NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Abortion care

NICE quality standard

Draft for consultation

August 2020

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| **This quality standard covers** care for women of any age (including girls and young women under 18) who request an abortion. It describes high-quality care in priority areas for improvement.  It covers women, girls and people who are pregnant. For simplicity of language the quality standard uses the term women throughout, but this should be taken to also include people who do not identify as women but who are pregnant.  **It is for** commissioners, service providers, health, public health and social care practitioners, and the public.  This is the draft quality standard for consultation (from 21st August to 21st September 2020). The final quality standard is expected to publish in January 2021.  [The Royal College of Obstetricians and Gynaecologists has produced guidance for gynaecological services during the COVID-19 pandemic](https://www.rcog.org.uk/en/guidelines-research-services/coronavirus-covid-19-pregnancy-and-womens-health/). This is relevant to statement 1 in this quality standard and may help to support using the quality standard when it publishes.  In response to the COVID-19 pandemic the [Department of Health and Social Care has issued new and temporary approval](https://www.gov.uk/government/publications/temporary-approval-of-home-use-for-both-stages-of-early-medical-abortion--2) to permit the home use of mifepristone as well as misoprostol up until 10 weeks’ gestation. This is relevant to statement 5 in this quality standard. |

# Quality statements

[Statement 1](#_Quality_statement_1:) Healthcare commissioning groups and providers work together to make abortion services easy to access.

[Statement 2](#_Quality_statement_2:) Women who request an abortion are given a choice between medical or surgical abortion to take place up to and including 23+6 weeks’ gestation.

[Statement 3](#_Quality_statement_3:) Women who have decided to have an abortion receive the procedure within 1 week of assessment.

[Statement 4](#_Quality_statement_4:) Women who request an abortion are asked if they want information on contraception and if they do, are offered a choice of all methods at the time of their abortion or as soon as possible after expulsion of the pregnancy.

[Statement 5](#_Quality_statement_5:) Women having an early medical abortion are given the option of expulsion at home and a choice of interval or simultaneous treatment as appropriate for their gestation.

[Statement 6](#_Quality_statement_6:) Women having an abortion are given advice on how to access support after the abortion.

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| NICE has developed guidance and a quality standard on patient experience in adult NHS services (see the [NICE Pathway on patient experience in adult NHS services](https://pathways.nice.org.uk/pathways/patient-experience-in-adult-nhs-services)).  Other quality standards that should be considered when commissioning or providing abortion care services include:   * [Sexual health. NICE quality standard 178](https://www.nice.org.uk/guidance/qs178) * [Contraception. NICE quality standard 129](https://www.nice.org.uk/guidance/qs129)   A full list of NICE quality standards is available from the [quality standards topic library](http://www.nice.org.uk/Standards-and-Indicators/Developing-NICE-quality-standards-/Quality-standards-topic-library). |
| Questions for consultationQuestions about the quality standard **Question 1** Does this draft quality standard accurately reflect the key areas for quality improvement?  **Question 2** Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?  **Question 3** Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment. Questions about the individual quality statements **Question 4** For draft quality statement 3: We are aware that women may wait for an assessment for an abortion as well as waiting after the assessment to receive the procedure. Have we focused on the most important part of the pathway?  **Question 5** For draft quality statement 4: Is it preferable to focus this statement on all women who are having an abortion or more specifically on women who indicate that they wish to access contraception after their abortion? Please explain your answer.  **Question 6** For draft quality statement 4: A similar quality statement is currently included in the NICE contraception quality standard (QS129). We are proposing to move this statement into this quality standard on abortion care. Do you agree or disagree with this proposal? Please explain your answer. Local practice case studies **Question 7** Do you have an example from practice of implementing the NICE guideline that underpins this quality standard? If so, please provide details on the comments form. |

# Quality statement 1: Access to abortion services

## Quality statement

Healthcare commissioning groups 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. It will help women to avoid stigma and negative attitudes when requesting an abortion and help them 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

### Structure

a) Evidence that healthcare commissioning groups 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 to women about how to access abortion services.

