Termination of Pregnancy

Consultation on draft scope
Stakeholder comments table

22/06/17 to 20/07/17

ID	Type	Organisation name	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
1	[for office use only]	Antenatal Results and Choices (ARC)	general		ARC provides specialised support to women undergoing terminations under Ground E of the Abortion Act, so those ending what is most often a wanted pregnancy after a diagnosis of fetal anomaly. There are approximately 5000 such terminations annually. We know there are particular issues for this group regarding access to second trimester surgical procedures and emotional support. We would strongly recommend that this subgroup be given special consideration. We can provide evidence as to why this is important if required.	Thank you for your comment. We have added a question about the optimal regimen for termination of pregnancy after 24 weeks to cover this group of women. Women having a termination for fetal abnormality will also be included as a subgroup in some of the other review questions where appropriate. This will be discussed by the Guideline Committee when they finalise the review questions and review protocols during their first few meetings.
2	[for office use only]	Bayer plc	general	general	Timely contraception advice and choice of all methods of contraception should be included in the scope.	Thank you for your comment. We agree that timely contraception advice and a choice of all methods of contraception are important issues. Question 3.2 has been amended and now covers how soon after a medical termination it is safe to insert an intrauterine contraceptive device. We also have an additional question 4.3, looking at strategies to facilitate update of contraception after a termination. There is also existing guidance from the FSRH which covers this issue.
3	[for office use only]	British Society of Abortion Care Providers (BSACP)	1	18	Suggest adding "…or surgically using general anaesthesia, intravenous sedation or as a "walk-in, walk-out" procedure under local anaesthesia"	Thank you for your comment. We have amended the current practice section of the scope to clarify that option of anaesthesia and sedation for surgical terminations are areas of variation in practice.
4	[for office use only]	British Society of Abortion Care Providers (BSACP)	1	23	Suggest adding "…to the NHS and be more acceptable to patients".	Thank you for your comment. We have added '… and be more acceptable to women.' to the text in light of your comment.
5	[for office use only]	British Society of Abortion Care Providers (BSACP)	1	23	There is widespread variation in type and choice of procedure offered to patients across the NHS with the inference that quality may also vary. Suggest being explicit about the variation in care offered within the NHS.	Thank you for your comment. We have clarified that there is variation in the type and choice of procedures offered.
6	[for office	British Society of Abortion	2	14	Suggest adding other key regulatory frameworks – CQC (who publish specific requirements for abortion providers) and the	Thank you for your comment. We have included reference to the CQC regulations and the Department of Health guidance on

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	use only]	Care Providers (BSACP)			Department of Health (who through statutory instruments administer and implement the Abortion Act).	termination of pregnancy in the scope.
7	[for office use only]	British Society of Abortion Care Providers (BSACP)	3	11	Suggest adding to including "victims of intimate partner intimidation, violence and domestic abuse and family and religious coercion." For them, any clinic visit is a risk up to and including death and may represent a total barrier to access services.	Thank you for your comment. The Equalities Impact Assessment that accompanies this scope has been updated to include 'women suffering domestic violence, abuse or coercion from their partner or family'
8	[for office use only]	British Society of Abortion Care Providers (BSACP)	4	10	Whilst accepting that this is a standard inclusion within the NICE framework, it is worthwhile being explicit that most drugs used for abortion care are not licensed for this indication, and that given the sensitivities over their use few pharmaceutical companies are likely to seek a licence for indications that include abortion	Thank you for your comment. This is standard text from NICE and we are unable to change it. However, the guideline will highlight any recommendations which contain an unlicensed use of a drug in line with standard NICE processes.
9	[for office use only]	British Society of Abortion Care Providers (BSACP)	5	17	It is essential that women are given accurate, evidence-based information to inform their decision. This can be problematic as groups opposed to abortion may disseminate biased and inaccurate data or seek to introduce barriers to access care. NICE guidance is authoritative and unbiased and will be an essential resource for women. The BSACP would strongly suggest being explicit here that NICE will update the systematic reviews that were in the RCOG abortion care guideline, specifically over long term consequences following an abortion: • Cancer risk (e.g. breast, ovary) • Infertility • Psychiatric and psychological morbidity, including later regret over decision • Evidence for need of compulsory counselling, or delay for reflection, prior to an abortion procedure	Thank you for your comment. We agree that evidence based recommendations are important in this area and have included a question about what information women need before having a termination. As this will not be an update of the existing RCOG abortion care guideline, we will not be updating the reviews conducted for that guideline. Therefore we are not able make the change that you request.
10	[for office use only]	British Society of Abortion Care Providers (BSACP)	5	29-30	Suggest re-wording (and combining with the next question) "What is the most effective regimen, including not being used routinely, for cervical priming before surgical termination of pregnancy in the first and second trimesters"	Thank you for your comment. In the first trimester of pregnancy, there is uncertainty around whether cervical priming should be conducted and if so what the optimal regimen is. In the second trimester, it is accepted that cervical priming is required but there uncertainty is around what the optimal regimen is. We have therefore decided not to combine question 2.5 and 2.6 as each question addresses different issues and different populations of women. We have made amendments to question 2.5 and 2.6 in the scope to further clarify the uncertainties that are to be addressed.
11	[for	British Society	6	1	Suggest adding new questions to cover innovations in surgical	Thank you for your comment. We agree that there is uncertainty

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	office use only]	of Abortion Care Providers (BSACP)			technique: • What are the comparative effectiveness, safety and acceptability of surgical procedures performed using general anaesthesia, intravenous sedation or as a "walk-in, walk-out" procedure under local anaesthesia (manual vacuum aspiration, MVA)? • What is the optimal dose and regimen for the administration of local anaesthetic and intravenous sedation?	around the optimal method of anaesthesia and sedation for the surgical termination of pregnancy and have therefore included this as an area to cover in the guideline under a new question 2.12. In terms of optimal dose of anaesthesia and sedation, NICE guidelines refrain from recommending specific dosage regimens and rather seek guidance from the BNF and summary of product characteristics (SPC), thus this will not be covered in the new question 2.12.
12	[for office use only]	British Society of Abortion Care Providers (BSACP)	6	5	Suggest either deleting "9 weeks" or adding another band (up to 9 weeks and 9-12 weeks) as this seems unnecessarily restrictive should evidence be available that includes abortions over 9 weeks	Thank you for your comment. The focus of this question is women who undergo early medical termination of pregnancy and go home to abort. We agree that 9 weeks may be restrictive, and therefore have amended question 2.8 to change the interval to up to 10 weeks which is in line with the latest timeframe for an early medical termination where women may go home to abort.
13	[for office use only]	British Society of Abortion Care Providers (BSACP)	6	23-31	Suggest combining these to a single question like "What strategies increase the uptake of long-acting reversible contraception in women who have a medical or surgical abortion?"	Thank you for your comment. We agree that facilitating the uptake of contraception in women who have undergone a medical or surgical termination of pregnancy is important and this is addressed in a new question 4.3.
14	[for office use only]	British Society of Abortion Care Providers (BSACP)	6	32	Suggest re-wording to "What counselling services should women be offered before and after an abortion?". The CQC explicitly define what they require as a "counsellor" for abortion care, so use of this term rather than "emotional support" would ensure the NICE guidelines do not inadvertently conflict with a regulator. Also, as stated above, the need for compulsory counselling has been used by anti-abortion groups to restrict access hence the need to broaden this question to both before and after an abortion	Thank you for your comment. We agree that the option for support both before and after a termination of pregnancy should be available for women. Question 1.1 should address women's preferences for counselling services prior to a termination of pregnancy, whereas question 3.3 will focus on the different modes of support after a termination of pregnancy. The wording of question 3.3 has been amended from 'emotional support' to 'support', to widen the interventions that the question can cover. We have not changed the wording to 'counselling services' as you suggest because this would restrict the question to specific healthcare professionals, but women may benefit from support from other sources such as support groups.
15	[for office use only]	British Society of Abortion Care Providers (BSACP)	7	3-4	Suggest putting this question first (as the new 4.1) so that patient perspective is above commissioning factors in the list	Thank you for your comment. The questions in the section on service organisation have been substantially re-written to more accurately reflect the issues that have been identified. Our questions are now as follows: • 4.1 What can the NHS and related public bodies do to ensure the sustainability of a safe and accessible termination of

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						pregnancy service? • 4.2 What strategies enable effective access to termination of pregnancy services? • 4.3 What strategies are effective at facilitating uptake of contraception after termination of pregnancy?
16	[for office use only]	British Society of Abortion Care Providers (BSACP)	7	1-2	Suggest adding, "…including the role of nurse delivered care, provision of complex care including later gestations, obesity, medical co-morbidities, age under 16"	Thank you for your comment. The questions in the section on service organisation have been substantially re-written to more accurately reflect the issues that have been identified. Our questions are now as follows: • 4.1 What can the NHS and related public bodies do to ensure the sustainability of a safe and accessible termination of pregnancy service? • 4.2 What strategies enable effective access to termination of pregnancy services? • 4.3 What strategies are effective at facilitating uptake of contraception after termination of pregnancy? We have not included the factors that you suggest in the questions as this would pre-empt the themes that might emerge when we review the evidence.
17	[for office use only]	British Society of Abortion Care Providers (BSACP)	7	3-4	Strongly recommend being explicit what this means by adding, "…including waiting times, direct access, choice of procedure, hospital versus community setting." The RCOG guidelines which these NICE guidelines will replace had a significant impact in improving quality of care by being explicit as to what constitutes acceptable practice in these areas, especially for waiting times.	Thank you for your comment. The questions in the section on service organisation have been substantially re-written to more accurately reflect the issues that have been identified. Our questions are now as follows: • 4.1 What can the NHS and related public bodies do to ensure the sustainability of a safe and accessible termination of pregnancy service? • 4.2 What strategies enable effective access to termination of pregnancy services? • 4.3 What strategies are effective at facilitating uptake of contraception after termination of pregnancy? We have not included the factors that you suggest in the questions as this would pre-empt the themes that might emerge when we review the evidence.
18	[for office use	British Society of Abortion Care Providers	7	11-12	Suggest moving the patient-reported outcomes to be the first in the list so that the list reads as being more patient-centred	Thank you for your comment. Although this list is not intended to convey an order of importance, we have moved the patient related outcomes to the top of the list as you suggest. We have also re-

