustainability of](https://www.nice.org.uk/guidance/ng140/documents/evidence-review)*  *[termination of pregnancy services](https://www.nice.org.uk/guidance/ng140/documents/evidence-review)*. NICE guideline tbc. Evidence reviews. April 2019  NICE 2019. [*Abortion care. Consultation on draft guideline - Stakeholder comments table*](https://www.nice.org.uk/guidance/ng140/documents/consultation-comments-and-responses-2)*. 12/04/19 to 31/05/19*  RCOG 2011. [*The Care of Women Requesting Induced Abortion*](https://www.rcog.org.uk/globalassets/documents/guidelines/abortion-guideline_web_1.pdf)(Evidence-based Guideline Number 7). |
| 44 | | North West Anglia Foundation Trust | | Key area for quality improvement 2 | Commissioners should ensure that waiting times to access abortion are ideally less than one week, with treatments completed within 2 weeks | Earlier abortions are safer and allows more choice of procedure so minimising delays is vital | NICE guidance |
| 45 | | NUPAS- National Unplanned Pregnancy Advisory Services UK | | Key area for quality improvement 1  **Waiting time from referral to procedure to be one week only** | Having an abortion is usually a very difficult time, and the sooner it is done once a decision has been made, the better it would be for the physical and psychological health of the client | Clients can currently wait varying intervals of time (sometimes over few weeks) , even after they have made a decision to have an abortion. This can be attributed to staffing issues, funding issues and other related issues | NICE abortion guidance |
| 46 | | RCOG | | Key area for quality improvement 5 | Following an initial appointment, a woman should be provided with an abortion within one week, as specified by NICE guidance. | By monitoring and reducing waiting times, more women can have earlier procedures. |  |
| 47 | | SCM1 | | Key area for quality improvement 5  **Waiting time from referral to abortion should not routinely exceed 2 weeks** | NICE recommendations 1.1.5 & 1.1.6 state that commissioners should work with providers to ensure that services have capacity and resources to offer a range of services with minimal delay (if the woman choices to wait this should be accommodated where possible) | Delay in accessing an abortion can increase the risk of abortion and also increase emotional and psychological stress of the woman. If services do not have a choice of methods at later gestations then this also minimises the woman’s choice of method (see key area number 4 above) | Heath et al (2019) A comparison of termination of pregnancy procedures: Patient choice,  emotional impact and satisfaction with care. Sexual & Reproductive Healthcare 19 (2019) 42-49  https://doi.org/10.1016/j.srhc.2018.12.002 |
| 48 | | SCM3 | | Providers should ensure that they can offer women, either themselves or through seamless pathways with other providers:   * Minimal delay – same day where feasible, and with the procedure within a week of assessment unless the woman requests further time | Choice and reducing delays were key themes of the NICE guidelines. Not all providers can offer all choices in all locations (there are advantages to community settings, nurse-delivered clinics and remote consultations for example), but they should have collaborative pathways so that women can access their choice without delay where it is not available where she presents. | There is marked variation in choice offered between providers. The development of care pathways & collaboration between different providers is rare. Reducing delay is essential for quality as it is safer, ensures the woman has more options, a better experience, and it is cheaper for the NHS (each day of delay costs £1.6m). | NICE 1.1.1, 1.1.6-8, 1.1.16, 1.6.1, 1.13.1 |
| 49 | | SCM4 | | Key area for quality improvement 1  **Ensure minimal delay in the abortion process, and ideally:**  **provide the assessment within 1 week of the request;**  **provide the abortion within 1 week of the assessment.** | Because although abortion in Britain is a very safe procedure, risk increases with increasing gestational age.  Women want speedy access to advice and then into care, once they have made the decision to end the pregnancy.  Earlier procedures are simpler and more cost-effective to provide than later procedures. | It is relatively easily measurable, although care must be taken to recognise that women may choose to delay an appointment for personal reasons and providers need to be able to evidence where that is the case to commissioners, so that providers are not penalised and women retain choice. | When considering waiting times and increase in clinical risk, it is worth noting that there are important ‘thresholds’ of risk and the key then is to avoid delaying a woman such that she is pushed from one type of procedure into another, particularly for instance, vacuum aspiration into D&E. |
| 50 | | SCM5 | | Key area for quality improvement 3  **waiting times** | Ideally women are offered short waiting times as earlier abortions are safer. Medical abortion is an option in early pregnancy. Depending on when a woman comes to the service, waiting times must be managed to offer the most choice in treatment. Consideration must be given to a woman’s desire for time to consider/counselling and for the options of abortion methods available. | Increased access to medical abortion would make financial savings and would reduce anxiety for women. |  |
| **Abortion procedures - Preventing infection** | | | | | | | |
| 51 | | SCM6 | | Key area for quality improvement 4  **HIV & STI Screening Uptake** | HIV & STI testing rates in termination of pregnancy services, whilst good/ high in some areas, is generally poor/ low.  This is in stark contrast to testing in the maternity pathway; and needs to be seen in the context of the success in diagnosing pregnant women living with HIV through the introduction of testing. | In general terms the uptake of HIV and STI testing in abortion care services is low, yet we know that women utilising these services are at heightened risk of infection. | HIV Testing in England Report 2017 tells us that the “uptake of HIV screening in pregnant women who engage with antenatal care has increased since 2011 and exceeded 98% for the first time in 2015. Positivity in all pregnant women has decreased by 21% since 2012 and rates of newly diagnosed infection decreased from 0.07 in 2011 to 0.03 in 2015”.  We have no comparable data for women undergoing an abortion; but know (i) the women are/were pregnant; (ii) have a low uptake rate of STI testing in abortion care services; and (iii) see positivity levels below those seen through the antenatal testing pathway, but given low uptakes rates cannot have confidence this reflects a lower prevalence level as opposed to, for example, those women seeking abortion who are taking-up a test happen to be those at lower risk.  The key difference is that HIV testing in the maternity pathway is opt-out.  https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\_data/file/759270/HIV\_testing\_in\_England\_2017\_report.pdf |
| 52 | | Umbrella Sexual Health Service/ University Hospitals Birmingham NHS Trust | | Key area for quality improvement 2  Preventing infection | Change in NICE guidance removes need for routine antibiotic prophylaxis in EMA; unclear on best regime for surgical TOP.  Need to consider how STI testing and risk affects this decision, and how this affects TOP provision (when TOP usually provided before STI testing results known) | Joint commissioning or provision of CCG and LA funded services | NICE guidance 2019 |
| **Abortion procedures - Early medical abortion** | | | | | | | |
| 53 | | SCM2 | | Pain management for early medical | Increasingly women are opting for early medical abortion as their treatment of choice when gestational age allows it. | There is no strong evidence on the best choice for pain relief for these women. Poor pain control may mean that the woman have an adverse experience and may not choose a medical abortion if seeking another abortion in the future | Clinical Updates in Reproductive Health  Ipas. (2019). Clinical Updates in Reproductive Health. L. Castleman & N. Kapp (Eds.). Chapel Hill, NC: Ipas. |
| 54 | | SCM2 | | Pharmacological regimens for early medical abortion at increasing gestations | Early medical abortion is associated with retained products of conception (5%) and ongoing viable pregnancy (1 to 2 %) Evidence suggests that increasing gestational age may be a factor in the increasing failure rate | Individual providers use different regimens of misoprostol. Women should be offered the most effective method so that the risk of an ongoing viable pregnancy and retained products of conception are minimised | Abortion Care  www.nice.org.uk/guidance/ng140 |