***Data source:*** Local data collection, for example availability of information in different formats and signposting from other 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 under 10 weeks.

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

Denominator – the number of abortions.

***Data source:***[Department of Health and Social Care’s Abortion statistics](https://www.gov.uk/government/collections/abortion-statistics-for-england-and-wales) includes data on abortions performed 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) and considering providing assessments by phone or video call and 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** (clinical commissioning groups and NHS England) 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. This includes making information about abortion services widely available, providing online booking systems and drop-in services that do not require referral from a healthcare professional, and considering 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](https://www.nice.org.uk/guidance/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 commissioning groups and providers should:

* 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
* 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](https://www.nice.org.uk/guidance/ng140), recommendations 1.1.1, 1.1.2, 1.1.4 and 1.1.9]

## Equality and diversity considerations

Healthcare commissioning groups 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 homeless, women in prison and women who may find it difficult to access healthcare services because they are not registered with a GP.

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](https://www.england.nhs.uk/ourwork/accessibleinfo/).

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. 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 or 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. Women’s satisfaction with their experience is increased if they can choose the abortion procedure to suit their individual circumstances. Currently, some women are not given a choice of procedure because not all procedures are available from their provider and referral pathways to alternative local providers are not in place. To support women’s choice, it is important to ensure that they can access services locally and avoid lengthy travel times.

## Quality measures

### 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](https://www.nice.org.uk/guidance/ng140/resources/patient-decision-aids-and-user-guides-6906582256) can help women discuss their options with healthcare professionals.

b) Evidence of referral pathways to local services 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

Proportion of women having 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 having an abortion up to and including 23+6 weeks’ gestation.

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

### Outcome

a) Proportion of women having an abortion who agree that they were able to have their preferred abortion procedure.

Numerator – the number in the denominator who agree that they were able to have their preferred abortion procedure.

Denominator – the number of women having an abortion.

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

b) Proportion of women having an abortion who are satisfied with their abortion care.

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

Denominator – the number of women having an abortion.

***Data source:***Local data collection, for example survey of women having 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 or 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 local provider 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 or surgical abortion to take place up to and including 23+6 weeks’ gestation, if clinically appropriate. If any 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** (clinical commissioning groups) ensure that they commission the range of abortion services needed, with the capacity across services so that women can choose between medical or surgical abortion to take place up to and including 23+6 weeks’ gestation. Commissioners support collaboration between providers and ensure that referral strategies and shared care pathways are in place so that women can be promptly referred to an alternative local provider if the service cannot provide their preferred method.

**Women who ask for an abortion to take place before 24 weeks** are able to 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.

## Source guidance

[Abortion care. NICE guideline NG140](https://www.nice.org.uk/guidance/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](https://www.england.nhs.uk/ourwork/accessibleinfo/).

# Quality statement 3: Waiting time for an abortion

## Quality statement

Women who have decided to have an abortion receive the procedure within 1 week of assessment.

## Rationale

Earlier abortions are safer than later ones. Some women experience long waiting times and delays when trying to access abortion services. Reducing waiting times can ensure that women have more options available for the abortion procedure, reduce the risk of complications, and improve the woman's experience. Once a woman has decided to have a medical or surgical abortion at their assessment the procedure should ideally be carried out within 1 week.

## Quality measures

### Structure

a) Evidence of local arrangements to ensure that women who have decided to have an abortion are offered an appointment to have the procedure within 1 week of assessment.

***Data source:*** Local data collection, for example service protocol and availability of appointments 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

Proportion of women who have decided to have an abortion who receive the procedure within 1 week of assessment.

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

Denominator – the number of women who have decided to have 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 from abortion assessment 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 women having an abortion who are satisfied with the waiting time between assessment and the procedure.

Numerator – the number in the denominator who are satisfied with the waiting time between assessment and the procedure.

Denominator – the number of women having an abortion.

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

c) Proportion of abortions performed under 10 weeks.