ID	Type	Organisation name	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
	only]	(BSACP)				worded these outcomes to read 'treatment preference' and 'treatment acceptability' in light of another stakeholder comment.
19	[for office use only]	British Society of Abortion Care Providers (BSACP)	7	8	Suggest clarifying what success means, e.g. "on-going pregnancy rate"	Thank you for your comment. We think that success of pregnancy termination will be understood and does not need further clarification.
20	[for office use only]	British Society of Abortion Care Providers (BSACP)	7	14	Suggest giving specific examples, e.g. "…(e.g. re-attendance, re-admission, need for repeat procedure")	Thank you for your comment. This level of detail will be discussed by the Guideline Committee when they finalise the review questions and review protocols during their first few meetings.
21	[for office use only]	British Society of Abortion Care Providers (BSACP)	8	Flowchart	Suggest separating "surgical and medical" and having two bullet points: • Surgical using general or local anaesthetic or intravenous sedation • Medical including same day regimes and abortion at home Also suggest expanding the service organisation box to include the factors outlined above (page 7 lines 1-4)	Thank you for your comment. The pathway will be revised to take into account changes made to the scope following consultation. As responded above, we have not include the factors that you suggested in the question as this would pre-empt the themes that might emerge from the review of the evidence. Therefore it will not be possible to make this change to the pathway.
22	[for office use only]	British Society of Abortion Care Providers (BSACP)	General	General	The term "termination of pregnancy" is not one recognised internationally and would not be found in many literature searches. The BSACP's preferred term would be "abortion care" or "therapeutic abortion" as the phrase "termination" has negative connotations for some women.	Thank you for your comment. Whilst it can be argued that termination has negative connotations for some women, the same can be argued for the term 'abortion'. We have therefore decided to retain the existing title and have clarified in the introductory text at the start of the scope that we are using this term as being synonymous with abortion.
23	[for office use only]	British Society of Abortion Care Providers (BSACP)	8	Flow chart	The pathway starts with a woman accessing the service so neglects the barriers women face accessing care in terrestrial based services. Some of these groups are included in the Equality Impact Assessment as commented upon below (page 3 line 1)	Thank you for your comment. The flow diagram is intended to be a pictorial representation of the areas covered by the guideline scope. Therefore it does not cover all areas of the pathway of care. Question 4.2 looks at strategies to enable effective access to termination of pregnancy services.
24	[for office use only]	British Society of Abortion Care Providers (BSACP)	3	1	Additional groups: Women who are poor; the cost of travel/ childcare/ loss of earnings/ potential job loss due to multiple clinic attendances at short notice/ frequency. They go to loan sharks if they have no financial independence/ access to credit/ in a controlling relationship; all of which increases hardship. NB also effect on	Thank you for your comment. The Equalities Impact assessment which accompanies this scope has been amended to include women who are socially disadvantaged, to cover the group of women that you specify.

ID	Type	Organisation name	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
					existing children. . Work or childcare / caring commitments. Especially single parents / stigmatized women / where coercive control. Aggravated by poverty.	
25	[for office use only]	British Society of Abortion Care Providers (BSACP)	3	7	Living in remote areas – it's not just remote. It can be mileage close, but for poor women who have to bring kids with them, 3 buses is a challenge even if it's not far as the crow flies. Aggravated by poverty.	Thank you for your comment. The Equalities Impact Assessment which accompanies this scope has been amended to include women who are socially disadvantaged, to cover the group of women that you specify.
26	[for office use only]	British Society of Abortion Care Providers (BSACP)	3	9	Coexisting mental health problems including agoraphobia, anxiety, and depression; previous negative experiences with health care in general, especially if the contracted abortion provider was the provider which delivered the previous negative experience (even if other dept may be the same building/ unit e.g. maternity) in particular. NB Issue of lack of choice in some CCGs when discussing provider issues.	Thank you for your comment. We have not specified particular mental health problems in the Equalities Impact Assessment as we think all co-existing mental health problems are potentially relevant. Previous negative experiences are not an equalities issue and so have not been included here. However they may be relevant to question 4.2 which looks at strategies to enable effective access to termination of pregnancy services.
27	[for office use only]	British Society of Abortion Care Providers (BSACP)	3	13/14	Could be extended to any woman in terms of information access barriers; difficulties in finding out how to access or receive clear information about services which is lacking for many CCGs (who, where, when, how to access). The provision of information & where to get more information on services is often poor on websites & in NHS Direct.	Thank you for your comment. Question 4.2 looks at strategies to enable effective access to termination of pregnancy services. Question 1.1 looks at what information women should receive before having a termination. Recommendations made in these areas should help address the issues that you raise.
28	[for office use only]	British Society of Abortion Care Providers (BSACP)		General	Evidence of best practice should still be presented even if women cannot access it because of UK Law / regulation	Thank you for your comment. The guideline will explore the evidence base in this area and make appropriate recommendations based on this evidence
29	[for office use only]	British Society of Abortion Care Providers (BSACP)		General	This is a highly stigmatized topic; we ask if NICE could consider ways not utilised before to hear women's voices directly. The stigma means the topic is not raised by NGO / advocacy groups who may be offering care & support for other needs, because it is not revealed by the woman with genuine fears such as partner abuse / honour violence. The needs of the most vulnerable groups can thereby go unrecognised.	Thank you for your comment. The standard methods used to develop NICE guidelines can be found at https://www.nice.org.uk/process/pmg20/chapter/introduction-and-overview. If any questions investigated by the guideline require alternative methods in order to effectively consider the evidence, this will be discussed with NICE.
30	[for	Chesterfield	General	General	First of all, we would like to thank you for developing the NICE	Thank you for your comment.

ID	Type	Organisation name	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
	office use only]	Royal Hospital Calow Chesterfield S44 5BL			guidance on termination of pregnancy and also to think in details about the scope of this draft, the problem or dilemma we face every day in providing the service. We would like to know "Is it safe and effective to start termination before there is ultrasound evidence of an intrauterine pregnancy (that is, before the appearance of a yolk sac)?" because we feel there is a chance of missing ectopic or miscarriage and further scan and follow up increases patient dissatisfaction and increase workload on service provision and cost. Should women who are Rhesus negative and having termination of a first trimester pregnancy receive Rhesus prophylaxis, we feel it is important to administer. What is the optimal antibiotic prophylaxis regimen (including no antibiotic prophylaxis as an option) for women who are having medical termination of pregnancy? we feel uncomplicated medical termination have less chance of infection and unnecessary exposure increases resistance and cost and at the same time there is no consensus regarding when to give antibiotics. What is the optimal antibiotic prophylaxis regimen for women who are having surgical termination of pregnancy? we feel 1 gram oral azithromycin is sufficient and inclusion of metronidazole increases resistance and cost. Should misoprostol be routinely used for cervical priming before first trimester surgical termination of pregnancy? We feel most of the times the cervix is not primed enough and due to time pressure the recommended minimum 2 hours insertion time is not maintained which increases unnecessary nursing time and cost. What is the optimal regimen for cervical priming before second trimester surgical termination of pregnancy? We feel osmotic cervical dilator is better than misoprostol for the above reason. For women who are having an early (up to 9 weeks) medical termination of pregnancy, what are the effectiveness, safety and	Thank you for your support for including this question in the guideline scope. The guideline will explore the evidence base on Rhesus prophylaxis and make appropriate recommendations based on this evidence. The guideline will explore the evidence base on antibiotic prophylaxis in medical termination and make appropriate recommendations based on this evidence. The guideline will explore the evidence base on antibiotic prophylaxis in surgical termination and make appropriate recommendations based on this evidence. We have amended this question to be 'What is the optimal regimen for cervical priming (including no cervical priming as an option) before surgical termination of pregnancy in the first trimester?' to more accurately describe the issue to be investigated. The guideline will explore the evidence base on cervical priming before surgical termination and make appropriate recommendations based on this evidence. We have changed this question to be 'For women who are having an early (up to 10 weeks) medical termination of pregnancy, what is the effectiveness, safety and acceptability of mifepristone and

ID	Type	Organisation name	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
					acceptability of mifepristone and misoprostol given simultaneously compared with giving them 24 hours apart? we feel that slight increase in failure rate might be a barrier in acceptance but in reality this has no statistical to clinical relationship and we feel this is acceptable. For women who are having medical termination of pregnancy, what gestational limit for expulsion at home offers the best balance of benefits and harms? What is the optimal dose and administration route of misoprostol for inducing medical termination in the second trimester? For women who are having medical termination of pregnancy and plan to use the progestogen-only contraceptive implant afterwards, does inserting the implant at first dose of mifepristone influence the efficacy of the termination? We feel that though it is not recommended by the product manual it is clinically not relevant. What is the best method of excluding an ongoing pregnancy after early (up to 9 weeks) medical termination of pregnancy, when the expulsion has not been witnessed by healthcare professionals (for example expulsion at home)? We feel it is difficult to follow up patients routinely after 3 weeks and it increases pressure on time and cost. We feel providing patients with information about the importance of doing a pregnancy test at home at 3 weeks for confirmation should be sufficient safety netting. We would like to you to include details about manual vacuum aspiration for termination of pregnancy (which is under utilised in NHS at present) as this is not included in the draft scope and we feel that would be a cost effective, less painful and a more acceptable option for patients.	misoprostol given simultaneously compared with other time intervals?'. The guideline will explore the evidence base in this area and make appropriate recommendations based on this evidence. The guideline will explore the evidence base for these areas and make appropriate recommendations based on this evidence. The guideline will explore the evidence base on the best method of excluding an ongoing pregnancy after early termination and make appropriate recommendations based on this evidence. The interventions covered in each question will be discussed by the Guideline Committee when they finalise the review questions and review protocols during their first few meetings. The effectiveness of manual vacuum aspiration may be included in several of the questions.
31	[for office use only]	Christian Medical Fellowship	1	11	The scoping document begins with the statement that ToP 'is an integral part of reproductive healthcare'. This description suggests that abortion falls within routine healthcare; it fails to reflect the fact that abortion remains an unlawful act, unless performed under the terms of the 1967 Abortion Act (amended by the HFEA 1990)	Thank you for your comment. The scope clarifies on page 3, line 5 that termination of pregnancy is regulated by the Abortion Act 1967 (as amended by the Human Fertilisation and Embryology Act 1990).
32	[for	Christian	1	14	That a pregnancy was 'unintended' does not in itself constitute	Thank you for your comment. As specified on page 4, line 9, the