| 55 | | SCM3 | | Additional developmental areas of emergent practice:   * Increasing gestation for home use medical abortion | Current service structure is restricted owing to the 1967 Abortion Act. Decriminalisation is expected during the lifetime of this guidance which would permit more woman-centred care, but even without that some innovations could be delivered. | Delivery of better woman-centred pathways, more cost effective and less invasive | NICE 1.1.9-11, IOG/ICGP Interim Clinical Guidance and Guidelines document on Termination of Pregnancy |
| 56 | | SCM6 | | Key area for quality improvement 5  **Access to full range of treatment options for Early Medical Abortion** (nurse support; same day dispensing; simultaneous administration; home administration) | In addition to the various forms of surgical intervention available, there is now also a suite of medical methods possible in offering women a medical abortion. | (Note: I acknowledge that one or more method of facilitating a medical abortion utilise the associated medicines ‘off-licence’ and imagine this will influence the possible associated QS).  These include, in lay terms, (i) Medicine 1 at Day-1 with Medicine 2 at Day-2 or Day-3; (ii) Medicine 1 at Hour-1 and Medicine 2 at Hour-6; (iii) Medicine 1 and Medicine 2 taken simultaneously; (iv) and Medicine 1 in clinic and Medicine 2 taken at home.  One or more of these methods, not least the latter that has been possible in England since December 2018, are not yet available to women across all commissioning geographies/ providers. |  |
| **Abortion procedures - Anaesthesia for surgical abortion** | | | | | | | |
| 57 | | Birth Companions | | **Abortion services during prison custody** | Birth Companions and bpas have significant concerns about women’s access to and experience of abortion services while in prison custody in England.  Women in prison have a right to healthcare provision equal to that accessed by women in the community. Yet despite this, both Birth Companions and bpas see and hear of inequalities and poor practice in abortion care for prisoners. | Women are also not being given information about or supported to follow the necessary procedures to prepare for an abortion. Women undergoing a surgical abortion under general anaesthetic or conscious sedation will be required to fast in advance of their procedure. Due to safety concerns, women in prison are often not informed of the dates of their appointments outside the prison. Consequently, women are unable to plan and follow fasting requirements independently. A lack of communication within the prison has resulted in women attending abortion appointments only to have to rearrange because they did not fast in advance. | We believe the following changes need to be prioritised to improve abortion care during prison custody:  1.Women’s legal rights to abortion, and to dignity and privacy while they access abortion must be protected and upheld. Prisons should ensure they have clear care pathways in place for pregnant women, which include specific, detailed requirements on the provision of information and support relating to abortions and clear standards of care throughout the process. |
| 58 | | British Society of Abortion Care Providers (BSACP) | | Key area for quality improvement 2 | **The NHS should aim to reduce the geographical variation and inequality that currently exists in access to a** **choice of both method of abortion and post abortion contraception offered.**  **Ensure a woman can have medical or surgical abortion by treatment within the service to which she initially presents or following a seamless transfer of her care.**  NICE recommendations:  1.8.1For women who are having a medical abortion and will be taking the mifepristone up to and including 9+6 weeks' gestation, offer the option of expulsion at home after they have taken the misoprostol. Misoprostol can be taken at home or in the clinic or hospital[[2](https://www.nice.org.uk/guidance/ng140/chapter/Recommendations#ftn.footnote_2)]. | There is geographical variation in  Those women for whom either method is medically suitable deserve to have a choice. They should also have choice around the type of anaesthesia for surgical procedures. |  |
| 59 | | SCM3 | | Providers should ensure that they can offer women, either themselves or through seamless pathways with other providers:   * For surgical options, a choice of anaesthesia including where appropriate local anaesthesia alone, conscious sedation with local anaesthesia, deep sedation or general anaesthesia | Choice and reducing delays were key themes of the NICE guidelines. Not all providers can offer all choices in all locations (there are advantages to community settings, nurse-delivered clinics and remote consultations for example), but they should have collaborative pathways so that women can access their choice without delay where it is not available where she presents. | There is marked variation in choice offered between providers. The development of care pathways & collaboration between different providers is rare. Reducing delay is essential for quality as it is safer, ensures the woman has more options, a better experience, and it is cheaper for the NHS (each day of delay costs £1.6m). | NICE 1.1.1, 1.1.6-8, 1.1.16, 1.6.1, 1.13.1 |
| **Access to contraception** | | | | | | | |
| 60 | | British Pregnancy Advisory Service | | Supporting clients’ future fertility control | Clients who present to ToP services have often had a contraceptive failure (more than 50% of women we treat were using contraception when they conceived) and so may welcome a discussion of their options for the future.  It should be noted, however, that any measure should not be about the uptake of contraception or the forced provision of contraceptive counselling as a condition of treatment – but instead on the availability and offer of contraceptive counselling to clients accessing the service.  Fertility returns immediately after an abortion, and evidence shows that women who receive referrals into the community are less likely to be using contraception in the months following an abortion than those who were provided with contraception as a part of their ToP treatment. | It is important to recognise the constraints on the ability of ToP providers to provide all forms of contraceptive – including but not limited to funding for IUD call-back visits after EMA, training of nursing and midwifery staff to fit LARCs, and funding for all different types of contraception including less-used types such as the vaginal ring.  Although existing regulation requires independent providers to offer contraceptive counselling, a quality standard in this area would place additional onus on commissioners and NHS providers. | Aiken ARA, Lohr PA, Aiken CE, Forsyth T, Trussell J. Contraceptive method preferences and provision after termination of pregnancy: a population-based analysis of women obtaining care with the British Pregnancy Advisory Service. BJOG 2016; DOI: 10.1111/1471-0528.14413.  FSRH Guideline – Contraception After Pregnancy (2017) <https://www.fsrh.org/documents/contraception-after-pregnancy-guideline-january-2017/contraception-after-pregnancy-guideline-final27feb.pdf> |
| 61 | | British Society of Abortion Care Providers (BSACP) | | Key area for quality improvement 2 | **The NHS should aim to reduce the geographical variation and inequality that currently exists in access to a** **choice of both method of abortion and post abortion contraception offered.**  **Commissioners should ensure that provision of all methods of contraception is funded – with providers getting payment in addition to tariff for the abortion care.**  NICE recommendations:  1.15.3 Providers should ensure they can provide the contraceptive implant, and that women who choose this method are offered it on: the day of the surgical abortion or the day they take mifepristone (for medical abortions). | There is geographical variation in quality of care around post-abortion contraception. We know that in some areas of the country abortion commissioning does not presently specify to this level and services do not all meet this standard. With diminishing alternative sources (via general practice or community clinics) this opportunity to tackle geographical variation/inequality should be taken.  All women are not aware of all contraceptive options. Many have unfounded concerns about certain methods. They deserve individualised support with making a choice. So providers should not only ensure their teams have healthcare practitioners (HCPs) with the skills to fit/insert/supply chosen methods of contraception but also that staff have been trained to do an effective/supportive contraception choices discussion with women who need/desire post-abortion contraception. |  |
