NICE National Institute for Health and Care Excellence

NICE quality standard

Abortion care

Quality standard
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This standard is based on NG140.

This standard should be read in conjunction with QS178 and QS129.

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

Quality statement 1: Access to abortion services

Quality statement

Healthcare commissioners and providers work together to make abortion services easy to access.

Rationale

Providing abortion services that are easy to access will help to improve women's experiences, enable earlier presentation and reduce delays and complications. It will help women to avoid stigma and negative attitudes when requesting an abortion and to maintain their privacy and confidentiality. Commissioners and providers should work together to remove barriers to accessing abortion services to meet the needs of the local population.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

a) Evidence that healthcare commissioners and providers work together to make abortion services easy to access.

Data source: Local data collection, for example a joint plan to reduce barriers to accessing abortion services.

b) Evidence of joint local arrangements to provide information about how to access abortion services.

Data source: Local data collection, for example availability of information in different formats and signposting from services such as general practices and sexual health services.

c) Evidence that women can self-refer to abortion services.

Data source: Local data collection, for example online booking system or drop-in service with no requirement for a referral.

Outcome

a) Proportion of abortions performed at under 10 weeks.

Numerator – the number in the denominator performed at under 10 weeks.

Denominator – the number of abortions.

Data source: The Department of Health and Social Care's abortion statistics includes data on abortions performed at under 10 weeks.

b) Proportion of women assessed for an abortion who are satisfied with ease of access to abortion services.

Numerator – the number in the denominator who are satisfied with ease of access to abortion services.

Denominator – the number of women assessed for an abortion.

Data source: Local data collection, for example survey of women assessed for an abortion.

What the quality statement means for different audiences

Service providers (such as NHS hospital trusts and independent abortion providers) work with commissioners to ensure that abortion services are easy to access. Service providers support initiatives to improve access. This includes making information about abortion services widely available, allowing self-referral (for example through an online booking

system or drop-in service), considering telemedicine (providing assessments by phone or video call) and providing information about any upfront funding for travel and accommodation.

Health and social care practitioners (such as doctors, midwives, nurses and social workers) give women information on how to access abortion services. Health and social care practitioners do not allow their personal beliefs to delay access to abortion services.

Commissioners work with providers to ensure that abortion services are easy to access, including facilitating self-referral pathways. Commissioners identify the needs of the local population and work with providers to improve access for women with pregnancies at all gestational stages where abortion is legal. This includes making information about abortion services widely available, providing online booking systems and drop-in services that do not need referral from a healthcare professional, and considering telemedicine (providing assessments by phone or video call) and upfront funding for travel and accommodation.

Women who are considering an abortion can easily find out how to contact an abortion service and arrange a convenient first appointment.

Source guidance

Abortion care. NICE guideline NG140 (2019), recommendations 1.1.1, 1.1.2 and 1.1.9

Definitions of terms used in this quality statement

Make abortion services easy to access

Healthcare commissioners and providers should work together to:

- make information about abortion services (including how to access them) widely available
- allow women to self-refer to abortion services
- consider providing abortion assessments by phone or video call, for women who prefer this (telemedicine)

- consider upfront funding for travel and accommodation for women who are eligible for the NHS Healthcare Travel Costs Scheme and/or need to travel to a service that is not available locally
- make information available about any upfront funding for travel and accommodation.

[NICE's guideline on abortion care, recommendations 1.1.1, 1.1.2, 1.1.4 and 1.1.9]

Equality and diversity considerations

Healthcare commissioners and providers should ensure that pregnant women who self-refer to an abortion provider and are eligible for the NHS Healthcare Travel Costs Scheme or upfront funding for travel and accommodation do not need a GP referral to access the funding.

Healthcare commissioners and providers should ensure that information about how to access abortion services is easily available to women in vulnerable groups. These include sex workers, women who are experiencing homelessness, women in prison and women who may find it difficult to access healthcare services because they are not registered with a GP.

Ensure that women experiencing homelessness can access online health and social care information and are supported to use online services, for example, by providing internet access at places where women experiencing homelessness spend time, such as day centres or hostels (for more information, see NICE's guideline on integrated health and social care for people experiencing homelessness, recommendation 1.5.8).

Women should be provided with information that they can easily read and understand themselves, or with support. Information should be in a format that suits their needs and preferences, for example video or written information. It should be accessible to women who do not speak or read English, and it should be culturally and age appropriate. Women should have access to an interpreter or advocate if needed. For women with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible Information Standard.