ID	Type	Organisation name	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
	office use only]	Medical Fellowship			legal grounds for its termination. Two doctors must separately form the opinion, in good faith,[1] that to continue the pregnancy would constitute a risk to the physical or mental health of the woman, greater than if the pregnancy were terminated. Medical practitioners must be able to justify how they formed their opinions for example by recording in the patient's record that they have assessed the relevant information and reached the conclusion based on this information. The wording of the draft document suggests that NICE supports termination of pregnancy on illegal grounds, and equates 'lack of intention' with 'risk to mental health'. The document appears to be based on the premise that abortion should be available for any woman, 'on request' and that 200,000 terminations annually is acceptable.	scope of this guideline starts at the point that a woman has requested a termination of pregnancy under the terms of the Abortion Act 1967 (as amended by the Human Fertilisation and Embryology Act 1990). The guideline will make recommendations on clinical aspects of how to conduct termination of pregnancy and how to organise services. It is implicit that any recommendations made in NICE guidelines will comply with the law. The purpose of the text that you cite is simply to provide background information on current practice in the UK and to illustrate why a guideline on clinical aspects of how to conduct termination of pregnancy and how to organise services is needed.
33	[for office use only]	Christian Medical Fellowship	1	17-18	Terminating a pregnancy is described as a 'safe procedure'. This ignores the emotional turmoil most women experience around the time of the procedure, the anxieties and fears associated with self-medication at home, and the longer term mental health issues that may complicate the procedure in some women. The largest, most comprehensive and systematic review into the mental health outcomes of women after induced abortion (by the Academy of Medical Royal Colleges, funded by the Department of Health in 2011) acknowledged that much of the evidence was of poor quality and was biased. However they concluded that having an *unwanted* pregnancy is associated with an increased risk of mental health problems. The report also found that the rates of mental health problems for women with an unwanted pregnancy were the same, *whether they had an abortion or gave birth*. Therefore, when a woman has an unwanted pregnancy, rates of mental health problems will be largely unaffected whether she has an abortion or goes on to give birth.	Thank you for your comment. The text about being a 'safe procedure' has been removed from the scope. Women with co-existing mental health problems, learning difficulties, communication difficulties and those living in remote areas have been included in the Equalities Impact Assessment form that accompanies the scope as groups who potentially need specific consideration during development of the guideline. As specified on page 4, line 9, the scope of this guideline starts at the point that a woman has requested a termination of pregnancy under the terms of the Abortion Act 1967 (as amended by the Human Fertilisation and Embryology Act 1990). It does not comment on how doctors should act to comply with this law.

[1] Department of Health. Guidance in Relation to Requirements of the Abortion Act 1967 for all those responsible for commissioning, providing and managing service provision. London: DH; 2014. bit.ly/1nCtswB

ID	Type	Organisation name	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
					However, women who have mental health problems before abortion are at greater risk of mental health problems after abortion: 'The most reliable predictor of post-abortion mental health problems is having a history of mental health problems prior to the abortion. A range of other factors produced more mixed results, although there is some suggestion that stressful life events, pressure from a partner to have an abortion, and negative attitudes towards abortions in general and towards a woman's personal experience of the abortion, may have a negative impact on mental health.[2] If childbirth does not constitute a greater risk of injury to mental health than abortion, it is arguable that doctors who authorise abortions in order to protect a woman's mental health may not be acting in accordance with the available evidence and may therefore be doing so illegally. Studies have shown that early medical abortion at home is associated with incomplete abortion in 2%-13% of cases, necessitating hospitalisation and a second procedure. Where adequate safety and support system resources are limited, for example for those living in remote areas, home-based abortions should not be offered.[3] Women with learning difficulties or co-existing medical or mental health conditions, who may struggle to understand or interpret guideline recommendations for medicines, will also be vulnerable where the trend is towards home-based abortions.	
34	[for office use only]	Christian Medical Fellowship	1	27	Non-NHS providers are profit-driven and will cherry-pick the most profitable procedures.	Thank you for your comment. This text describes the current variation in practice in termination of pregnancy services. An aim of this guideline is to reduce that variation.
35	[for office use	Christian Medical Fellowship	4	13	We recommend that assessment for abortion necessarily include the provision of neutral and non-directive counselling in a setting free of time-pressures and other forms of coercion, by a qualified	Thank you for your comment. As specified on page 4, line 9, the scope of this guideline starts at the point that a woman has requested a termination of pregnancy under the terms of the

[2] National Collaborating Centre for Mental Health. Induced Abortion and Mental Health. London: Academy of Medical Royal Colleges; 2011.bit.ly/2aOxGgZ
[3] http://www.who.int/bulletin/volumes/89/5/10-084046/en/

ID	Type	Organisation name	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
	only]				counsellor who is not employed by a private abortion provider. DH regulations state that every woman who requests an abortion 'should be offered' the opportunity to discuss her options and choices with a 'trained pregnancy counsellor'.[4] 'A trained pregnancy counsellor is someone trained to Diploma level. Counselling must be non-directive and non-judgmental and should not create barriers or delays. Counsellors should undergo continuous professional development and training similar to other professionals.'[5]	Abortion Act 1967 (as amended by the Human Fertilisation and Embryology Act 1990). The issues that you cite are therefore outside the scope of this guideline.
36	[for office use only]	Christian Medical Fellowship	4 6	15 32-33	We are concerned that care after termination of pregnancy be limited to immediate, post-abortion progress whereas there are longer-term risks that must be taken into account. Research shows that women can sometimes suffer harm – particularly psychological harm – post-abortion. It can take days and sometimes weeks to end a pregnancy following a medical abortion – the time needed is not predictable and it 'fails' more frequently than do surgical abortions. Bleeding can be very heavy and last longer than with a surgical abortion. Cramping can be very severe and lasts longer than with a surgical abortion. Taken together, these factors significantly increase the physical, emotional and psychological risks associated with home-based medical abortions. The review into the mental health outcomes of induced abortion by the Academy of Medical Royal Colleges[6] found that women with mental health problems before an abortion were at greater risk of mental health problems post abortion. It also found that other factors may be associated with increased rates of post-abortion	Thank you for your comment. Question 1.1 looks at what information women should receive before having a termination. Question 3.3 looks at what support women should receive after having a termination. The recommendations made in both of these areas should address the concerns that you raise.

[4] Department of Health. Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy (Abortion). London: DH; 2014:24. bit.ly/1PJlqy1
[5] Ibid 26
[6] National Collaborating Centre for Mental Health. Induced Abortion and Mental Health. London: Academy of Medical Royal Colleges; 2011. bit.ly/2aOxGgZ

ID	Type	Organisation name	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
					mental health problems, such as a woman having a negative attitude towards abortions in general, being under pressure from her partner to have an abortion or experiencing other stressful life events. It is therefore in the interest of doctors to ensure that all women with an unplanned pregnancy have sufficient information about the different options, and the risks involved, before consenting to proceed with the option chosen. They should be informed that a recent major review of research found that abortion does not reduce the risk of mental health problems compared to giving birth and certain attitudes and/or circumstances may increase the risk of post-abortion mental health problems. Explaining these findings will help to ensure that sufficient information has been imparted to allow valid, informed, consent to be given. We recommend that follow-up over at least twelve months be undertaken, to ensure early detection of any mental health issues that may arise as a result of the abortion.	
37	[for office use only]	Christian Medical Fellowship	5	16	DH guidance for abortion providers states that women: 'must be given impartial, accurate and evidence-based information (verbal and written) delivered neutrally and covering': ■ Alternatives to abortion (for instance adoption and motherhood) ■ Abortion methods appropriate to gestation ■ The range of emotional responses that may be experienced during and following an abortion ■ What to expect during and after the abortion (including potential side-effects, complications and any clinical implications). ■ Full discussion of contraception options and the supply of chosen method ■ Testing for sexually transmitted infections including HIV and strategies in place for infection prevention GMC and BMA guidance encourages doctors to explain to patients the importance of knowing the options open to them while respecting a person's wish not to know. Women should be informed of possible adverse outcomes or	Thank you for your comment. The guideline will explore the evidence base on the information needs of women before they have a termination and make appropriate recommendations based on this evidence.

ID	Type	Organisation name	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
					complications of the procedure, including any small risks. For example, there is a small but real risk of physical complications from abortion, including subsequent preterm birth.	
38	[for office use only]	Christian Medical Fellowship	7	6	There is no proposal to gather data relating to the number of women who come forward for an abortion but whom when given impartial information about the options and risks choose to continue with their pregnancy. We suggest this would be a useful addition to the list of outcomes.	Thank you for your comment. As specified on page 4, line 9, the scope of this guideline starts at the point that a woman has requested a termination of pregnancy under the terms of the Abortion Act 1967 (as amended by the Human Fertilisation and Embryology Act 1990). Collection of the data that you cite is therefore outside the scope of this guideline.
39	[for office use only]	Department of Health	general		I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.	Thank you for your comment.
40	[for office use only]	Faculty of Sexual and Reproductive Healthcare	2	4	Something should be added about the background change of increasing the offer of local anaesthetic and sedation options for a surgical procedure and the impact on service delivery here.	Thank you for your comment. We have now mentioned anaesthesia/sedation as an example of changing practice in the first paragraph of the Current practice section.
41	[for office use only]	Faculty of Sexual and Reproductive Healthcare	3	8	This will include obesity.	Thank you for this information
42	[for office use only]	Faculty of Sexual and Reproductive Healthcare	3	11	This should also include women who are limited in getting to services through (fear of) domestic abuse.	Thank you for your comment. The Equalities Impact Assessment that accompanies this scope has been updated to include 'women suffering domestic violence, abuse or coercion from their partner or family'
43	[for office use only]	Faculty of Sexual and Reproductive Healthcare	4	9	This is unfortunately standard wording and it was recognised that all use of misoprostol in abortion care is outside of license.	Thank you for your comment. This is standard text from NICE and we are unable to change it. However, the guideline will highlight any recommendations which contain an unlicensed use of a drug in line with standard NICE processes.
44	[for office use	Faculty of Sexual and Reproductive	5	21	FSRH agreed that this should also cover cases where there was not a gestation sac	Thank you for your comment. We agree that safe and effective termination should include the pre-gestational sac stage. To clarify this, we have amended the wording in question 2.1 to 'before there