| 62 | | Doctors for Choice UK | | Key area for quality improvement 3  Access to all methods of contraception after an abortion | There is a wide variation in provision of post abortion contraception across providers.  It can take weeks (even months) to get an appointment for contraception at GP and sexual health services. | Provision of effective contraception immediately after an abortion is associated with higher uptake, higher continuation rates and fewer unwanted pregnancies in the future.  It also saves money - every £1 spent on contraception saves the NHS £9. | NICE recommendations 1.15.2 Providers should ensure that healthcare professionals have the knowledge and skills to provide all contraceptive options.  1.15.3 Providers should ensure they can provide the contraceptive implant, and that women who choose this method are offered it on: the day of the surgical abortion **or** the day they take mifepristone (for medical abortions). |
| 63 | | Faculty of Sexual and Reproductive Healthcare (FSRH) | | **Key area for quality improvement 3**  **Access to the full range of contraceptive methods in abortion services** | Almost half of pregnancies in Britain are unplanned or ambivalent. Abortion rates have generally increased by 4% since 2017 and are now the highest number on record. It is estimated that more than half of unplanned pregnancies in Britain end in abortion.  Women need access to contraception so that they can avoid unplanned pregnancies. If women cannot access contraception through abortion services, they might risk another unplanned pregnancy shortly after the previous pregnancy.  The NICE guideline on abortion care clearly recommends that commissioners and providers should ensure that the full range of reversible contraceptive options is available for women on the same day as their surgical or medical abortion, whilst taking into account timing of provision may vary if a woman opts for a medical abortion. It also recommends that providers should ensure that healthcare professionals have the knowledge and skills to provide all contraceptive options.  The FSRH guideline on Contraception after Pregnancy recommends that all women who are pregnant should receive the highest standard of contraceptive care, regardless of pregnancy outcome and irrespective of where they receive their care and by whom care is provided. The guideline recommends:   * Services providing care to pregnant women should be able to offer all appropriate methods of contraception, including Long-Acting Reversible Contraception (LARC), to women before they are discharged from the service. * Insertion of intrauterine contraception (IUC) and progestogen-only implants (sub-dermal implant, SDI) - LARCs - at the time of abortion is convenient and highly acceptable to women. This has been associated with high continuation rates and a reduced risk for another unintended pregnancy than when provision of IUC and IMP are delayed. * Choice of contraception should be initiated at the time of abortion or soon after, as sexual activity and ovulation can resume very soon after abortion. * A woman’s chosen method of contraception should be initiated immediately after abortion (medical and surgical). * All clinicians involved in the care of pregnant women should provide the opportunity to discuss contraception. * Services involved in the care of pregnant women should have agreed pathways of care to local community sexual and reproductive health (SRH) services for women with complex medical conditions or needs which may require specialist contraceptive advice.   Provision of highly effective contraceptive methods at the time of abortion has distinct advantages, as the woman is known not to be pregnant, her motivation to use effective contraception may be high, and she is already accessing healthcare services. Evidence from randomised controlled trials has shown that immediate initiation of contraception is associated with higher continuation rates and reduced risk of another unintended pregnancy.  The provision of LARC, the most effective methods of contraception, at the same time as abortion is both convenient and highly acceptable to women who wish to initiate them, avoiding the need for an extra visit which has been identified as a barrier to the uptake of LARC after abortion. Women who choose to commence LARC immediately after abortion have a significantly reduced likelihood of undergoing another abortion within 2 years, compared with women provided with medium-acting, short-acting or no contraceptive methods.  The abortion assessment visit is an excellent opportunity for clinicians to discuss a woman’s future fertility intentions and use of effective contraception after abortion. Evidence from the UK suggests women value the opportunity to discuss contraception and to be offered their chosen method. One qualitative UK study reported that more than half of the women interviewed wanted or were happy to address contraceptive needs at the pre-abortion assessment visit and suggested that it was an ‘obvious’ time to do so.  All national SRH strategies across the UK highlight the importance of contraception for women after pregnancy, especially for women identified as being from vulnerable groups who are at high risk of future unintended pregnancy. Accessing timely contraceptive counselling and the full range of contraceptive methods will enable women to plan the number of children they would like to have and the optimum spacing between them.  Unintended pregnancies can also accrue increased costs to the NHS, contributing to higher demand for maternity services and abortion care. Public Health England estimates that for every £1 spent on publicly-funded contraception £9 is saved in averted direct public sector healthcare and nonhealthcare costs (£3.68 in direct healthcare costs to the NHS, including birth costs, abortion costs, miscarriage costs and ongoing child health care costs). | More than 50% of women have been reported to resume sexual activity within two weeks after abortion. Therefore, it is paramount that women have immediate access to contraception in abortion services. FSRH Service Standards for Sexual and Reproductive Healthcare services recommend that abortion providers should advise and facilitate the supply of contraception, including LARC methods, as part of the episode of care.  Evidence by independent providers such as BPAS and Marie Stopes, who provide most abortion care, shows that some CCGs do not adequately fund contraception as an integral part of post-abortion care. The evidence points out that there are a number of areas where less widespread forms of hormonal contraception such as the patch or vaginal rings are not funded by default. It also shows independent providers’ clinics have encountered difficulties, with some commissioners who have asserted that they would not fund LARC provision within the abortion service as women are able to access those services in local SRH clinics.  What compounds the problem is that SRH services are struggling due to successive cuts to the Public Health budget. Not commissioning these contraceptive methods in abortion services because women can supposedly access them in SRH services means that women are put at unnecessary risk of further unplanned pregnancy.  There is significant variation in the provision of contraceptive services and counselling within abortion services, since the level of integration is dependent on the understanding of individual Clinical Commissioning Group (CCG) commissioners that contraception should be provided as part of the abortion service. Even when a CCG does fund contraception for a specific service, it may still be the case that some methods of contraception are not commissioned; in such situations people experience substantial lack of choice. | [NICE 2019. *Abortion care. NICE guideline*](https://www.nice.org.uk/guidance/ng140).  DHSC & ONS 2019. [*Abortion Statistics, England and Wales: 2018. Summary information from the abortion notification forms returned to the Chief Medical Officers of England and Wales*](https://www.gov.uk/government/collections/abortion-statistics-for-england-and-wales)  FSRH 2017. [*Contraception After Pregnancy*](https://www.fsrh.org/standards-and-guidance/documents/contraception-after-pregnancy-guideline-january-2017/). London: FSRH  FSRH 2016. [*Service Standards for Sexual and Reproductive Healthcare*](https://www.fsrh.org/standards-and-guidance/documents/fsrh-service-standards-for-sexual-and-reproductive-healthcare/). London: FSRH  Wellings, K. et.al 2013. [*The prevalence of unplanned pregnancy and associated factors in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3)*.](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3898922/) *Lancet* 382(9907): 1807–1816  PHE 2018. [*Contraception: Economic Analysis Estimation of the Return on Investment (ROI) for publicly funded contraception in England*](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/730292/contraception_return_on_investment_report.pdf). London: Public Health England  Heller R, Cameron S, Briggs R, *et al.