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

Denominator – the number of abortions.

***Data source:***[Department of Health and Social Care’s Abortion Statistics](https://www.gov.uk/government/collections/abortion-statistics-for-england-and-wales) includes data on abortions performed under 10 weeks.

## What the quality statement means for different audiences

**Service providers** (such as NHS hospital trusts and independent abortion providers) ensure that 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 are offered an appointment to have the procedure within 1 week of the original assessment.

**Healthcare professionals** (such as doctors, nurses and midwives) offer women an appointment to have the abortion as soon as possible and 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** (clinical commissioning groups) commission abortion services with the capacity and resources to ensure that women who have decided to have an abortion can have the procedure 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 and the procedure can be arranged without delay.

**Women who have decided to have an abortion** are offered an appointment to have the abortion within 1 week of their assessment.

## Source guidance

[Abortion care. NICE guideline NG140](https://www.nice.org.uk/guidance/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 commissioning groups 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 and/or need to travel to a service that is not available locally. Healthcare commissioning groups should make information available about how to access any upfront funding.

## Question for consultation

We are aware that women may wait for an assessment for an abortion as well as waiting after the assessment to receive the procedure. Have we focussed on the most important part of the pathway?

# Quality statement 4: Contraception

## Quality statement

Women who request an abortion are asked if they want information on contraception and if they do, are offered a choice of all methods at the time of their abortion or as soon as possible after expulsion of the pregnancy.

## Rationale

Ensuring that women can make an informed choice about contraception, and that they can access their preferred contraceptive method at the time of their abortion will reduce the risk of future unintended pregnancies and abortions. Providing contraception as soon as possible after an abortion improves the uptake of contraception and its continued use, as well as the woman’s satisfaction.

## Quality measures

### Structure

a) Evidence that staff providing care for women who request an abortion are trained to offer a choice of all methods of contraception.

***Data source:*** Local data collection, for example staff training records.

b) Evidence of local processes to ensure that women who request an abortion are asked if they want information on contraception.

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

c) Evidence of local processes to ensure that women who want information on contraception are offered a choice of all methods at the time of their abortion or as soon as possible after expulsion of the pregnancy.

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

d) Evidence that the full range of reversible contraceptive options are available for women 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

a) Proportion of women who request an abortion who are asked if they want information on contraception.

Numerator – the number in the denominator who are asked if they want information on contraception.

Denominator – the number of women who request an abortion.

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

b) Proportion of women who want information on contraception who are offered a choice of all contraceptive methods at the time of their abortion or as soon as possible after expulsion of the pregnancy.

Numerator – the number in the denominator who are offered a choice of all contraceptive methods at the time of their abortion or as soon as possible after expulsion of the pregnancy.

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

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

### Outcome

a) Proportion of women having an abortion who were provided with their preferred contraceptive method at the time of the abortion or as soon as possible after expulsion of the pregnancy.

Numerator – the number in the denominator who were provided with their preferred contraceptive method at the time of their abortion or as soon as possible after expulsion of the pregnancy.

Denominator – the number of women having an abortion.

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

b) 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 and independent sector services) establish protocols to ensure that staff ask women who request an abortion if they want information on contraception. If the woman wants this, they provide information on and offer a choice of all contraceptive methods at the time of their abortion or as soon as possible after expulsion of the pregnancy. Service providers ensure that staff are trained to administer long-acting methods of contraception and that the full range of reversible contraceptive options are available for women on the same day as their abortion, or as soon as possible after expulsion of the pregnancy.

**Healthcare professionals** (including doctors, nurses and midwives) ask women who request an abortion if they want information on contraception. If the woman wants this, they provide information on and offer a choice of all contraceptive methods. Healthcare professionals arrange for the woman’s chosen method of contraception to be provided either at the same time as the abortion or as soon as possible after expulsion of the pregnancy.