ID	Type	Organisation name	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
	only]	Healthcare				is ultrasound evidence', which will include pre-gestational sac.
45	[for office use only]	Faculty of Sexual and Reproductive Healthcare	5	29	FSRH agreed that this should be broadened to become "should cervical priming be routinely used"	Thank you for your comment. We agree that there is uncertainty around the use of cervical priming before surgical termination of pregnancy in the first trimester. Therefore we have amended the wording of question 2.5 to include the option of no cervical priming to address this. As cervical priming is standard clinical practice in the termination of pregnancy in the second trimester, the option of no cervical priming will not be explored in question 2.6.
46	[for office use only]	Faculty of Sexual and Reproductive Healthcare	6	5	This should be amended to cover the First Trimester, not just up to 9 weeks.	Thank you for your comment. The focus of this question is women who undergo early medical termination of pregnancy and go home to abort. We agree that 9 weeks may be restrictive, and therefore have amended question 2.8 to change the interval to up to 10 weeks which is in line with the latest timeframe for an early medical termination where women may go home to abort.
47	[for office use only]	Faculty of Sexual and Reproductive Healthcare	6	8	FSRH agreed that this should be broadened to look at mifepristone and misoprostol given simultaneously compared with all other intervals, not just 24 hours.	Thank you for your comment. We agree that only using 24 hours as a comparison to the simultaneous administration of mifepristone and misoprostol may be restrictive. Therefore we have amended the wording of question 2.8 to "other time intervals" to be more inclusive and capture all other intervals.
48	[for office use only]	Faculty of Sexual and Reproductive Healthcare	6	15	FSRH agreed that this should be broadened to all progestogen-only contraceptives, including injectable as well as implant.	Thank you for your comment. We agree that the long acting progestogen-only contraceptives should include both implant and injection, as there is uncertainty as to whether long acting progestogen-only contraceptives reduces the effectiveness of mifepristone if administered concomitantly. We have amended the wording in question 2.11 to reflect this and will specify the progestogen-only implant and injection in the protocol. Progestogen-only oral contraceptives are not included in this question as the oral contraceptive can be initiated by the woman herself at a later date avoiding concomitant use, whereas long acting progestogen-only contraceptive implants and injections need to be administered by a healthcare provider. This is of particular importance as women may only have a single visit during their termination of pregnancy, where the long acting progestogen-only contraceptive is concomitantly administered with the termination.
49	[for office use	Faculty of Sexual and Reproductive	6	20	FSRH agreed that this should be 'up to 10 weeks', not 9 weeks.	Thank you for your comment. We have amended the timeframe to up to 10 weeks in question 3.1 as you suggest.

ID	Type	Organisation name	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
	only]	Healthcare				
50	[for office use only]	Faculty of Sexual and Reproductive Healthcare	6	23	FSRH agreed that this should be broadened to both medical and surgical terminations.	Thank you for your comment. These questions have been changed following stakeholder comments. The focus of question 3.2 is now about the safe timing of inserting an intrauterine contraceptive device in women who have undergone a medical termination of pregnancy. After discussion, it was agreed that the safe timing of inserting an intrauterine contraceptive device in women undergoing a surgical termination was not a priority for investigation by the guideline as they do not need to wait to expel the pregnancy before inserting the contraceptive device. Therefore it has not been included.
51	[for office use only]	Faculty of Sexual and Reproductive Healthcare	7	3	The ACCESS issue is hoped to be encompassed within this. FSRH agreed that something similar to the RCOG recommendations relating to maximum wait times needs to be present in the NICE output as well.	Thank you for your comment. Question 4.2 looks at strategies to enable effective access to termination of pregnancy services. The guideline will explore the evidence base in this area and make appropriate recommendations based on this evidence.
52	[for office use only]	International Campaign for Women's Right to Safe Abortion (ICWRSA)	general		As an advocate for safe abortion internationally, I hope to bring international experience and examples of best practice from several countries to my participation in proposals regarding this guideline. I can also provide published evidence and will give some examples here.	Thank you for your comment and for your assistance.
53	[for office use only]	International Campaign for Women's Right to Safe Abortion (ICWRSA)	1	15; 20-23	I think one purpose of the guideline should be to propose policy and service delivery changes that will increase the number of abortions that are very early, while protecting the minority of abortions that are late. The UK's record on more abortions becoming early is good but not as good as countries such as Sweden and Norway because our service delivery modalities are making us out of date in spite of what early provision of medical abortion pills could accomplish, in line with World Health Organization guidance.	Thank you for your comment. This text describes current practice. When developed, the guideline will make evidence based recommendations on Termination of pregnancy. At this stage we are not able to say what recommendations the guideline will make. However we have included questions on service organisation and added a question about the optimal regimen for termination of pregnancy after 24 weeks, so it is likely that these issues will be covered.
54	[for office use only]	International Campaign for Women's Right to Safe Abortion (ICWRSA)	1	27	Several things are contributing to the reduction in NHS provision of abortion, not least the absence of training in our medical schools in abortion provision (see presentation by Dr Tracey Masters at a recent RCOG day conference on abortion), not only for gynaecologists but also for GPs, nurses and midwives, including those who specialise in family planning. These need to be	Thank you for your comment. We agree that the reduction in NHS provision of termination of pregnancy is a critical issue and have changed question 4.1 to address this.

ID	Type	Organisation name	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
					addressed as lack of NHS commitment to abortion services is one of the most important reasons why abortions are not as early as they could be today. WHO 2015 guidance Health Worker Roles in Providing Safe Abortion Care and Post-Abortion Contraception says that "many of the evidence-based interventions for safe abortion and post-abortion care, particularly those in early pregnancy, can be provided on an outpatient basis at the primary care level". This calls for a sea-change in service delivery in the UK, comparable to the shift of contraceptive services from FP clinics to GP practices, raising issues of the implications for abortion regulations regarding approved places and approved providers. Bpas and MSI are already implementing these changes to the extent that the law will allow them, but it will need NICE and others to weigh here to see the extent of changes possible being accepted.	
55	[for office use only]	International Campaign for Women's Right to Safe Abortion (ICWRSA)	2	2	Groups in Australia, Canada and the USA are pioneering the use of telemedicine for provision of medical abortion pills, especially for women living in remote areas. The Tabbot Foundation in Australia is the most advanced example, see http://www.safeabortionwomensright.org/?s=Tabbot+Foundation . This is proving highly popular among women because it acknowledges the safety and simplicity of medical abortion pills, which have been shown to work well as early as six weeks. I am a co-editor of a special edition of Contraception which will carry a paper on the latter. The Campaign newsletter has carried several articles on all these services.	Thank you for providing this information. The text you have cited is part of the context section of the scope which describes the current situation in termination of pregnancy care in the UK. As such it would not be appropriate to mention telemedicine here.
56	[for office use only]	International Campaign for Women's Right to Safe Abortion (ICWRSA)	4	2	I see that you do not wish to cover settings that are not licensed to provide termination of pregnancy services. However, I feel we cannot avoid this with regard to medical abortion pills, which are rapidly changing every aspect of abortion care. You must be aware that women are able to take use of this method into their own hands without medical supervision. While it is clear from growing evidence that this is safe when women know what pills to buy and how many and how to take them, it is proving very problematic if they do not have this information. I am involved in publishing evidence about this. Criminalising via the 19861 OAPA or condemning self-use as dangerous is useless, which has been the only official response in the UK so far, not only in Northern Ireland but also in England. This is totally counter-productive and	Thank you for your comment. We recognise that there are issues around the use of medical abortion pills outside licensed premises. The guideline scope includes questions about several aspects of the clinical effectiveness of medical termination. However, we are not able to make recommendations that go against the law.

ID	Type	Organisation name	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
					self-defeating because it is precisely women who feel they have least access to the health system with regard to abortion who are accessing and using the pills on their own.	
57	[for office use only]	International Campaign for Women's Right to Safe Abortion (ICWRSA)	5	3	Self-management is one of the headings in the Medicines optimisation guidance. Self-management of medical abortion is a critical aspect of its use though I don't think the general guidance needs to mention it. But the autonomy of the patient is a crucial aspect here, and trusting women is the crux. Allowing women to use both kinds of pills at home should in my opinion form the basis of provision of early medical abortion pills via the health service, as with telemedicine.	Thank you for your comment and for pointing out this inconsistency. We have therefore removed reference to the Medicines optimisation guidance.
58	[for office use only]	International Campaign for Women's Right to Safe Abortion (ICWRSA)	5	19-21	Again, the paper I mention in Note 4 is relevant to this question. It reviews and analyses the literature on early medical abortion use. It may be that this evidence is not as extensive as it needs to be yet.	Thank you for providing this information. The guideline will explore the evidence base on whether it is safe and effective to start termination before there is ultrasound evidence on an intrauterine pregnancy and make appropriate recommendations based on this evidence. The paper you have mentioned may well be identified by our evidence searches.
59	[for office use only]	International Campaign for Women's Right to Safe Abortion (ICWRSA)	5	22-23	At a recent conference in New York on medical abortion, a senior staffperson at the National Abortion Federation in the USA said he believed there was not sufficient evidence of the need to require Rh prophylaxis, but that because it is required in the US, other countries are starting to think it is necessary. The WHO Safe Abortion Guidance 2012 discusses this on page 45.	Thank you for this information. In question 2.2, the guideline will explore the evidence base on Rhesus prophylaxis and make appropriate recommendations based on this evidence.
60	[for office use only]	International Campaign for Women's Right to Safe Abortion (ICWRSA)	5	24-28	The WHO Safe Abortion guidance page 16 recommends antibiotic prophylaxis for surgical abortion pre- or peri-operatively, but not for medical abortion. It does not state type or amount.	Thank you for this information. In questions 2.3 and 2.4, the guideline will explore the evidence base on antibiotic prophylaxis and make appropriate recommendations based on this evidence.
61	[for office use only]	International Campaign for Women's Right to Safe Abortion (ICWRSA)	6	9-10	An important question. Gynuity Health Projects research with others has shown 10 weeks gestation to be an acceptable limit. The US FDA has accept this limit.	Thank you for your support for including this question in the scope. The guideline will explore the evidence base on the gestational limit for expulsion at home and make appropriate recommendations based on this evidence.