* [Postpartum contraception: a missed opportunity to prevent unintended pregnancy and short inter-pregnancy intervals](https://www.ncbi.nlm.nih.gov/pubmed/26645197). *J Fam Plann Reprod Health Care* 2016;**42**:93–98  Bigelow CA, Bryant AS. [Short interpregnancy intervals: an evidence-based guide for clinicians](https://www.ncbi.nlm.nih.gov/pubmed/26185917). *Obstet Gynecol Surv* 2015;**70**:458–464  Smith GCS, Pell JP, Dobbie R. [Interpregnancy interval and risk of preterm birth and neonatal death: retrospective cohort study](https://www.bmj.com/content/327/7410/313). *Br Med J* 2003;**327**:313  Department of Health 2013. [*A Framework for Sexual Health Improvement in England*](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/142592/9287-2900714-TSO-SexualHealthPolicyNW_ACCESSIBLE.pdf)  RCOG 2011. [*The Care of Women Requesting Induced Abortion*](https://www.rcog.org.uk/globalassets/documents/guidelines/abortion-guideline_web_1.pdf)(Evidence-based Guideline Number 7).  AGC 2018. [*Cuts to contraceptive care deepen as new data reveal half of councils closed sites providing contraception since 2015 – September 2018*](http://theagc.org.uk/our-work/)  FSRH 2019. [*FSRH statement: number of women accessing services falls by 15% since 2014-15*](https://www.fsrh.org/news/fsrh-statement-number-of-women-accessing-services-falls-by-15/)  BPAS 2019. [*Access to contraception. bpas submission to the APPG on Sexual and Reproductive Health – March 2019*](https://www.bpas.org/media/3147/bpas-submission-srh-appg-access-to-contraception.pdf).  APPG SRH final report inquiry access to contraception - forthcoming |
| 64 | | Homerton University Hospital NHS Foundation Trust | | Key area for quality improvement 1 | **Contraception choice discussions with trained providers and immediate post-abortion supply/insertion of LARC methods (when chosen) from trained staff**.  NICE recommendations 1.15.2 Providers should ensure that healthcare professionals have the knowledge and skills to provide all contraceptive options.  1.15.3 Providers should ensure they can provide the contraceptive implant, and that women who choose this method are offered it on: the day of the surgical abortion **or** the day they take mifepristone (for medical abortions). | There is geographical variation of commissioning standards and quality of care for post-abortion contraception.  Abortion for an unintended pregnancy is an opportunity to avoid further unintended conception by starting contraception.  LARC is a highly cost-effective Public Health Intervention. Public Health England estimates that for every £1 spent on publicly-funded contraception £9 is saved in averted direct public sector healthcare and nonhealthcare costs (£3.68 in direct healthcare costs to the NHS, including birth costs, abortion costs, miscarriage costs and ongoing child health care costs). | Colleagues in our service are aware of services in parts of London that do not offer all LARC (long-acting reversible contraception) at the time of surgical abortion. |
| 65 | | North West Anglia Foundation Trust | | Key area for quality improvement 3 | All women should be provided with the contraception of their choice at the time of the abortion. This should be funded appropriately on top of the national tariff. Counselling should focus on improving uptake of LARC. | Women are more likely to take up the offer of contraception at the time of abortion compared to distant to it. LARC provided at the time of abortion reduces repeat abortion. Services should be properly funded to provide contraception | NICE |
| 66 | | NUPAS- National Unplanned Pregnancy Advisory Services UK | | Key area for quality improvement 3  **Full range of contraceptive provision to be made for all at time of Abortion** | If commenced on reliable contraception, especially LARCS at time of abortion, incidence of unwanted pregnancies could be reduced | Statistics published in UK showing rates of abortion show steady increase in rate of abortion in ages 30 years and over . These clients are usually are good candidates for considering long term reversible contraceptive methods |  |
| 67 | | RCOG | | Key area for quality improvement 1  Post abortion immediate contraception provision eg at end of surgical TOP | Evidence shows certain groups of women do not go through with securing LARC/definitive contraception after abortion, possibly resulting in repeat pregnancy and repeat abortion | Women do wish for contraception but do not ‘get round to it’, cost implications of repeat abortion vs LARC | Include decision aid for which contraception to choose as part of abortion work up. |
| 68 | | Royal College General Practitioners | | Key area for quality improvement 1  A. The number of women who are offered information about contraception at the pre termination appointment. B. The number of women who want contraception who have contraception started at the time of termination of pregnancy | When women are accessing care for termination of pregnancy, it is essential that they are offered information on contraception and provided with their contraception of choice if they wish to have this. This may be inserted/ commenced on the day of the termination to prevent further pregnancies in many cases | 1/4 terminations are performed on women who have had a previous termination (Schunman C. 2006). Specialist contraceptive counselling and provision after termination of pregnancy improves uptake of long-acting methods but does not prevent repeat abortion: a randomized trial <https://academic.oup.com/humrep/article/>  21/9/2296/2938951). Many of these women have to attend their GP surgery or a sexual health clinic after their termination is complete, often with a delay to commencing contraception. If the clinics providing termination care were adequately staffed and trained, then this contraception could be provided at an earlier stage, preventing further unwanted pregnancies | This relates to NICE NG140 recommendation 1.2.6 “Ask women if they want information on contraception, and if so provide information about the options available to them”  The Faculty sexual and reproductive health and clinical guideline 2017. “Contraception after pregnancy” (https://www.fsrh.org/standards-and-guidance/documents/contraception-after-pregnancy-guideline-january-2017) clearly details the gold standard of treatment options available:   * Abortion service providers should be able to offer all methods of contraception, including LARC, to women before they are discharged from the service after abortion. * Abortion services should ensure that there are sufficient numbers of staff able to provide IUC or IMP so that women who choose these methods and are medically eligible can initiate them immediately after abortion. * Women who are unable to be provided with their chosen method of contraception should be informed about services where their chosen method can be accessed. A temporary (bridging) method should be offered until the chosen method can be initiated. * Abortion services should have agreed pathways of care to local specialist contraceptive services [e.g. community sexual and reproductive health (SRH) services] for women with complex medical conditions or needs which may require specialist contraceptive advice. |
| 69 | | SCM1 | | Key area for quality improvement 3  **All women accessing abortion services should have the opportunity to obtain their contraceptive method of choice including LARCs** | NICE recommendations 1.15.1 – 1.15.5  Recommendations state that commissioners and providers should offer the full range of contraceptive services including LARCs, that staff are knowledgeable and trained as appropriate, that services can offer the fitting of LARCs at the time of the abortion so that women do not need to return to the service (unless they choose to) | Wide variation in commissioning, contracting and provision of contraception throughout England.  Extensive changes to commissioning of Sexual Health Services have also meant that women find it very difficult to access LARCs outside of the abortion service (at GP or local SHS) which may result in subsequent unplanned pregnancy.  Training of all staff working in abortion services is vital to ensure that women get the most appropriate unbiased information and access to the contraceptive method of their choice. |  |
| 70 | | SCM2 | | Delivery of contraception at the time of abortion | To reduce the risk of recurrent unplanned pregnancy | 1 in 3 women have an abortion in their life time and of those having 40% will have more than one abortion. Providing high quality information and counselling for contraception at the time of the abortion is effective at reducing the risk of repeat unplanned pregnancy | FSRH Guideline (January 2017) Contraception After Pregnancy |