**Commissioners** (clinical commissioning groups) ensure that they commission abortion services that can offer a choice of all contraceptive methods and provide the chosen contraceptive at the time of abortion or as soon as possible after expulsion of the pregnancy. Commissioners ensure that they commission abortion services that have the full range of reversible contraceptive options available to women on the same day as their abortion or as soon as possible after expulsion of the pregnancy.

**Women who plan to have an abortion** are asked if they want information on contraception. If the woman wants this, a healthcare professional will tell them about their options for contraception and provide their preferred method of contraception at the time of their abortion or as soon as possible afterwards.

## Source guidance

* [Abortion care. NICE guideline NG140](https://www.nice.org.uk/guidance/ng140) (2019), recommendations 1.2.6 and 1.15.1
* [Contraceptive services for under 25s. NICE guideline PH51](http://www.nice.org.uk/guidance/ph51) (2014), recommendation 7

## Definitions of terms used in this quality statement

### Information on contraception

Emphasise that women are fertile immediately after an abortion and give details of all contraceptive methods including:

* how the method works
* how to use it
* how it is administered
* insertion and removal (for implants and intrauterine devices [IUDs])
* suitability
* how long it can be used for
* risks and possible side effects
* failure rate
* non-contraceptive benefits
* when to seek help.

[Adapted from NICE’s guidelines on [contraceptive services for under 25s](https://www.nice.org.uk/guidance/ph51) and [long-acting reversible contraception](https://www.nice.org.uk/guidance/cg30) and expert opinion.]

**All contraceptive methods**

This quality standard focuses on all methods of contraception. These are divided into 3 groups:

* Long-acting reversible contraceptives that need administration less than once per month. These are:
  + contraceptive implant
  + contraceptive injection such as depot medroxyprogesterone acetate (DMPA)
  + intrauterine system
  + intrauterine device.
* Methodsthat depend on the person remembering to take or use them. These include:
  + oral contraceptives, for example combined oral contraceptive pill and progestogen-only pill
  + combined vaginal ring
  + combined transdermal patch
  + barrier contraception, for example male condom, female condom, diaphragm or cap with spermicide
  + fertility awareness.
* Permanent methods of contraception. These are:
  + vasectomy
  + female sterilisation.

[Adapted from [NICE’s guidelines on abortion care](https://www.nice.org.uk/guidance/ng140) and [long-acting reversible contraception](http://www.nice.org.uk/guidance/cg30/chapter/Introduction), the Faculty of Sexual & Reproductive Healthcare guidelines on [barrier methods for contraception and STI prevention](http://www.fsrh.org/pages/Clinical_Guidance_2.asp), [fertility awareness methods](http://www.fsrh.org/pages/Clinical_Guidance_2.asp), [progestogen-only pills](http://www.fsrh.org/pages/Clinical_Guidance_2.asp) and [combined hormonal contraception](http://www.fsrh.org/pages/Clinical_Guidance_2.asp)]

## Equality and diversity considerations

Age, religion and culture may affect which contraceptive methods the woman considers suitable. Healthcare professionals should give information about all methods and allow the woman to choose the one that suits her best.

## Questions for consultation

Is it preferable to focus this statement on all women who are having an abortion or more specifically on women who indicate that they wish to access contraception following their abortion? Please explain your answer.

A similar quality statement is currently included in the NICE contraception quality standard (QS129). We are proposing to move this statement into this quality standard on abortion care. Do you agree or disagree with this proposal? Please explain your answer.

# Quality statement 5: Early medical abortion

## Quality statement

Women having an early medical abortion are given the option of expulsion at home and a choice of interval or simultaneous treatment as appropriate for their gestation.

## Rationale

Women should be given a choice of the different options available for early medical abortion so that the procedure meets their individual priorities. Enabling women to choose home expulsion up to and including 10+0 weeks’ gestation will reduce hospital admissions and waiting times for early medical abortions.

## Quality measures

### Structure

a) Evidence of local processes to ensure that women having a medical abortion up to and including 10+0 weeks’ gestation are given the option of expulsion at home.

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

b) 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.

c) Evidence of local processes to ensure that women having a medical abortion up to and including 9+0 weeks’ gestation are given information about the choice of interval or simultaneous treatment.