ID	Type	Organisation name	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
62	[for office use only]	International Campaign for Women's Right to Safe Abortion (ICWRSA)	6	12-13	Information to answer this question is changing rapidly. Research by Gynuity Health Projects is showing that for second trimester abortion, misoprostol should be repeated until the abortion is complete. They published a study from Armenia to this effect in 2016 in the European Journal of Contraception & Reproductive Health Care and I believe there is other more recent evidence too.	Thank you for this information. The guideline will explore the evidence base on the optimal dose and administration route for misprostol after mifepristone to induce medical termination in the second trimester and make appropriate recommendations based on this evidence.
63	[for office use only]	International Campaign for Women's Right to Safe Abortion (ICWRSA)	6	19-22	This is an important question. Again Gynuity are working on several methods including specific kinds of pregnancy tests that can be used at home.	Thank you for your support for including this question in the scope. The guideline will explore the evidence base on the most effective method of excluding an ongoing pregnancy after early medical termination and make appropriate recommendations based on this evidence.
64	[for office use only]	International Campaign for Women's Right to Safe Abortion (ICWRSA)	general		You have not asked a question about pain management. It is my understanding from many countries that pain management, especially with medical abortion, is very poor on the part of abortion providers. For women using the pills at home, information is likely to be slim. I wonder how good the practice is in the UK. I've heard it is not first class everywhere.	Thank you for your comment. We agree that pain management is important, however other areas of variation and uncertainty were agreed to be higher priorities for inclusion in the guideline. It may be that pain management is encompassed in question 1.1 that looks at what information women need before having a termination of pregnancy. This level of detail will be discussed by the Guideline Committee when they finalise the review questions and review protocols during their first few meetings.
65	[for office use only]	International Campaign for Women's Right to Safe Abortion (ICWRSA)	7	10	I hope you will be considering whether routine ultrasound before medical abortion is necessary. The WHO Guidance says it is not.	Thank you for your comment. The use of routine ultrasound before medical abortion was not considered to be a priority for investigation by this guideline because there is already existing guidance on this issue from the WHO and RCOG.
66	[for office use only]	International Campaign for Women's Right to Safe Abortion (ICWRSA)	7	12	In some countries medical abortion is pretty much the only option for first trimester pregnancy (Sweden, Norway, Uruguay). In most countries D&E training is reaching fewer and fewer providers and D&E is becoming scarce except perhaps for women with fetal problems that will affect delivery. The possibility that medical abortion may become the only method on offer for first and second trimester is a serious one and needs consideration. When I was the editor of Reproductive Health Matters we published a special edition on second trimester abortion that has papers on this	Thank you for your comment. The text that you cite lists the main outcomes that will be considered across the guideline when searching for and assessing the evidence. Whilst patient preference may not be an option in some countries we consider that it is an important outcome to assess in this NICE guideline. We have also changed question 4.1 to look at what can be done to ensure the sustainability of a safe and effective NHS termination of pregnancy service to address the issues identified about training of the workforce.

ID	Type	Organisation name	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
					question which I think would be valuable.	
67	[for office use only]	International Campaign for Women's Right to Safe Abortion (ICWRSA)	general		Is it within the scope of this guideline to recommend that sex & relationships education in schools, now compulsory, should include a module on abortion and take it up also in relation to first sex, rape and sexual abuse? Perhaps this guideline should contain something on abortion after rape and sexual abuse too.	Thank you for your comment. We appreciate that this is an issue of concern. However NICE does not have a remit to make recommendations about content of sex and relationships education in schools.
68	[for office use only]	International Campaign for Women's Right to Safe Abortion (ICWRSA)	general		I would like to stress the importance of increasing the training of UK abortion service providers in 21st century provision and the importance of this guideline for moving this country into line with the best abortion care from a global perspective.	We have also changed question 4.1 to look at what can be done to ensure the sustainability of a safe and effective NHS termination of pregnancy service to address the issues identified about training of the workforce.
69	[for office use only]	International Campaign for Women's Right to Safe Abortion (ICWRSA)	general		There has been discussion in the safe abortion advocacy movement of the needs of trans people who become men by identification but retain a female reproductive system and are therefore at risk of unwanted pregnancy. This is a group whose needs are only just emerging. Numbers are unknown.	Thank you for your comment. As the number of individuals affected by this particular set of circumstances are likely to be small, we do not think that they are a subgroup that needs to be stated in the guideline for explicit consideration.
70	[for office use only]	International Campaign for Women's Right to Safe Abortion (ICWRSA)	general		Sex workers in countries where contraceptive use is low or non-existent are emerging as a group with special needs for abortion services because they have multiple abortions. I have no idea what the situation is in this country but it may be worth addressing.	Thank you for your comment. Vulnerable women (including sex workers) have been included in the Equalities Impact Assessment that accompanies the scope as a group who may need specific consideration during development of the guideline.
71	[for office use only]	International Campaign for Women's Right to Safe Abortion (ICWRSA)			Thank you for this work and the opportunity to comment on it.	Thank you for your comment.
72	[for office use	MSD Ltd	General		We have no comments on the draft scope	Thank you for your comment.

ID	Type	Organisation name	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
	only]					
73	[for office use only]	NHS England	general		We can confirm that there are no comments to be made on behalf of NHS England.	Thank you for your comment.
74	[for office use only]	NICE (Medicines and Technologies Programme)	4	20	Would the following guidelines also be relevant? Sexually transmitted infections and under-18 conceptions: prevention (PH3) *General signposting for higher risk people?* Sexually transmitted infections: condom distribution schemes (NG68) *Section 1.1 (targeting services) seems relevant* Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors (CG110) *Rec 1.1.11 discusses booking appointment for women considering termination* HIV testing: increasing uptake among people who may have undiagnosed HIV (NG60) *Rec 1.1.4 recommends everyone attending ToP services be tested at first appointment*	Thank you for your comment. These have been added to the scope.
75	[for office use only]	NICE (Medicines and Technologies Programme)	5	18 onwards	No mention of gemeprost- will this be considered in the review?	Thank you for your comment. This level of detail will be discussed by the Guideline Committee when they finalise the review questions and review protocols during their first few meetings.
76	[for office use only]	NICE (Medicines and Technologies Programme)	5	18 onwards	Just a general note that some regimens and routes of administration of mifepristone and misoprostol aren't licensed for termination of pregnancy (although standard clinical practice). I assume the guideline will highlight any unlicensed use.	Thank you for your comment. The guideline will highlight any recommendations which contain an unlicensed use of a drug in line with standard NICE processes
77	[for office use only]	NICE (Medicines and Technologies Programme)	5	24-28	When you consider which the optimal antibiotic prophylaxis regimen will you be considering antimicrobial resistance (an key outcome measure)	Thank you for your comment. This level of detail will be discussed by the Guideline Committee when they finalise the review questions and review protocols during their first few meetings.
78	[for office	NICE – Quality Standards and	5	16	The Quality Standard Advisory Committee for the contraception quality standard discussed the pros and cons of providing	Thank you for your comment. We agree that the uptake of contraception after a termination of pregnancy is important.

ID	Type	Organisation name	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
	use only]	Indicators Team			information about contraception to women who are having an assessment for an abortion. It was felt that women may not wish to discuss this at this stage but that if it is not discussed then opportunities to fit contraception at the time of the termination would be missed. It would be helpful to clarify the most effective approach to discussing contraception with women who have requested a termination of pregnancy. (PH51 recommendation 7 is not specific).	Therefore we have added a new question 4.3 that addresses the effective strategies at facilitating the uptake of contraception after a termination of pregnancy.
79	[for office use only]	NICE – Quality Standards and Indicators Team	6	18	It would be helpful to clarify the most effective approach to discussing contraception with women who have a termination but who choose not to have an implant fitted immediately.	Thank you for your comment. We agree that the uptake of contraception after a termination of pregnancy is important. Therefore we have added a new question 4.3 that addresses the effective strategies at facilitating the uptake of contraception after a termination of pregnancy.
80	[for office use only]	NICE – Quality Standards and Indicators Team	7	5	It would be helpful to add 'Repeat abortions'	Thank you for your comment. We have not included this as an outcome as this term is viewed as being stigmatising.
81	[for office use only]	NICE – Quality Standards and Indicators Team	7	20	We agree that this guideline may have an impact on QS129, statement 3. Please also note that we have a separate referral for a quality standard on termination of pregnancy. There are no current indicators on the NICE menu on this topic.	Thank you for this information.
82	[for office use only]	Public Health England	2	22 and 23	It is assumed that this section includes general practice but it would be good to see general practice named explicitly since it is one of the largest services doing referrals, and potentially where some access barriers might arise, particularly if there are conscientious objectors in the practice.	Thank you for your comment. We have clarified in the scope that GPs would be an example of services providing advice to women and referring them for termination of pregnancy.
83	[for office use only]	Public Health England	3	7	**Equality considerations: inequalities list:** Remote areas: Problems are not just confined to remote areas (e.g. large rural counties) For reference, see 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'. BJOG. 2016 Sep;123 (10):1684-91. doi: 10.1111/1471-0528.14117. They can equally apply in areas where there are transport	Thank you for your comment. We have added 'women who are socially disadvantaged' and 'women experiencing cultural barriers to accessing services' to the Equalities Impact Assessment that accompanies the scope. These groups have been highlighted as potentially needing specific consideration when developing the guideline. Younger women are already specified as a group that may require special consideration. We think that these amendments should address the groups that you have highlighted.

ID	Type	Organisation name	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
					difficulties or prohibitive costs and therefore limiting choices for those with no/limited money and/or not able to take half days out to get to abortion centres. This occurs in places where there may have been improved provision but for young people (especially if they are not involving parents) the practicalities of getting an abortion still eliminate choice .For reference, please see Public Health England. 'Health promotion for sexual and reproductive health and HIV Strategic action plan', 2016 to 2019 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/488090/SRHandHIVStrategicPlan_211215.pdf No reference to inequalities amongst black and minority ethnic groups made and evidence or guidance to improve care and outcomes within the relevant groups; we recommend providing guidance for black and minority ethnic groups. For reference, see the Department of Health's 'Equality Impact Assessment for National Sexual Health Policy', January 2010 http://webarchive.nationalarchives.gov.uk/20130124053112/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_111231.pdf	
84	[for office use only]	Public Health England	3	9	We agree with the inclusion of co-existing mental health problems. We would recommend adding other co-existing problems associated with unplanned pregnancy, such as drugs and alcohol misuse.	Thank you for your comment. We have added 'women who are socially disadvantaged' to the Equalities Impact Assessment, which should cover the group that you are highlighting.
85	[for office use only]	Public Health England	3	11	Asylum seekers and refugees should be added.	Thank you for your comment. We think this group would be covered by the addition of the group 'women who are socially disadvantaged' to the Equalities Impact Assessment. Also, the Assessment already lists women who have communication difficulties because they have difficulty understanding English.
86	[for office use only]	Public Health England	3	12	Recommend using the term 'adolescents and younger women' rather than 'girls and younger women'. 'Girls' has no lower age limit thus the preferred use of adolescents.	Thank you for your comment. The World Health Organisation (WHO) defines an adolescent as any person between ages 10 and 19. This age range falls within WHO's definition of young people, which refers to individuals between ages 10 and 24. We have therefore amended the text to be 'Young women.
87	[for office use	Public Health England	3	14	There are higher rates of domestic violence amongst populations attending for abortions and therefore the guidance should explore the evidence for utilising this opportunity to identify and support	Thank you for your comment. We appreciate that this is an issue of concern. However, this is a guideline about termination of pregnancy and making recommendations about identifying and