| 71 | | SCM3 | | Ensure that the full range of reversible contraceptive options (depot medroxyprogesterone acetate [DMPA], contraceptive implant, intrauterine methods, oral contraceptives, contraceptive patches, vaginal rings or barrier contraception) is available for women on the same day as their surgical or medical abortion | There is currently marked variation in provision depending on local contracting and skills of the provider. Where providers cannot offer immediate access to effective contraception, waiting times from their GP or family planning service are often excessive. Immediate provision of effective contraception is associated with higher uptake, higher continuation rates and lower subsequent unwanted pregnancies | For every £1 spent on contraception the NHS saves £9. Immediate provision of effective contraception is better both for the woman and the wider NHS | NICE 1.15.1, FSRH Clinical Guideline: Contraception After Pregnancy, 2017 |
| 72 | | SCM4 | | Key area for quality improvement 5  **Improving access to contraception** | It is important that women are offered a choice of contraception (including but not exclusively long-acting methods) at the time of the abortion as the risk of a subsequent pregnancy returns within a very short space of time. Women are more likely to take up a contraceptive method if it is supplied/fitted at the time of the abortion rather than at an interval afterwards. | Many commissioners use contraception uptake as a ‘quality’ indicator for the providers but that is not appropriate in a service which respects women’s autonomy.  The key quality indicator should be that women, at the point of an abortion, are offered immediate access to the contraceptive method of their choice (recognising the limitations of IUC fitting in the case of medical abortion). That way the indicator speaks to the quality of staff training and competence, and the availability of a good range of methods. |  |
| 73 | | SCM6 | | Key area for quality improvement 2  **Contraception Provision** | Providing active advice, offer and supply of the full range of contraception to women as part of the termination of pregnancy care pathway is an important element of supporting women to avoid the need to undergo more than one abortion procedure. NICE QS129 states that *“Women who request an abortion discuss contraception with a healthcare practitioner and are offered a choice of all methods when they are assessed for abortion and before discharge”*. | Why most/ all providers of abortion care report that they make an active offer of contraception to women, as in all areas of healthcare it is likely that this ‘offer’ takes many forms.  What we do know is that uptake rates vary materially, as does the % of contraception provided that is user vs. non-user dependent in method (the latter being much more effective in ‘real-life use’ than the former). |  |
| 74 | | SCM6 | | Key area for quality improvement 3  **LARC Provision**  (excluding injections/ depo-provera) | Continuing from QI-2 above, it is recognised that as a result of both the day-to-day non-user dependent nature of LARC contraceptive methods, and their length of ‘coverage’/ effectiveness; they provide a ‘best in class’ clinical offer to women as well as an efficient and cost effective health intervention for the taxpayer.  Increasingly injectable contraception, which is only effective for 12-weeks, is not spoken of as a LARC and indeed is excluded from the metrics utilised by PHE to measure LARC use/ uptake. | Uptake rates vary widely, indicating that the form of offer/ perception of access varies from provider to provider (potentially through differing expectations across commissioners).  Note: Provider organisations often cite the potential of ‘unintended consequences’ as a rationale for not holding to a ‘KPI’ for LARC uptake (that setting a fixed % target could inadvertently lead to a deterioration of choice as providers feel pressure to meet a LARC threshold). I have some sympathy with this view, and would recommend (and have modelled locally) a wish to see an ‘increase’ – a reasonable expectation when considering the weight of information available for women on the benefits of choosing LARC. |  |
| 75 | | Umbrella Sexual Health Service/ University Hospitals Birmingham NHS Trust | | Key area for quality improvement 4  Improving access to contraception | Current suboptimal provision of standard contraception and LARC, due to lack of clinicians trained to counsel and provide this.  Often not provided in a timely manner, or “passed on” to GP or CASH services to provide, missing window of opportunity. | Need for defining “appropriately trained” ie: DFSRH, LoC.  Need for this to be within contracts, appropriately remunerated | NICE guidance TOP 2019  FSRH Contraception After pregnancy Guidance |
| **Follow-up care and support** | | | | | | | |
| 76 | | RCOG | | Key area for quality improvement 3  Support for women following a diagnosis of fetal anomaly | Following a diagnosis of fetal anomaly where the woman wishes to terminate, she should have access to high quality, personalised support. | All Trusts which provide abortion services should implement the national bereavement care pathway for termination of pregnancy for fetal anomaly |  |
| 77 | | Royal College General Practitioners | | Key area for quality improvement 2  The number of GPs informed that a woman has had a termination of pregnancy completed (with consent) to enable follow up | To ensure on-going continuity of care it is important that the central GP patient record is kept up to date and sharing of information regarding termination of pregnancy is the gold standard. If the GP knows a patient has had a termination of pregnancy, follow up can be provided to ensure psychological support is available and any contraception is continued. This information does not always reach the GP making decisions regarding care when complications arise, or for contraception advice difficult. | Sharing of information does not always happen between primary care and termination providers due to several reasons, including patient consent or clinic protocols. Since women with complications present to primary care, and any contraception commenced needs to be continued or removed (coil, implant) in primary care, this information is essential to provide on-going effective seamless patient care. | Unknown |
| 78 | | Royal College of Midwives | | Key area for quality improvement 5  **Appropriate follow up – including advice regarding contraception and access to national support groups** | Provision of follow-up care, including aftercare and support is variable. | Women may need support following abortion for a number of reasons for example: management of future fertility, access to support, and in the event of complications. | Royal College of Obstetricians and Gynaecologists (2015) Best practice in comprehensive abortion care <https://www.rcog.org.uk/globalassets/documents/guidelines/best-practice-papers/best-practice-paper-2.pdf> |
| 79 | | SCM5 | | Key area for quality improvement 5  **follow up support** | It is important that women know how to access support after an abortion. It is hard to predict how they will feel and when support might be needed eg. the due date of a baby can be a trigger for some women. | Targeted support from professionals is important and effective. The knowledge that a support service eg. telephone counselling is available for them would be reassuring to women even if they do not choose to use it. |  |
| 80 | | Umbrella Sexual Health Service/ University Hospitals Birmingham NHS Trust | | Key area for quality improvement 5  Follow-up and support after an abortion | Women may experience barriers to appropriate follow-up due to factors such as distance from TOP provider, need for confidentiality, transport.  Access to appropriate medical follow-up relies on clear triage and pathways between ISP, primary and secondary care and SRH services. | Need to define who requires medical follow-up, how to triage this and who should deliver this.  Maximum wait times for this should exist in ISPs, who may not have doctors on site or be open every weekday, and where to access OOH advice and medical input (eg: direct admission to gynae unit if required) | NICE guidance 2019 |
| **Additional areas - Training for healthcare professionals** | | | | | | | |