***Data source:*** Local data collection, for example service protocol and information pack for women who are taking misoprostol at home.

### Process

a) Proportion of women having a medical abortion up to and including 10+0 weeks’ gestation who are given the option of expulsion at home.

Numerator – the number in the denominator who are given the option of expulsion at home.

Denominator – the number of women having a medical abortion up to and including 10+0 weeks’ gestation.

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

b) Proportion of women having a medical abortion up to and including 9+6 weeks’ gestation who are given the option to take misoprostol at home.

Numerator – the number in the denominator who are given the option to take misoprostol at home.

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

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

c) Proportion of women having a medical abortion up to and including 9+0 weeks’ gestation who are given information about the choice of interval or simultaneous treatment.

Numerator – the number in the denominator who are given information about the choice of interval or simultaneous treatment.

Denominator – the number of women having a medical abortion up to and including 9+0 weeks’ gestation.

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

### Outcome

a) Hospital admissions for administration of early medical abortion.

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

b) Average waiting time from first contact to receipt of procedure for early medical abortion.

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

c) Proportion of women having an early medical abortion who are satisfied with their abortion care.

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

Denominator – the number of women having an early medical abortion.

***Data source:***Local data collection, for example survey of women having an early medical 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 women having an early medical abortion are given the option of expulsion at home (up to and including 10+0 weeks’ gestation). This includes the option to take misoprostol at home (up to and including 9+6 weeks’ gestation) and the choice of interval or simultaneous treatment (up to and including 9+0 weeks’ gestation). Providers ensure that healthcare professionals are aware of the importance of giving information about the options to help women to make decisions about their care. Providers also ensure that healthcare professionals explain the risk of ongoing pregnancy may be higher with simultaneous treatment and how to be sure that the pregnancy has ended.

**Healthcare professionals** (such as doctors, nurses and midwives) give women who are having an early medical abortion the option of expulsion at home (up to and including 10+0 weeks’ gestation). This includes the option to take misoprostol at home (up to and including 9+6 weeks’ gestation) and the choice of interval or simultaneous treatment (up to and including 9+0 weeks’ gestation). Healthcare professionals give women information about the options to help them to make decisions about their care. Healthcare professionals explain the risk of ongoing pregnancy may be higher with simultaneous treatment and how to be sure that the pregnancy has ended.

**Commissioners** (clinical commissioning groups) ensure that they commission abortion services that give women who are having an early medical abortion the option of expulsion at home (up to and including 10+0 weeks’ gestation). This includes the option to take misoprostol at home (up to and including 9+6 weeks’ gestation) and the choice of interval or simultaneous treatment (up to and including 9+0 weeks’ gestation).

**Women having an early medical abortion** can opt to take the second medicine at home (up to and including 9+6 weeks into the pregnancy) and pass the pregnancy at home (up to and including 10+0 weeks into the pregnancy) if they prefer. Women having an early medical abortion can also choose to take the first and second medicines 1 to 2 days apart or at the same time (up to and including 9+0 weeks into pregnancy) if they wish. If they take the medicines at the same time they should be aware that the risk that the pregnancy will continue may be higher. It may take longer for the bleeding and pain to start and the abortion may take less time overall.

## Source guidance

[Abortion care. NICE guideline NG140](https://www.nice.org.uk/guidance/ng140) (2019), recommendations 1.8.1, 1.8.2, 1.9.1 and 1.9.2

## Definitions of terms used in this quality statement

### Option of expulsion at home

Women having a medical abortion and taking the mifepristone up to and including 9+6 weeks’ gestation should be offered the option of expulsion at home after they have taken the misoprostol either at home or in the clinic or hospital.

Women having a medical abortion and taking the mifepristone at 10+0 weeks’ gestation should be offered the option of expulsion at home after they have taken the misoprostol in the clinic or hospital.

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](https://www.gov.uk/government/publications/approval-of-home-use-for-the-second-stage-of-early-medical-abortion).