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	only]				women who are victims.	supporting victims of domestic violence is outside the scope of the guideline.
88	[for office use only]	Public Health England	3	14	'Inequality in access to late abortions' could be on this list as well as in section one. It would be beneficial if the National Institute for Health and Care Excellence would acknowledge the range of reasons and risk factors for late presentation here so that these can be addressed in terms of targeting more vulnerable populations.	Thank you for your comment. Question 4.2 looks at strategies to enable effective access to termination of pregnancy services. This detail of what each question will cover will be discussed by the Guideline Committee when they finalise the review questions and review protocols during their first few meetings. It may be that accessing late abortions is an area that is included.
89	[for office use only]	Public Health England	5	15	**Section 3 – What the guideline will cover** **Section 3.4 Key Issues and Questions** This section needs more analysis of access difficulties before addressing assessment e.g. i) Very limited access to late abortions and inequality of access and its impact on experience and safety (through delays in procedure) is an issue that needs to be addressed and; ii) Pre-existing medical conditions. Some women with pre-existing medical conditions can experience delays in receiving the right support, making their procedures higher risk; please see: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/01/e11-spec-serv-matrnty-insrt.pdf Pathways of care and liaison between abortion providers and NHS need to be emphasised.	Thank you for your comment. We agree that there are barriers in accessing termination of pregnancy services and identifying strategies to enable effective access is important. Therefore, we have added in a new question 4.2 to address this. In addition, women with complex pre-existing medical conditions have now been specified in the scope as a subgroup requiring specific consideration.
90	[for office use only]	Public Health England	5	16-17	In 'Assessment for termination of pregnancy', it would be beneficial to include what information women might need, but might not identify, to support the best outcomes as well as the information they want. For example, discuss recommendations in terms of abortion as an opportunity to identify other health issues, including testing for *human immunodeficiency virus*, sexually transmitted infection screening, domestic violence and opportunistic cervical screening.	Thank you for your comment. We agree that it is also important to provide beneficial information that women might need, but not necessarily identify, and therefore have amended the wording in question 1.1 to reflect this.
91	[for office use only]	Public Health England	6	18	Care after termination of pregnancy: Clinical management of abortion also includes management of complications. The scope does not include guidance for management of the commonest complications such as retained products of conception or infection.	Thank you for your comment. We agree that the management of complications related to termination of pregnancy is important. However, given that the management of complications is not an area of variation or uncertainty, it was agreed that an evidence review in this area would be of limited benefit and so this was not

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						prioritised for inclusion in the scope. Complications are likely to be covered by question 1.1, as an area that women need information on before they have termination of pregnancy. They are also likely to be included as outcomes for relevant questions on clinical management. This level of detail will be discussed by the Guideline Committee when they finalise the review questions and review protocols during their first few meetings.
92	[for office use only]	Public Health England	6	27	Include evidence about what is the optimal time for insertion of intrauterine devices (IUD) post medical termination and what effect this has on uptake and continued use of the IUD.	Thank you for your comment. We agree that the timing and uptake of the intra-uterine contraceptive device following a medical termination of pregnancy is important. The optimal timing is addressed in the revisions to question 3.2, whilst uptake is considered in a new question 4.3 which looks at strategies to facilitate uptake.
93	[for office use only]	Public Health England	7	1	There is evidence that women who have an assertive follow-up after abortion are more likely to take up or continue with a contraception method. However, the scope does not include a review of the evidence for which interventions are likely to increase immediate and interval uptake and how the intervention is likely to relate to longer term continuation .For reference, please see Leeners B et al 'Why prevention of repeat abortion is so challenging: psychosocial characteristics of women at risk'. Eur J Contracept Reprod Health Care. 2017 Feb;22(1):38-44 and Sedlecky K Stanković Z 'Contraception for adolescents after abortion'. Eur J Contracept Reprod Health Care. 2016; 21 (1):4-14.	Thank you for this comment. We agree that this is an important issue and have now revised the scope to include a question asking "What strategies are effective at facilitating uptake of contraception after termination of pregnancy?" (Q4.3).
94	[for office use only]	Royal College of GP's	1	17	This is a relatively safe procedure. It is not entirely without any risk with the risk of complications increases the later in pregnancy an abortion is carried out.	Thank you for your comment. We have removed the text 'is a safe procedure'.
95	[for office use only]	Royal College of GP's	1	23	This is not just about reducing costs but also about improving the choices for women and improving their experience	Thank you for your comment. We have added '… and be more acceptable to women.' to the text as a result of your comment.
96	[for office use	Royal College of GP's	2	6	These services should be non-judgemental or supportive	Thank you for your comment. We agree. By developing recommendations based on the available evidence, rather than consensus, our intention is to promote non-judgemental and

ID	Type	Organisation name	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
	only]					supportive care for women having a termination of pregnancy.
97	[for office use only]	Royal College of GP's	2	19	This guideline is ALSO for……	Thank you for your comment, we have made this change.
98	[for office use only]	Royal College of GP's	2	23	Maybe add, 'including SRH (sexual and reproductive health) services and GPs' for clarity	Thank you for your comment. We have listed SRH services and GPs as examples, for clarity.
99	[for office use only]	Royal College of GP's	3	6-14	More patient centred to phrase like this… The guideline will look at inequalities relating to women who: live in remote areas have complex pre-existing medical conditions have coexisting mental health problems are trafficked and those with substance misuse concerns have learning disabilities are vulnerable (including sex workers and women who are homeless) are young (??Specify which ages you mean <18 years? <21 years) have communication difficulties, because of vision or hearing problems or because they have difficulty understanding English	Thank you for your comment. The text in the Equalities Impact Assessment that accompanies the scope now reflects some of your suggested wording changes. We have not added 'women who are trafficked and those with substance misuse concerns' as these groups would be encompassed by 'vulnerable women' and a new category 'women who are socially disadvantaged.
100	[for office use only]	Royal College of GP's	4	3	Needs clarification as some care after the procedure includes contraceptive care which may be offered by LA commissioned SRH clinics	Thank you for your comment. We have changed the text to 'settings that are not commissioned by publicly funded bodies…' in light of your comment.
101	[for office use only]	Royal College of GP's	4	20	Also NICE guidance on HIV testing: increasing uptake among people who may have undiagnosed HIV - NICE guideline [NG60] Published date: December 2016 '1.1.4. Routinely offer and recommend an HIV test to everyone attending their first appointment (followed by repeat testing in line with recommendation 1.2.6) at drug dependency programmes,	Thank you for your comment. We have added this guidance to the scope as you suggest.

ID	Type	Organisation name	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
					termination of pregnancy services…'	
102	[for office use only]	Royal College of GP's	5	15	Assessment for TOP – What is the expected standard of care and minimal amount of information that a practitioner with a conscientious objection to abortion must provide to women requesting an abortion?	Thank you for your comment. We agree that women who have requested a termination of pregnancy should be given appropriate information before the procedure and this is addressed in amended question 1.1. The guideline will explore the evidence base on what information women require before having a termination and make appropriate recommendations based on this evidence. These recommendations will then be the standard of care that women can expect to receive.
103	[for office use only]	Royal College of GP's	6	18	Care after termination of pregnancy: Should GPs be informed if one of their patients has had an abortion? What information should be provided? How quickly should this be done? What post-abortion care should be provided by GPs? (where a woman has consented to her GP being informed) (eg review of contraception, STI and HIV testing up to date, emotional support where needed)	Thank you for your comment, which raises important issues. Questions 2.11, 3.2 and 3.3 are likely to cover some of the post-abortion care issues you have raised. There is also existing guidance from the GMC, BMA and Department of Health regarding confidentiality of information around abortions and the woman's wishes on whether or not she wants her GP to be informed of this. We therefore do not propose to cover this in this guideline.
104	[for office use only]	Royal College of GP's	6	23	This should include other contraceptive methods as well as the SDI; DMPA and oral methods	Thank you for your comment. The focus of this question is now around the safe timing of inserting an intrauterine contraceptive device in women who have undergone a medical termination of pregnancy (including the expulsion of pregnancy). As the other contraceptive methods do not require insertion into the uterine cavity, the same concerns around the safe timing of inserting an intrauterine contraceptive device in women undergoing a medical termination were not prioritised. Amendments to question 3.2 have been made to further clarify the focus of the question.
105	[for office use only]	Royal College of GP's	6	27	There should be a discussion about the insertion of the IUD/S after medical termination and the timing of that and benefits of that	Thank you for your comment. We agree that the timing of the insertion of an intrauterine contraceptive device is important. This issue has been addressed by making amendments to question 3.2 so that if focuses on the safe timing of insertion after a medical termination.
106	[for office use only]	Royal College of GP's	7	1	Commissioning in England is fragmented with CCGs commissioning Terminations and LA commissioning SRH care (LARC). This point could add a comment about joined up commission to prevent further Termination procedures being required to improve the patient experience as well as improving outcomes and reducing costs	Thank you for your comment. NICE guidelines are not able to tell Commissioners where to commission services from. However, recognition of the issues that you raise we have added a new question 4.1 (What can the NHS and related public bodies do to ensure the sustainability of a safe and accessible termination of pregnancy service?)

ID	Type	Organisation name	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
107	[for office use only]	Royal College of GP's	8	8	It is not clear why the insertion of contraceptive implants is specifically listed here and why this is not more around contraception in general	Thank you for your comment. The flow diagram is intended to be a pictorial representation of the areas covered by the guideline scope and will be amended following revisions to the scope. After feedback from stakeholders we have made amendments to the questions on contraception. The scope now includes the following two questions about contraception which have been identified as the most important questions for the guideline to cover: • 3.2 For women who have had medical termination of pregnancy, how soon afterwards is it safe to insert an intrauterine contraceptive device? • 4.3 What strategies are effective at facilitating uptake of contraception after termination of pregnancy?
108	[for office use only]	Royal College of GP's	General		Comprehensive document. with a good scope and tackles most of the essential outstanding issues.	Thank you for your comment.
109	[for office use only]	[Royal College of Nursing]	General	General	The Royal College of Nursing welcomes proposals to develop this guideline. The RCN invited members who work with women and with knowledge and experience of sexual health to review the draft document on its behalf. The comments below reflect the views of our members.	Thank you for your comment.
110	[for office use only]	[Royal College of Nursing]	3	Point 21	*"No specific sub-group of people have been identified as needing specific consideration".* We consider that the scope should include the young persons and vulnerable adults, particularly in terms of safeguarding at some point.	Thank you for your comment. Women with complex pre-existing medical conditions have now been included as a subgroup who require specific consideration in the guideline. Vulnerable women and young women will be considered in those questions where there are particular safeguarding issues. This level of detail will be discussed by the Guideline Committee when they finalise the review questions and review protocols during their first few meetings.
111	[for office use only]	[Royal College of Nursing]	5	18	*Termination of pregnancy* *2.1 Is it safe and effective to start termination before there is ultrasound evidence of an intrauterine pregnancy (that is, before the appearance of a yolk sac)?* We welcome that the guideline will address this key question. We would however, have concerns about the criteria by "ultrasound evidence" if one is starting a termination of pregnancy (TOP)	Thank you for your comment. The guideline will explore the evidence base on whether it is safe and effective to start termination before there is ultrasound evidence of an intrauterine pregnancy and make appropriate recommendations based on this evidence. As well as considering the evidence on this issue, the Guideline Committee will consider practical issues around the recommendations they wish to make. It may well be that they