| 81 | | British Society of Abortion Care Providers (BSACP) | | Key area for quality improvement 3 | **It must be ensured that GPs in training and student doctors, nurses and midwives can have practical experience of abortion services and procedures during their training programmes.**  **It must be ensured that all O&G Schools can provide practical experience of abortion services and procedures; and training in abortion skills to all its trainees.**  NICE recommendations:  1.1.12 Trainee healthcare professionals and students who may care for women who request an abortion (for example nurses, midwives, and GPs) should have the chance to gain experience in abortion services during their training.  1.1.13 For specialities that include training in abortion as part of the core curriculum: ensure all trainees have the training, unless they opt out due to a conscientious objection include practical experience of abortion services and procedures in the curriculum.  1.1.14 If a trainee's placement service does not provide abortions, the trainee should gain experience with whoever is providing this service (either in the NHS or in the independent sector). | Training and developing the future abortion care workforce of the future is vital to ensure sustainability.  Where abortion services are limited to just a few providers, with subsequent minimal exposure to abortion amongst the workforce, then this serves to compound existing workforce and training issues and also perpetuate stigma for women who need to access abortion whereas exposure to abortion care services for any HCPs who deal with other areas of women’s reproductive health will reduce the stigma of abortion and encourage a future committed workforce. | Doctors for Choice UK Position Statement on Training and workforce  <https://www.doctorsforchoiceuk.com/position-statements>  FSRH consultation response: Facing the Facts, Shaping the Future – a draft health and care workforce strategy for England to 2027 by HEE – March 2018  <https://www.fsrh.org/documents/fsrh-consultation-response-hee-health-care-workforce-strategy/> |
| 82 | | Doctors for Choice UK | | Key area for quality improvement 1  Healthcare Professional student and trainee abortion education | Abortion education in undergraduate education for medical, nursing and midwifery students varies throughout the UK, with some institutions having no formal teaching or assessment on the clinical aspects of abortion care.  Many NHS trainees are unable to gain experience or training in abortion care as it isn’t provided in their local NHS units. | It is crucial for workforce sustainability that HCP students and trainees are exposed to good quality abortion education and trainees have access to clinical experience | NICE recommendations  1.1.12 Trainee healthcare professionals and students who may care for women who request an abortion (for example nurses, midwives, and GPs) should have the chance to gain experience in abortion services during their training.  1.1.13 For specialities that include training in abortion as part of the core curriculum: ensure all trainees have the training, unless they opt out due to a conscientious objection include practical experience of abortion services and procedures in the curriculum.  1.1.14 If a trainee's placement service does not provide abortions, the trainee should gain experience with whoever is providing this service |
| 83 | | Faculty of Sexual and Reproductive Healthcare (FSRH) | | **Key area for quality improvement 4**  **Training for medical and non-medical healthcare professionals to deliver abortion care** | The NICE abortion care guideline clearly states that trainee healthcare professionals and students who may care for women of reproductive age should have the chance to gain experience in abortion services during their training. For Specialties that include training in abortion as part of the core curriculum, it states that all trainees should have the training, unless they opt out due to a conscientious objection. If a trainee's placement service does not provide abortions, the trainee should gain experience with whoever is providing this service either in the NHS or in the independent sector. | The way abortion care is commissioned and delivered has an impact on doctors’ access  to training, while the low prestige and stigma that can be associated with abortion care affect morale within those providing abortion care.  Most abortion care is provided in the independent sector. This has been identified as a significant issue for clinical training and mentorship of clinicians undertaking abortions across all gestations, but particularly for later gestations. Junior doctors are finding it difficult to access training, as there are fewer NHS consultants working in abortion care. There is a lack of role models and career pathways in abortion care.  Therefore, there is a serious risk that the future workforce will continue not to be trained to provide this essential care for women. Over the last decade, only slightly more than 20 people have successfully completed the FSRH Special Skills Module in abortion care.  The independent sector has neither the resources nor the responsibility to provide training, and as the amount of abortions performed in the independent sector increases, the opportunities for training in NHS facilities decrease.  The crisis is particularly acute when it comes to abortion services for women with complex co-morbidities and/or in need of a late-term abortion. According to the RCOG, there are dwindling numbers of consultants providing this service in the UK, with few doctors in training who will be in position to carry out these procedures in the future.  Further compounding the problem, the tariff used by CCGs is similar for medical, surgical and complex cases. However, costs are greater for abortions taking place at a later  gestation and/or where there are additional complexities. Commissioning must not be based  on a single tariff, but instead based on the complexity of the procedure, which is determined  by each woman’s individual needs. CCGs should commission the training of doctors and other staff in abortion services.  Additionally, the current legal framework also has an impact on healthcare professionals’ willingness to undergo training, as abortion care is still a matter of criminal law in England. | RCOG 2011. [*The Care of Women Requesting Induced Abortion*](https://www.rcog.org.uk/globalassets/documents/guidelines/abortion-guideline_web_1.pdf)(Evidence-based Guideline Number 7).  DHSC & ONS 2019. [*Abortion Statistics, England and Wales: 2018. Summary information from the abortion notification forms returned to the Chief Medical Officers of England and Wales*](https://www.gov.uk/government/collections/abortion-statistics-for-england-and-wales)  RCOG 2017. [*Abortion Care: Our Responsibility*](https://www.rcog.org.uk/globalassets/documents/members/membership-news/og-magazine/spring-2017/abortion-care-services.pdf)  RCOG 2017. [*The Royal College of Obstetricians and Gynaecologists submission to the APPG on Population, Development and Reproductive Health*](http://www.appg-popdevrh.org.uk/RCOG%20Submission%20APPG%20PDRH%20Abortion%20UK.pdf)*. Call for evidence on Abortion in the Developing World and UK*.  To support NICE recommendations focused on workforce and training, FSRH draws attention to three key qualifications that are relevant for healthcare professionals working in abortion services. Their inclusion in the standards would be of particular use to commissioners, healthcare professionals and those responsible for training curriculums:  1. The FSRH Special Skills Module in Abortion Care. FSRH and the Royal College of Gynaecologists and Obstetricians (RCOG) continue to work closely to align our qualifications in this area where viable. <https://www.fsrh.org/about-the-special-skills-module-ssm-abortion-care/>  2. The FSRH Diploma. <https://www.fsrh.org/education-and-training/diploma--nurse-diploma/>  3. Letter of Competence Subdermal Contraceptive Implants Techniques Insertion Only (LoC SDI-IO) <https://www.fsrh.org/education-and-training/letter-of-competence-subdermal-implants-loc-sdi-insertion-only/> |