Providing assessments by phone or video call can be particularly beneficial for women living in remote areas; women experiencing domestic violence, abuse or coercion from their partner or family; and women experiencing cultural barriers to accessing abortion

services. Providers should, however, ensure that safeguarding procedures are in place for all women, including those accessing the service remotely. Providing a choice of assessment by phone, video call or face to face ensures that women can access abortion services in the way that best suits their personal circumstances.

Quality statement 2: Choice of abortion procedure

Quality statement

Women who request an abortion are given a choice between medical and surgical abortion to take place up to and including 23+6 weeks' gestation.

Rationale

If clinically appropriate, medical and surgical abortion procedures are both safe and effective up to and including 23+6 weeks' gestation. A woman's experience is better if she can choose the abortion procedure to suit her individual circumstances. To support a woman's choice, it is important that women can access services as locally as possible and avoid lengthy travel times. If a provider does not offer the preferred method, the woman should be able to easily access the procedure from an alternative provider.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

a) Evidence of local processes to support a discussion about the differences between medical and surgical abortion, including the benefits and risks, with women who request an abortion.

Data source: Local data collection, for example service protocol. The NICE patient decision aid on abortion care can help women discuss their options with healthcare professionals.

b) Evidence of referral pathways to alternative services that are as local as possible if a

provider cannot provide an abortion by the woman's preferred method.

Data source: Local data collection, for example referral strategies and shared care pathways, including pathways for women with complex needs.

Process

a) Proportion of women who had an abortion up to and including 23+6 weeks' gestation with a record of their choice of medical or surgical abortion.

Numerator – the number in the denominator with a record of their choice of medical or surgical abortion.

Denominator – the number of women who had an abortion up to and including 23+6 weeks' gestation.

Data source: Local data collection, for example local audit of patient records.

b) Proportion of women who had an abortion up to and including 23+6 weeks' gestation who had a medical abortion.

Numerator – the number in the denominator who had a medical abortion.

Denominator – the number of women who had an abortion up to and including 23+6 weeks' gestation.

Data source: The Department of Health and Social Care's abortion statistics includes data on method of abortion. It is not expected that achievement will be 100%. Healthcare commissioners may wish to focus on variation in method for different gestational ages for their population compared with the national average.

c) Proportion of women who had an abortion up to and including 23+6 weeks' gestation who had a surgical abortion.

Numerator – the number in the denominator who had a surgical abortion.

Denominator – the number of women who had an abortion up to and including 23+6 weeks' gestation.

Data source: The Department of Health and Social Care's abortion statistics includes data on method of abortion. It is not expected that achievement will be 100%. Healthcare commissioners may wish to focus on variation in method for different gestational ages for their population compared with the national average.

Outcome

Proportion of women who had an abortion who were satisfied with their abortion care.

Numerator – the number in the denominator who were satisfied with their abortion care.

Denominator – the number of women who had an abortion.

Data source: Local data collection, for example survey of women who had an abortion.

What the quality statement means for different audiences

Service providers (such as NHS hospital trusts and independent abortion providers) ensure that processes are in place so that staff give women a choice between medical and surgical abortion to take place up to and including 23+6 weeks' gestation, if clinically appropriate. Providers ensure that referral pathways are in place so that women can be promptly referred to an alternative provider that is as local as possible if the service cannot provide their preferred method.

Healthcare professionals (such as doctors, nurses and midwives) give women who request an abortion a choice between medical and surgical abortion to take place up to and including 23+6 weeks' gestation, if clinically appropriate. If any of the methods would not be clinically appropriate, healthcare professionals explain the reason why. Healthcare professionals are aware of local referral pathways for abortion care and ensure that women are promptly referred to an alternative provider if the service cannot provide their preferred method.

Commissioners ensure that they commission the range of abortion services needed, with the capacity across services so that women can choose between medical and surgical abortion to take place up to and including 23+6 weeks' gestation. Commissioners support collaboration between providers and ensure that shared care pathways are in place for

women to be promptly referred to an alternative provider that is as local as possible, if the service cannot provide their preferred method.

Women who ask for an abortion to take place before 24 weeks can choose between taking medicines and having an operation to end their pregnancy. If the service cannot provide their chosen method, they are referred to a service that can. This should be in an area that is as close to them as possible.