ID	Type	Organisation name	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
					having identified an "intrauterine sac" before a yolk sac. This would equate to approximately four weeks. The healthcare professional performing the scan will need to be certain that what they are seeing is actually an early intrauterine pregnancy with a good decidual reaction and eccentrically located within the cavity and they are not mistaking it for a ? "Pseudo sac" and then they would refer the patient to the Early Pregnancy Assessment Unit (EPAU) services as a Pregnancy of unknown location (PUL) - to exclude an ectopic? This would cause unnecessary worry to the patient and more follow up appointments would be required which we are obviously trying to avoid. There would need to be the right training and competency in order to confidently report an early intrauterine pregnancy without a yolk sac (which equates to five weeks).	consider training and competency implications in their deliberations.
112	[for office use only]	[Royal College of Nursing]	8	Flowchart	The flow chart seems only refers to contraceptive implants. The flow chart should cover all methods of contraception, it currently seems to infer that women who have an abortion will have implants only.	Thank you for your comment. The flow diagram is intended to be a pictorial representation of the areas covered by the guideline scope and will be amended following revisions to the scope. The questions in the scope are focused on areas of variation and uncertainty in practice. Question 3.2 has been revised to look at the safe timing of inserting an intrauterine contraceptive device in women who have undergone a medical termination of pregnancy (including the expulsion of pregnancy). As the other contraceptive methods do not require insertion into the uterine cavity, the same concerns around the safe timing of insertion do not apply, and so other forms of contraception have not been prioritised for investigation.
113	[for office use only]	[Royal College of Nursing]	8	Flow chart	The chart mentions timing of implant fitting but there is also a need for a general mention of how to address contraceptive needs.	Thank you for your comment. The flow diagram is intended to be a pictorial representation of the areas covered by the guideline scope and will be amended following revisions to the scope. After feedback from stakeholders we have made amendments to the questions on contraception. The scope now includes the following two questions about contraception which have been identified as the most important questions for the guideline to cover: • 3.2 For women who have had medical termination of pregnancy, how soon afterwards is it safe to insert an

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						intrauterine contraceptive device? • 4.3 What strategies are effective at facilitating uptake of contraception after termination of pregnancy?
114	[for office use only]	[Royal College of Nursing]	General	General	One member identified that the word 'abortion' is not used in the scoping document? "Women refer to the procedure as abortion, the Royal College of Obstetrics and Gynaecology (RCOG) guidelines were called 'abortion' and the Act was abortion". We recognise the decision some years ago to refer to the term Termination for Pregnancy.	Thank you for your comment. As the guideline is called 'Termination of pregnancy' we have used this terminology throughout the scope for consistency. However, we have amended the context section of the scope to clarify that 'termination of pregnancy' is used synonymously with 'abortion'.
115	[for office use only]	Royal College of Obstetricians and Gynaecologists	1	24	Think that this sentence would read better as 'TOP services have provided other important sexual health services to women (and their partners) for decades.'	Thank you for your comment. We have changed the text to read 'Termination of pregnancy services provide other important sexual and reproductive health services to women, such as contraceptive advice and provision of contraceptive methods.'
116	[for office use only]	Royal College of Obstetricians and Gynaecologists	2	25	The guideline is intended for fetal medicine and obstetric services – this implies that the guideline will cover termination for fetal abnormality and cases of 2nd trimester membrane rupture. This needs to be clearer and perhaps elaborated, in the scope (e.g. to include specific counselling, involvement of fetal medicine specialists, role of the geneticists, feticide at advanced gestations, place of termination, and importance of post-mortem and follow up).	Thank you for your comment. We have added a question about the optimal regimen for termination of pregnancy after 24 weeks to cover women having a termination for fetal abnormality. Women having a termination for fetal abnormality/cases of second trimester membrane rupture may also be included as subgroups in some of the other review questions where appropriate. This will be discussed by the Guideline Committee when they finalise the review questions and review protocols during their first few meetings.
117	[for office use only]	Royal College of Obstetricians and Gynaecologists	2		Would NICE like to make recommendations about the choice of services for abortion which they should be able to access at each trimester and how this service should be provided? (Medical and surgical/local and general anaesthesia).	Thank you for your comments. In response to this and other stakeholder comments we have revised the scope such that it now includes more questions that address how medical and surgical abortions should be undertaken (Q2.1--13, Q3.1, Q3.3) as well as a question about anaesthesia for surgical abortion (Q2.12). We have also revised question 4.1 so that it now looks at 'What can the NHS and related public bodies do to ensure the sustainability of a safe and accessible termination of pregnancy service?'. We would envisage that the recommendations resulting from these questions will shape what services are made available for women having a termination of pregnancy.

ID	Type	Organisation name	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
118	[for office use only]	Royal College of Obstetricians and Gynaecologists	2		I think this section should contain a question about what risks and complication should be discussed with women undergoing induced abortion.	Thank you for your comment. We agree that discussing risks and complications with the woman before undergoing a termination of pregnancy is important. These are likely to be addressed in amended question 1.1
119	[for office use only]	Royal College of Obstetricians and Gynaecologists	2		This section should also include consideration of venous thrombotic risk.	Thank you for your comment. We have added a question to the scope on VTE prophylaxis.
120	[for office use only]	Royal College of Obstetricians and Gynaecologists	2		This section should also discuss opportunities for STI screening prior to abortion.	Thank you for your comment. STI screening is outside the scope of this guideline, so this will not be covered.
121	[for office use only]	Royal College of Obstetricians and Gynaecologists	3		Discussion should include information giving to women after abortion including other contraceptive methods available, common symptoms and symptoms suggestive of ongoing pregnancy.	Thank you for your comment. Question 1.1 covers information provision before the termination. The guideline will explore the evidence base on what information women require before having a termination and make appropriate recommendations based on this evidence. It may be that the evidence identifies the information you suggest as things that women need to know about before their termination.
122	[for office use only]	Royal College of Obstetricians and Gynaecologists	3	18	Groups that will be covered are 'women (of any age) requesting termination of pregnancy …'. Women undergoing emergency abortion to save their life, do not request termination. Could extend the sentence to say, "… including those undergoing termination for fetal abnormality or to save the life of the woman".	Thank you for your comment. Women undergoing termination for fetal abnormality are encompassed within the existing text. However, we have added a bullet point about women (of any age) undergoing a termination of pregnancy as a life-saving procedure.
123	[for office use only]	Royal College of Obstetricians and Gynaecologists	4	18	Wording is ambiguous. Does this mean that counselling about the decision about whether to have an abortion isn't included in the scope? It doesn't seem to be, from section 3.4 'Key issues and questions'. This is an important part of the care provided to women and should be included. The wording on page 4 line 18 could be made more specific by saying 'Antenatal care' or 'Pregnancy care'.	Thank you for your comment. You are correct that counselling about the decision whether or not to have a termination is excluded from the scope. The guideline starts at the point that a decision has been made to have a termination. We think that the term 'care' is accurate, because this might encompass pregnancy testing, counselling, early pregnancy ultrasound, anomaly scans etc. Therefore, we have not made your

ID	Type	Organisation name	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
						suggested change.
124	[for office use only]	Royal College of Obstetricians and Gynaecologists	7	5-11	It would be helpful to have a question addressing the role of manual vacuum aspiration in the early first trimester.	Thank you for your comment. This level of detail will be discussed by the Guideline Committee when they finalise the review questions and review protocols during their first few meetings.
125	[for office use only]	Royal College of Obstetricians and Gynaecologists	7	23-31	These points were comprehensively addressed in the recent guidance from the Faculty of Sexual & Reproductive Health, 'Contraception after pregnancy', January 2017	Thank you for your comment and for providing this information.
126	[for office use only]	Royal College of Obstetricians and Gynaecologists	7		The scope for this section is very broad. Would the authors consider using subheadings as part of the scope to further define what should be included in this section e.g. Access to services for abortion care, Time interval between referral and procedure, referral pathways to emergency care facilities, recommendations regarding tailored care for specific groups (e.g. women with co-morbidity, need for interpreter services, signposting to appropriate support services).	Thank you for your comment. In section 3.4, the broad key issues have been specified and then subdivided into the specific questions that sit within these key issues.
127	[for office use only]	Miss Jen Heslop Consultant Obstetrician & Gynaecologist, Lead for Unplanned Pregnancy, Royal Derby Hosptial	General	General	There is no guidance related to sensitive disposal of pregnancy tissue and how this should be conveyed to women. It should discuss areas of good practice such as written information and written consent for preferences of sensitive disposal e.g cremation versus burial	Thank you for your comment. We agree that sensitive disposal of pregnancy tissue is important, however this was not prioritised as a specific question include in the guideline as there is existing Department of Health guidance in this area.
128	[for office use only]	Miss Jen Heslop Consultant Obstetrician & Gynaecologist, Lead for	6	32	What guidance is recommended as the minimum standard for follow up. Is there a role to recommend routine GP follow up for all patients to ensure physical and emotional well being. What guidance is recommended for NHS services to provide post-procedure follow-up and how best should this be delivered / re-imbursed?	Thank you for your comment. Question 3.4 will explore the evidence base on what support women should be offered after a termination of pregnancy and make appropriate recommendations based on this evidence. Reimbursement is an issue for commissioning services and NICE

ID	Type	Organisation name	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
		Unplanned Pregnancy, Royal Derby Hosptial				guidelines are not able to make recommendations on this.
129	[for office use only]	Miss Jen Heslop Consultant Obstetrician & Gynaecologist, Lead for Unplanned Pregnancy, Royal Derby Hosptial	5	Section 3.3	Patients with complex medical histories have often been rejected through independent services and attend through NHS services often at more advanced gestation. With increasing medical comorbidities and complexities will this guideline be working with NHS commissioning to allow recognition for this (tariff design?).	Thank you for your comment. Tariff design is outside the scope of this guideline, although consideration of resource impact and cost-effectiveness of each stage of the service will be made. We hope that NHS commissioning might find the results of these economic analyses useful in designing subsequent tariffs.
130	[for office use only]	Miss Jen Heslop Consultant Obstetrician & Gynaecologist, Lead for Unplanned Pregnancy, Royal Derby Hosptial	5	16	What information should be provided at the initial referral level for TOP e.g in general practice prior to attendance.	Thank you for your comment. Question 1.1 will assess the evidence base on what information women should be offered before a termination of pregnancy and make appropriate recommendations based on this evidence. A specific question on the provision of information at the initial referral for termination of pregnancy from the GP was not prioritised for inclusion in the guideline.
131	[for office use only]	Miss Jen Heslop Consultant Obstetrician & Gynaecologist, Lead for Unplanned Pregnancy, Royal Derby Hosptial	2	12	Guidance on completing HAS forms and how to achieve this in practice if units are attempting to deliver same day services. Can HSA1 be completed electronically in general practice?	Thank you for your comment. We appreciate that this is an issue of concern. However, this is a clinical guideline about termination of pregnancy and making recommendations about the process for completing forms is outside the scope. There is existing Department of Health guidance on this issue.
132	[for	Miss Jen	6	9	For Medical termination at home, what is the guidance for follow –	Thank you for your comment. It is not possible for a NICE guideline