| 84 | | Homerton University Hospital NHS Foundation Trust | | Key area for quality improvement 4 | **Student midwives and nurses and undergraduates studying Medicine must have practical experience of abortion services and procedures during their training programmes.**  *NICE recommendations*  *1.1.12 Trainee healthcare professionals and students who may care for women who request an abortion (for example nurses, midwives, and GPs) should have the chance to gain experience in abortion services during their training.*  *1.1.13 For specialities that include training in abortion as part of the core curriculum: ensure all trainees have the training, unless they opt out due to a conscientious objection include practical experience of abortion services and procedures in the curriculum.*  *1.1.14 If a trainee's placement service does not provide abortions, the trainee should gain experience with whoever is providing this service (either in the NHS or in the independent sector).*  *Commissioners will need to work with national organisations such as Health Education England to agree changes to training curriculums.* | Training and developing the future abortion care workforce of the future is vital to ensure sustainability.  Where abortion services are limited to just a few providers, with subsequent minimal exposure to abortion amongst the workforce, then this serves to compound existing workforce and training issues and also perpetuate stigma for women who need to access abortion whereas exposure to abortion care services for any HCPs who deal with other areas of womens reproductive health will reduce the stigma of abortion and encourage a future committed workforce. | At Homerton we have students of various professional backgrounds attending as observers in the abortion care service and receive positive feedback.  We offer medical students from our aligned Medical School (QMUL) but also from UCL .  Doctors for Choice UK Position Statement on Training and workforce  <https://www.doctorsforchoiceuk.com/position-statements>  FSRH consultation response: Facing the Facts, Shaping the Future – a draft health and care workforce strategy for England to 2027 by HEE – March 2018  <https://www.fsrh.org/documents/fsrh-consultation-response-hee-health-care-workforce-strategy/> |
| 85 | | North West Anglia Foundation Trust | | Key area for quality improvement 4 | Healthcare professionals potentially involved in abortion care (eg GPs, O and G trainees, nurses, medical students) should all have access to good quality training | Access to training for healthcare professionals can be difficult as the majority of abortion work is done in the third sector. Facilitating training within these organisations is vital | NICE |
| 86 | | Royal College of Midwives | | Key area for quality improvement 3  **Appropriate training for staff, including midwives, to ensure, amongst other things, that all staff are able to refer onwards with accurate and current information on alternative services available** | There is evidence that women prefer nurse-midwife-led services over physician-led services. | Nurse and midwife led services are more cost effective.  There is also evidence that there is a shorter time between referral and assessment in nurse-midwife led services compared with physician-led services.  However, nurse-midwife led services are hindered by shortfalls in training.  Please note, workforce pressures have an impact on the availability of training for midwives and the RCM continues to campaign for staff shortages to be addressed. | Sjöström S, et al. (2016) Medical Abortion Provided by Nurse-Midwives or Physicians in a High Resource Setting: A Cost-Effectiveness Analysis. <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0158645>  Royal College of Midwives (2018) State of Maternity Services – England <https://www.rcm.org.uk/media/2373/state-of-maternity-services-report-2018-england.pdf> |
| 87 | | Royal College of Midwives | | Key area for quality improvement 4  **Dignified care – finding ways to reduce the stigma around abortion** | There is good evidence that there is a stigma associated with abortion. | Women who have had abortions experience fear of judgment, self‐judgment and a need for secrecy. Secrecy is associated with increased psychological distress and social isolation.  Aside from the negative impact on women’s experiences and health, negative experiences may cause delays both in terms of accessing the service and in any subsequent presentations. | Hansscmidt, F. (2016) Abortion Stigma: A Systematic Review <https://onlinelibrary.wiley.com/doi/full/10.1363/48e8516> |
| 88 | | SCM1 | | Key area for quality improvement 2  **Educational facilities should ensure that all trainee doctors, nurse and midwives have access to theoretical and practical training as part of the standard curriculum** | NICE recommendation 1.1.11 – 1.1.14 state that abortion providers should maximise the role of nurses and midwives, training should be provided for all those that want to acre for women undergoing an abortion unless they choose to opt out | Majority of abortions are carried out at less than 10 weeks by medical methods which can easily be managed by nurses and midwives without the need for medical intervention.  Making abortion part of the core curriculum for undergraduate student doctors, nurses & midwives would normalise the practice of abortion and help reduce the stigma thatched to those that work in abortion services | DH abortion statistics  Doctors for Choice position on training and workforce  [www.doctorsforchoiceuk.com/position-statements](http://www.doctorsforchoiceuk.com/position-statements) |
| 89 | | SCM3 | | Additional developmental areas of emergent practice:   * Increased role of nurses | Current service structure is restricted owing to the 1967 Abortion Act. Decriminalisation is expected during the lifetime of this guidance which would permit more woman-centred care, but even without that some innovations could be delivered | Delivery of better woman-centred pathways, more cost effective and less invasive | NICE 1.1.9-11, IOG/ICGP Interim Clinical Guidance and Guidelines document on Termination of Pregnancy |
| 90 | | SCM3 | | Commissioners and service providers must ensure that training can be delivered by the trainee’s local provider whether this is in the NHS or independent sector:   * Trainee healthcare professionals who may care for women should gain experience with abortion services   Where abortion care is part of the core curriculum, trainees should have practical experience | In many areas there is no provision for NHS staff to gain experience or training in abortion care as it is delivered outside of their NHS unit. This has resulted in a shortage of clinicians with the skills to deliver the service | Even though abortion is one of the commonest procedures delivered within gynaecology, there are currently only five trainees registered to train in abortion care, and only one to later gestations. This is largely owing to lack of opportunity to experience the field, with independent sector providers not integrated with training programmes. | NICE 1.1.12-14 |
| 91 | | SCM5 | | Key area for quality improvement 4  **training of staff** | Respect for women having an abortion can be shown verbally and non verbally. Women report that the way they are treated when having an abortion greatly affects their experience. | Staff working in abortion care report that use of respectful language is important to them as well as to clients.It can improve the working environment for all. |  |
| Additional areas - Commissioning | | | | | | | |
| 92 | | British Society of Abortion Care Providers (BSACP) | | Key area for quality improvement 1 | **Commissioners (and providers) must ensure that contracts for abortion care are financially adequate for sustainable services that can offer both quality care and provide training.**  *Within the scope for HG140 NICE identified a service configuration question 4.1 What strategies ensure the sustainability of a safe and accessible termination of pregnancy service?*  It seems there were no recommendations that address the fundamental of the commissioning process but we wish to raise the suggestion that it could be picked up through this Quality Standards process, because this is such a crucial and fundamental issue. | A “mixed economy” of providers (independent sector and NHS) with networking and collaboration facilitated across a geographical area is required for a stable and sustainable provision of high-quality abortion care. The recent situation in the last few years of restrictive tenders has resulted in fragmentation and unhealthy competition. Standards should require collaborative working; and commissioning from a variety of providers.  Many NHS Trusts have opted to stop offering services with subsequent negative effects on the whole system. These reductions in NHS provision have had a particularly deleterious effect on the care of women with co-morbidity and on training the future workforce of abortion providers (see Key Point 3). | Commissioners have a duty to report local variations in commissioning to NHSE and NHSI, but they do not do this, despite 70% of abortions being delivered outside of PbR by within the independent sector.  Offering contracts where the payments are significantly lower than national tariff and are “below-cost” is clearly a way to create an unstable and unsustainable system but this happens. |