Source guidance

Abortion care. NICE guideline NG140 (2019), recommendation 1.6.1

Equality and diversity considerations

Women should be provided with information that they can easily read and understand themselves, or with support. Information should be in a format that suits their needs and preferences, for example video or written information. It should be accessible to women who do not speak or read English, and it should be culturally and age appropriate. Women should have access to an interpreter or advocate if needed. For women with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible Information Standard.

Quality statement 3: Waiting time for an abortion

Quality statement

Women who decide to go ahead with an abortion have the option to have the procedure within 1 week of assessment.

Rationale

Abortion is very safe overall, but as morbidity and mortality increases for every additional week of gestation, earlier abortions are safer than later ones. Reducing waiting times for assessment and treatment can ensure that women have more options for procedures, reduce the risk of complications and improve the woman's experience. Once a woman has decided to go ahead with a medical or surgical abortion at their assessment with the abortion provider, they should have the option to have the procedure within 1 week if they wish.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

a) Evidence of local arrangements to ensure that women who decide to go ahead with an abortion have the option to have the procedure within 1 week of assessment.

Data source: Local data collection, for example service protocol and availability within 1 week of assessment for different abortion methods and gestational ages.

b) Evidence of local referral pathways if a service cannot provide the procedure within 1 week of assessment.

Data source: Local data collection, for example referral strategies and shared care pathways, including pathways for women with complex needs.

Process

a) Proportion of women who decide to go ahead with an abortion who have the option to have the procedure within 1 week of assessment.

Numerator – the number in the denominator who have the option to have the procedure within 1 week of assessment.

Denominator – the number of women who decide to go ahead with an abortion.

Data source: Local data collection, for example waiting time to the next available treatment slot.

b) Proportion of women who decide to go ahead with an abortion who have the procedure within 1 week of assessment.

Numerator – the number in the denominator who have the procedure within 1 week of assessment.

Denominator – the number of women who decide to go ahead with an abortion.

Data source: Local data collection, for example audit of patient records. As some women will choose to wait longer for an abortion, local areas should agree the expected performance in relation to this measure.

Outcome

a) Average waiting time for abortion from initial referral to receipt of procedure.

Data source: Local data collection, for example abortion provider annual reports include data on average waiting times for medical and surgical abortions and different gestational ages.

b) Proportion of abortions performed at under 10 weeks.

Numerator – the number in the denominator performed at under 10 weeks.

Denominator – the number of abortions.

Data source: The Department of Health and Social Care's abortion statistics includes data on abortions performed at under 10 weeks.

What the quality statement means for different audiences

Service providers (such as NHS hospital trusts and independent abortion providers) ensure that they have the capacity to provide abortions as soon as possible and within 1 week of assessment. Service providers work together and share information so that women who are referred to another provider do not need a repeated assessment and can have the procedure within 1 week of the original assessment.

Healthcare professionals (such as doctors, nurses and midwives) ensure that women who have decided to go ahead with an abortion have the option to have the procedure within 1 week of their assessment. Healthcare professionals have a discussion with women who would prefer to wait longer for an abortion about the implications of waiting longer. If the woman needs to be referred to another provider, healthcare professionals arrange the referral and share information about the assessment without delay.

Commissioners commission abortion services with the capacity and resources to provide abortions as soon as possible and within 1 week of assessment. Commissioners support collaboration between providers and ensure that shared care pathways and information sharing agreements are in place between providers. This is so that women do not need a repeated assessment if they are referred to another provider and the procedure can be arranged without delay.

Women who decide to go ahead with an abortion can have the abortion within 1 week of their assessment if they wish.

Source guidance

Abortion care. NICE guideline NG140 (2019), recommendation 1.1.6

Equality and diversity considerations

Some women in vulnerable groups may find it difficult to attend an appointment for an abortion at short notice for a variety of reasons. These include caring responsibilities, difficulty in making travel arrangements, financial difficulties, mental health problems, domestic violence and stigma. Service providers should have a flexible and supportive approach that helps women to choose a convenient time to have the abortion.

Healthcare commissioners should consider providing upfront funding for travel and accommodation for women on a low income who are eligible for the NHS Healthcare Travel Costs Scheme or need to travel to a service that is not available locally (including those who self-refer to the abortion provider). Healthcare commissioners and providers should make information available about how to access any upfront funding.

Quality statement 4: Early medical abortion

Quality statement

Women having a medical abortion up to and including 9+6 weeks' gestation are given the option to take misoprostol at home.