ID	Type	Organisation name	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
	office use only]	Heslop Consultant Obstetrician & Gynaecologist, Lead for Unplanned Pregnancy, Royal Derby Hosptial			up of these patients? What information should be given. Telephone support for how long? What guidance is there to ensure successful procedure and what recommendations are there for patients who do not engage with follow up	to provide a complete pathway of care and other issues were thought to be higher priority for inclusion in the guideline. However, some of the issues that you raise may be addressed by question 3.1 (best method of excluding an ongoing pregnancy after early medical termination of pregnancy, when the expulsion has not been witnessed by healthcare professionals (for example expulsion at home)) and question 3.3 (What support, should women be offered after a termination of pregnancy?).
133	[for office use only]	Miss Jen Heslop Consultant Obstetrician & Gynaecologist, Lead for Unplanned Pregnancy, Royal Derby Hosptial	7	20	Adequate renumeration (from commissioners) for NHS units to provide contraception at the same time of TOP, rather than the default be for community services to provide as this increases the rate of unintended pregnancy	Thank you for your comment. The scope describes what the NICE guideline on Termination of pregnancy will and will not cover. The guideline will make recommendations based on evidence of clinical effectiveness and cost effectiveness. We are not able to specify how these recommendations will be implemented, either in the scope or the guideline.
134	[for office use only]	[Royal Devon & Exeter NHS Foundation Trust]	6	19	What is meant by 'the best'? Is this - what is 'The Best' for the service user, 'The Best' for a Hospital, 'The Best' for the CCG or does 'The Best' mean the safest?	Thank you for your comment. "The best" refers to the most clinically and cost effective method. This wording will remain as it currently stands.
135	[for office use only]	The Clinical Effectiveness Unit of the Faculty of Sexual and Reproductive Health	3	6	We suggest looking also at inequalities in service provision relating to regional variation in across the UK funded by the NHS ie Northern Ireland and other regions where NHS provision is poor.	Thank you for your comment. The purpose of the guideline is to assess the evidence base on the questions in the scope and make appropriate recommendations based on this evidence. The result should be that provision in termination of pregnancy services will be standardised, removing the current variation that you describe.
136	[for office use only]	The Clinical Effectiveness Unit of the Faculty of Sexual and	3	23	Please consider full home use of medical abortion.	Thank you for your comment. We are not able to look at settings that would fall outside of the law relating to where termination of pregnancy services can be provided.

ID	Type	Organisation name	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
		Reproductive Health				
137	[for office use only]	The Clinical Effectiveness Unit of the Faculty of Sexual and Reproductive Health	7	14	We would stress the importance of assessing future psychological wellbeing following abortion.	Thank you for your comment. This level of detail will be discussed by the Guideline Committee when they finalise the review questions and review protocols during their first few meetings.
138	[for office use only]	The Clinical Effectiveness Unit of the Faculty of Sexual and Reproductive Health	6	18	Please consider factors relating to coercion to use particular methods of contraception following abortion.	Thank you for your comment. This level of detail will be discussed by the Guideline Committee when they finalise the review questions and review protocols during their first few meetings.
139	[for office use only]	The Clinical Effectiveness Unit of the Faculty of Sexual and Reproductive Health	4	16	We would consider the issue of training and retention of staff working in abortion services an important issue to consider – services commissioned by the NHS in general do not train staff. In addition, many units face issues relating to staff opting out of abortion care which is a major problem for some services.	Thank you for your comment. We agree that the training and retention of staff working in termination of pregnancy is a critical issue and have added in a new question 4.1 to address this.
140	[for office use only]	The Clinical Effectiveness Unit of the Faculty of Sexual and Reproductive Health	GENERAL	GENERAL	Overall scope of the guideline is excellent.	Thank you for your comment.
141	[for office use only]	The Royal College of Midwives (RCM)	General		The RCM welcomes the development of NICE guidance on this topic and agrees with the general outline of the scope.	Thank you for your comment.

ID	Type	Organisation name	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
142	[for office use only]	The Royal College of Midwives (RCM)	2	'who the guideline is for…… fetal medicine and obstetric services.	The wording should reflect the whole of the maternity services here, rather than specifying fetal medicine and obstetric services	Thank you for your comment. We have amended the text to 'fetal medicine and wider maternity services'
143	[for office use only]	The Royal College of Midwives (RCM)	3		We are very pleased to see that the potential inequality impact for women 'living in remote area' has been included.	Thank you for your comment.
144	[for office use only]	The Royal College of Midwives (RCM)	4	**Areas that will not be covered** Care between conception and the request for termination of pregnancy	It is unclear why care between conception and the request for termination of pregnancy is not to be included. This is the important time when the women will be needing a context in which to have input from health professionals in accessing and reviewing the relevant evidence as described in existing guidance on this subject https://www.rcn.org.uk/professional-development/publications/pub-005957 https://www.rcog.org.uk/globalassets/documents/guidelines/abortion-guideline_web_1.pdf https://www.rcm.org.uk/sites/default/files/RCM%20Abortion%20Statement.pdf	Thank you for your comment. This guideline starts at the point that a women has requested a termination of pregnancy. The time period between conception and the request for a termination being made is therefore explicitly excluded.
145	[for office use only]	The Royal College of Midwives (RCM)	5	***Key issues and questions***	All of the questions described in this section are relevant to the scope.	Thank you for your comment

ID	Type	Organisation name	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
146	[for office use only]	The Royal College of Midwives (RCM)	5	Assessment for termination of pregnancy 1.1 What information do women who have requested a termination of pregnancy want before they have the procedure?	There should another question in here asking in what formats and in what contexts women will want access to the information.	Thank you for your comment. Other areas of variation were agreed to be higher priorities for investigation that the format in which women will want to access information. Recommendations on this issue are already provided by the NICE Guideline on Patient experience in adult NHS services (CG138)
147	[for office use only]	The Royal College of Midwives (RCM)	6	What emotional support, should women be offered after a termination of pregnancy?	We are very pleased to see the inclusion of this particular question.	Thank you for your comment.
148	[for office use	The Royal College of Midwives	6	What factors influence	These are clearly 2 different and important questions that should not be lumped together as they appear to be here.	Thank you for your comment. We agree that this is really two questions. Based on feedback, we have amended and focused the question so it instead concentrates on strategies that enable

ID	Type	Organisation name	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
	only]	(RCM)		women's access to termination of pregnancy services, and what affects their satisfaction with their services?		effective access to termination of pregnancy services.
149	[for office use only]	The Royal College of Midwives (RCM)	7	**Main outcomes** Patient acceptability Patient preference	Why is the term 'patient' being used here? This group of women have been correctly referred to as 'women' throughout the rest of the scope.	Thank you for your comment. We have now changed these outcomes to read 'treatment preference' and 'treatment acceptability'

Document processed	Organisation name – Stakeholder or respondent	Disclosure on tobacco funding / links	Number of comments extracted	Comments
Antenatal Results and Choices.doc	Antenatal Results and Choices (ARC)	None	1	
Bayer plc.doc	Bayer plc	Current Situation Bayer does not have	1	

		direct or indirect links with, or funding from, manufacturers, distributors or sellers of smoking products but Bayer provides pesticides for crops, which would therefore include tobacco crops. Bayer is a member of the Cooperation Centre for Scientific Research Relative to Tobacco (CORESTA) (http://www.coresta.org/) within the scope of recommendations of pesticides used for protection of tobacco plants. It is also a member of country and EU business federations such as the Confederation of British Industry (CBI) and 'Business Europe', which include tobacco companies. Past Situation In 2006, Bayer and its subsidiary Icon Genetics piloted a new process for producing biotech drugs in tobacco plants. Icon Genetics was acquired by Nomad Bioscience GmbH from Bayer in 2012.		
British Society of Abortion Care Providers.doc	British Society of Abortion Care Providers (BSACP)	The British Society of Abortion Care Providers (BSACP) has been formed to promote best practice, education, training and research in	27	

		abortion care. The BSACP is recognised by the RCOG as the national specialist society for abortion care.		
Chesterfield Royal Hospital.doc	Chesterfield Royal Hospital Calow Chesterfield S44 5BL	None	1	
Christian Medical Fellowship.doc	Christian Medical Fellowship	None	8	
Department of Health.doc	Department of Health		1	
Faculty of Sexual and Reproductive Healthcare.doc	Faculty of Sexual and Reproductive Healthcare	[None]	12	
International Campaign for Women's Right to Safe Abortion.docx	International Campaign for Women's Right to Safe Abortion (ICWRSA)	No links of any kind	20	
MSD Ltd.doc	MSD Ltd	None	1	
NHS England.doc	NHS England		1	
NICE 2.doc	NICE (Medicines and Technologies Programme)	None	4	
NICE.doc	NICE – Quality Standards and Indicators Team	None	4	
Public Health England.docx	Public Health England	None	12	
Royal College of GP's.doc	Royal College of GP's	None Known	15	
Royal College of Nursing.doc	[Royal College of Nursing]	[None]	6	
Royal College of Obstetricians and Gynaecologists.DOC	Royal College of Obstetricians and Gynaecologists	N/A	12	
Royal Derby Hosptial.doc	Miss Jen Heslop Consultant Obstetrician & Gynaecologist, Lead for Unplanned Pregnancy, Royal Derby Hosptial	Nil	7	
Royal Devon & Exeter NHS Foundation Trust.doc	[Royal Devon & Exeter NHS Foundation Trust]	[Nothing to disclose]	1	
The Clinical Effectiveness Unit of the Faculty of Sexual and Reproductive Health.doc	The Clinical Effectiveness Unit of the Faculty of Sexual and Reproductive Health	none	6	
The Royal College of Midwives.doc	The Royal College of Midwives (RCM)	The Royal College of	9	

		Midwives has no current or past links or funding from the tobacco industry		

Registered stakeholders [Insert link]