| 93 | | Homerton University Hospital NHS Foundation Trust | | Key area for quality improvement 5 | **Commissioners (and providers) must ensure that contracts for abortion care are financially sustainable.**  *Within the scope for HG140 NICE identified a service configuration question 4.1 What strategies ensure the sustainability of a safe and accessible termination of pregnancy service?*  It seems there were no recommendations that address the fundamental of the commissioning process but we wish to raise the suggestion that it could be picked up through this Quality Standards process. | We note that a highly competitive “market” with tendering, and contracts with financial elements that are not sustainable in the long-term, have historically created situations of unstable provision in other parts of London.  This has a negative impact on the quality of care in the short-medium term but also has longer-term impacts on training opportunities if NHS providers cannot function.  Standards should require commissioning from a variety of providers and collaborative working between these providers. | Homerton is an NHS provider and we are contracted to deliver using national tariff agreements. We are aware that many other services providing abortion in London are not. (Certainly most NHS abortions in London are not charged at national tariff).  Offering contracts where the payments are significantly lower than national tariff and are “below-cost” is clearly a way to create an unstable and unsustainable system but this has happened in other London areas. |
| 94 | | NUPAS- National Unplanned Pregnancy Advisory Services UK | | Key area for quality improvement 5  **Commissioners to agree and comply with agreed nationwide tariffs for termination services** | Uniform tariff would result in uniformity and standardisation of abortion services in UK, along with inbuilt contraception and STI screening services | Currently due to unpaid and less paid tariffs , services in UK have had to cut corners whilst providing termination of pregnancy services. The quality of services can be compromised in doing so |  |
| **Additional areas - Women in prison** | | | | | | | |
| 95 | | Birth Companions | | **Abortion services during prison custody** | Birth Companions and bpas have significant concerns about women’s access to and experience of abortion services while in prison custody in England.  Women in prison have a right to healthcare provision equal to that accessed by women in the community. Yet despite this, both Birth Companions and bpas see and hear of inequalities and poor practice in abortion care for prisoners. | These concerns are compounded by a number of incidents reported to our organisations about women’s experiences. We have heard reports of women being escorted to clinics to access counselling or to have an abortion who have experienced the expression of judgemental attitudes from the prison staff accompanying them. This has been corroborated by clinic staff, who have also reported abuse directed towards them by prison staff.  We have received many reports of women being placed in restraints during consultations, examinations and procedures in abortion clinics. The National Security Framework clearly states that restraints should only be applied to pregnant women at healthcare appointments during exceptional circumstances, (National Security Framework 2015 – PSI 33/2015).  Finally we are concerned that women are not being allowed to access available support during abortion procedures. Birth Companions has offered to arrange for trained, security-cleared volunteers to support women while visiting abortion clinics, but this support (and that offered by women’s family members) has not been allowed by prisons. | We believe the following changes need to be prioritised to improve abortion care during prison custody:   1. Reports of judgemental and abusive attitudes from prison staff before, during and after an abortion should be investigated and responded to as a matter of urgency. 2. 1.Protocols on the restraint of pregnant women should be followed, and training and guidance should make clear that these protocols hold equal weight in abortion clinics. Any use of restraints in these circumstances must be exceptional and clearly justified. 3. Officers responsible for women in these situations should be appropriately trained. 4. Where possible, women should be allowed to access volunteer support during abortions.   Together Birth Companions and bpas are working to improve abortion care across the prison estate for pregnant women choosing to end their pregnancies while in custody. Find out more about our work at:  www.birthcompanions.org.uk  www.bpas.org |
| **Additional areas - Standardising patient surveys** | | | | | | | |
| 96 | | NHS Merton & Wandsworth Clinical Commissioning Groups/ Pan-London Joint Abortion Network | | Key area for quality improvement 1  The service user (patient) survey for ToP services standardising questions where possible and making recommendations for service user questions. | This would help reduce the number of different service user questionnaires. Ensuring service user questions are meaningful appropriate and allow patient survey to be comparable across CCGs, LA and providers for benchmarking services. | Meaningful feedback can highlight clinical and quality concerns across providers and improve patient experience for a difficult service where sensitivity is required as well as appropriate advice and guidance and signposting to other services. | Last year the CCGs ran a ToP KPI workshop with the Pan London Group and other ToP stakeholders ( CCGS , ToP providers ,LA and NHS organisations ) Nationally to review ToP KPIs to be recommended and incorporated to the DoHSC National service specification for ToP services. In addition, we also streamlined service user surveys (patient user surveys).  From this work we identified 9 key survey questions to ask service users. These were selected from feedback and then rated on perceived importance in measuring the associated outcomes by the working group on their importance.  Attached are the rating and the following confirmed patient survey questions selected following further discussion and comments by the working group.  Additional papers and agendas from the original KPI workshop are available if required. |

1. Department of Health and Social Care [Abortion Statistics, England and Wales: 2018](https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2018) [↑](#footnote-ref-1)
2. Department of Health and Social Care [Abortion Statistics, England and Wales: 2018](https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2018) [↑](#footnote-ref-2)
3. Department of Health and Social Care [Abortion statistics 2018: data tables](https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2018) [↑](#footnote-ref-3)
4. Heath, Mitchell, Fletcher A comparison of termination of pregnancy procedures: Patient choice, emotional impact and satisfaction with care Sexual and reproductive Healthcare 19 (2019) 42-49 [↑](#footnote-ref-4)
5. [British Pregnancy Advisory Service (2018) Medically complex women and abortion care](https://www.bpas.org/get-involved/campaigns/reports/) [↑](#footnote-ref-5)
6. British Pregnancy Advisory Service (2018) [Medically complex women and abortion care](https://www.bpas.org/media/2074/briefing-medically-complex-women-and-abortion-care.pdf) [↑](#footnote-ref-6)
7. Aiken et al [Barriers to accessing abortion services and perspectives on using mifepristone and misoprostol at home in Great Britain](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5801070/) Contraception. 2018 Feb; 97(2): 177–183. [↑](#footnote-ref-7)
8. Grazia Daily [Shocking Stats Show Just How Long Women In England Are Forced To Wait For An Abortion](https://graziadaily.co.uk/life/real-life/abortion-waiting-times-exclusive-investigation/) [↑](#footnote-ref-8)
9. Marie Stopes [Quality Account 2018/19](https://www.mariestopes.org.uk/media/3192/marie_stopes_uk_quality_account_-2018_19.pdf) [↑](#footnote-ref-9)
10. British Pregnancy Advisory Service [Quality Report 2018/19](https://assets.nhs.uk/prod/documents/British-Pregnancy-Advisory-Service-qa-2019.pdf) [↑](#footnote-ref-10)
11. Aiken et al [Barriers to accessing abortion services and perspectives on using mifepristone and misoprostol at home in Great Britain](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5801070/) Contraception. 2018 Feb; 97(2): 177–183. [↑](#footnote-ref-11)
12. Department of Health and Social Care [Abortion Statistics, England and Wales: 2018](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/808556/Abortion_Statistics__England_and_Wales_2018__1_.pdf) [↑](#footnote-ref-12)
13. Logan et al HIV testing in abortion services: Missed opportunities for earlier diagnosis Sexually Transmitted Infections; 2017; vol. 93 (no. Supplement 1); a8 [↑](#footnote-ref-13)
14. Bury, Louise; Hoggart, Lesley and Newton, Victoria Louise (2014). ”[I thought i was protected” Abortion, contraceptive uptake and use among young women: a quantitative survey.](https://oro.open.ac.uk/45140/1/MSI_quantreport_final_10-15.pdf) The Open University, Milton Keynes, UK [↑](#footnote-ref-14)
15. Marie Stopes [Quality Account 2018/19](https://www.mariestopes.org.uk/media/3192/marie_stopes_uk_quality_account_-2018_19.pdf) [↑](#footnote-ref-15)