Rationale

Women who are having a medical abortion and taking mifepristone up to and including 9+6 weeks' gestation should be given the option to take misoprostol at home. They can then be at home when expulsion begins, rather than on their journey home. Home expulsions will reduce hospital attendance and waiting times for early medical abortions. The legal limit for the gestational age at which misoprostol can be taken at home is specified in the Secretary of State's approval order of December 2018.

In response to the COVID-19 pandemic the Department of Health and Social Care issued temporary approval of home use for both stages of early medical abortion.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local processes to ensure that women having a medical abortion up to and including 9+6 weeks' gestation are given the option to take misoprostol at home.

Data source: Local data collection, for example service protocol.

Process

Proportion of women having a medical abortion up to and including 9+6 weeks' gestation who take misoprostol at home.

Numerator – the number in the denominator who take misoprostol at home.

Denominator – the number of women having a medical abortion up to and including 9+6 weeks' gestation.

Data source: The Department of Health and Social Care's abortion statistics includes data on medical abortions where the second stage treatment was administered at home.

Outcome

a) Hospital attendances for administration of misoprostol for early medical abortion.

Data source: Local data collection, for example provider data returns.

b) Average waiting time for early medical abortion from initial referral to receipt of procedure.

Data source: Local data collection, for example provider annual reports.

What the quality statement means for different audiences

Service providers (such as NHS hospital trusts and independent abortion providers) ensure that processes are in place so that women having a medical abortion up to and including 9+6 weeks' gestation are given the option to take misoprostol at home. Providers ensure that healthcare professionals can give women information about the options available to help them make decisions about their care.

Healthcare professionals (such as doctors, nurses and midwives) give women who are having a medical abortion up to and including 9+6 weeks' gestation the option to take misoprostol at home. They give them information about the options available to help them make decisions about their care.

Commissioners ensure that they commission abortion services that give women who are having a medical abortion up to and including 9+6 weeks' gestation the option to take misoprostol at home.

Women having a medical abortionup to and including 9+6 weeks into the pregnancy can take the second medicine (misoprostol) at home rather than in a clinic or hospital, if they prefer.

Source guidance

Abortion care. NICE guideline NG140 (2019), recommendation 1.8.1

Equality and diversity considerations

Women should be given information that they can easily read and understand themselves, or with support. Information should be in a format that suits their needs and preferences, for example video or written information. It should be accessible to women who do not speak or read English, and it should be culturally and age appropriate. Women should have access to an interpreter or advocate if needed. For women with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible Information Standard.

Quality statement 5: Contraception

Quality statement

Women having an abortion who want contraception receive their chosen method before discharge, either at the time of their abortion or as soon as possible after expulsion of the pregnancy.

Rationale

Ensuring that women can access their preferred method of contraception at the time of their abortion, or soon after, will reduce the risk of future unintended pregnancies and abortions. It will improve the uptake of contraception and its continued use, as well as the woman's satisfaction with ease of access to contraception.

Quality measures

Structure

Evidence that the full range of reversible contraceptive options is available for women before discharge from an abortion provider, either on the same day as their abortion or as soon as possible after expulsion of the pregnancy.

Data source: Local data collection, for example service specification, rota for staff with skills to administer the full range of contraceptive methods, and return appointments for contraception offered if needed.

Process

Proportion of women having an abortion who want contraception who receive their chosen method before discharge.

Numerator – the number in the denominator who receive their chosen method of contraception before discharge.

Denominator – the number of women having an abortion who want contraception.

Data source: Local data collection, for example audit of patient records.

Outcome

Contraception uptake rate after abortion.

Data source: Local data collection, for example survey of women who have had an abortion.

What the quality statement means for different audiences

Service providers (including secondary care, community genitourinary medical services and independent sector services) ensure that staff are trained to administer long-acting methods of contraception. They also ensure that the full range of options for reversible contraception is available to women before discharge, either on the same day as their abortion, or as soon as possible after expulsion of the pregnancy.

Healthcare professionals (including doctors, nurses and midwives) arrange for the woman's chosen method of contraception to be provided before discharge, either at the same time as the abortion or as soon as possible after expulsion of the pregnancy.

Commissioners ensure that they commission abortion services that have the full range of options for reversible contraception available to women before discharge, either on the same day as their abortion or as soon as possible after expulsion of the pregnancy. They ensure that funding is available for abortion providers if a separate appointment to provide contraception is needed.

Women having an abortionwho want contraception are able to get their preferred method before discharge from the abortion service, either at the time of their abortion or as soon as possible afterwards.

Source guidance

Abortion care. NICE guideline NG140 (2019), recommendations 1.15.1 and 1.15.3 to 1.15.5

Quality statement 6: Support after an abortion

Quality statement

Women having an abortion are given advice on how to access care and support after the abortion.

Rationale

After an abortion some women may need support with physical or emotional issues. Women have individual preferences and needs for support after an abortion and they can sometimes find it difficult to get the support they need. Giving them advice about what to expect after the abortion and how to access care and support will help them get support if, and when, they need it.

Quality measures

Structure

a) Evidence of local arrangements to provide care and support to women after an abortion, including referral pathways to counselling or psychological interventions.

Data source: Local data collection, for example telephone helpline and service protocols, including referral pathways.

b) Evidence of local processes to ensure that women having an abortion are given advice on how to access care and support after the abortion, including how to get help out of hours.

Data source: Local data collection, for example service protocol and information sources such as a helpline number, leaflet or webpage.

Process

Proportion of women having an abortion who are given advice on how to access care and support after the abortion, including how to get help out of hours.

Numerator – the number in the denominator who are given advice on how to access care and support after the abortion, including how to get help out of hours.

Denominator – the number of women having an abortion.

Data source: Local data collection, for example audit of patient records and information leaflets.

Outcome

Proportion of women who had an abortion who agree they were able to access care and support after the abortion if they needed to.

Numerator – the number in the denominator who agree they were able to access care and support after the abortion if they needed to.

Denominator – the number of women who had an abortion.

Data source: Local data collection, for example survey of women who had an abortion.

What the quality statement means for different audiences

Service providers (such as NHS hospital trusts and independent abortion providers) ensure that they can provide assessment for physical symptoms and emotional support after an abortion, and provide advice to women about the care and support available locally. Service providers ensure that they can refer women for counselling or psychological interventions if requested.

Healthcare professionals (such as doctors, nurses and midwives) give advice to women on how to access care and support after the abortion, the support available locally and how to get help out of hours. Healthcare professionals carry out assessments for physical

symptoms and emotional support after an abortion and refer women for counselling or psychological interventions if requested.

Commissioners ensure that they commission abortion services that provide care and support to women after an abortion. Commissioners ensure that referral pathways are in place for women who have had an abortion to be able to access care and support, including counselling and psychological interventions, if needed.

Women having an abortion know how they can get care and support after the abortion if they need it, including how to get help out of hours.

Source guidance

Abortion care. NICE guideline NG140 (2019), recommendations 1.14.3 and 1.14.4

Definitions of terms used in this quality statement

Advice on how to access care and support after the abortion

Explain to women what to do if they have any problems after the abortion, including how to get help out of hours.

Explain that it is common to feel a range of emotions after the abortion. Advise women to seek support if they need it, and how to access it. This could include:

- support from family and friends or pastoral support
- emotional support from the abortion service provider
- peer support, or support groups for women who have had an abortion
- counselling or psychological interventions.

[NICE's guideline on abortion care, recommendations 1.14.3 to 1.14.5]

Equality and diversity considerations

Services that provide care and support after an abortion should make reasonable

adjustments to ensure that women with additional needs such as physical, sensory or learning disabilities, and women who do not speak or read English or who have reduced communication skills, can use the service. Women should have access to an interpreter (including British Sign Language) or advocate if needed.

Update information

Minor changes since publication

March 2022: The equality and diversity considerations section for statement 1 was updated in line with NICE's guideline on integrated health and social care for people experiencing homelessness.

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about how NICE quality standards are developed is available from the NICE website.

See our webpage on quality standard advisory committees for details of standing committee 3 members who advised on this quality standard. Information about the topic experts invited to join the standing members is available from the webpage for this quality standard.

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Resource impact

NICE quality standards should be achievable by local services. The potential resource

impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the impact on NHS workforce and resources, resource impact report and template for the NICE guideline on abortion care to help estimate local costs.

Diversity, equality and language

Equality issues were considered during development and equality assessments for this quality standard are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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Endorsing organisations

This quality standard has been endorsed by the following organisations, as required by the Health and Social Care Act (2012):

- NHS England
- Department of Health and Social Care

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- Royal College of Nursing (RCN)
- Royal College of Midwives

- Royal College of Obstetricians and Gynaecologists
- Faculty of Sexual and Reproductive Healthcare
- British Society of Abortion Care Providers (BSACP)
- British Association for Sexual Health and HIV