[[NICE’s guideline on abortion care](https://www.nice.org.uk/guidance/ng140), recommendations 1.8.1 and 1.8.2]

### Choice of interval or simultaneous treatment

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

Offer simultaneous treatment with mifepristone and vaginal misoprostol given at the same time to women who are having a medical abortion up to and including 9+0 weeks’ gestation. Explain that:

* the risk of ongoing pregnancy may be higher, and it may increase with gestation
* it may take longer for the bleeding and pain to start
* it is important for them to complete the follow-up programme via self-assessment, remote assessment or clinic follow-up including a low-sensitivity or multi-level urine pregnancy test to exclude an ongoing pregnancy.

Healthcare professionals should be aware of the current UK marketing authorisation for mifepristone and misoprostol. The prescriber should follow relevant professional guidance for unlicensed uses of mifepristone and misoprostol, taking full responsibility for the decision. Informed consent should be obtained and documented. See the [General Medical Council's Prescribing guidance: prescribing unlicensed medicines](http://www.gmc-uk.org/guidance/ethical_guidance/14327.asp) for further information.

[[NICE’s guideline on abortion care](https://www.nice.org.uk/guidance/ng140), recommendations 1.9.1, 1.9.2, 1.14.1 and 1.14.2]

## 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](https://www.england.nhs.uk/ourwork/accessibleinfo/).

# Quality statement 6: Support after an abortion

## Quality statement

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

## Rationale

After an abortion some women may need support with physical or emotional issues. Women have specific 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 support will help them get support if, and when, they need it.

## Quality measures

### Structure

a) Evidence of local arrangements to provide 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 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 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 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 having an abortion who agree they were able to access support after the abortion if they needed to.

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

Denominator – the number of women having an abortion.

***Data source:***Local data collection, for example survey of women having 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 support available locally. Service providers ensure that they can refer women for counselling if requested.

**Healthcare professionals** (such as doctors, nurses and midwives) give advice to women on how to access support after the abortion, the support available locally and how to get help out of hours. Healthcare professionals refer women for counselling if requested.

**Commissioners** (clinical commissioning groups) ensure that they commission abortion services that provide support to women after an abortion. Commissioners ensure that referral pathways are in place for women who have had an abortion to access counselling if required.

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

## Source guidance

[Abortion care. NICE guideline NG140](https://www.nice.org.uk/guidance/ng140) (2019), recommendation 1.14.4

## Definitions of terms used in this quality statement

### Advice on how to access 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](https://www.nice.org.uk/guidance/ng140), recommendations 1.14.3, 1.14.4 and 1.14.5]

## Equality and diversity considerations

Services that provide 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.

# 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](https://www.nice.org.uk/standards-and-indicators/timeline-developing-quality-standards) is available from the NICE website.

See [quality standard advisory committees](http://www.nice.org.uk/Get-Involved/Meetings-in-public/Quality-Standards-Advisory-Committee) on the website 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](https://www.nice.org.uk/guidance/indevelopment/gid-qs10084/documents).

This quality standard has been included in the [NICE Pathway on abortion care](https://pathways.nice.org.uk/pathways/abortion-care) and the [NICE Pathway on contraception](https://pathways.nice.org.uk/pathways/contraception), which bring together everything we have said on a topic in an interactive flowchart.

NICE has produced a [quality standard service improvement template](https://www.nice.org.uk/about/what-we-do/into-practice/measuring-the-uptake-of-nice-guidance) 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 produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

## Improving outcomes

This quality standard is expected to contribute to improvements in the following outcomes:

* choice of abortion procedure
* time between abortion request and procedure
* early medical abortions
* women’s satisfaction with abortion care.

It is also expected to support delivery of the following national frameworks:

* [NHS outcomes framework](https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework)
* [Public health outcomes framework for England](https://www.gov.uk/government/collections/public-health-outcomes-framework)
* [Quality framework for public health](https://www.gov.uk/government/publications/quality-in-public-health-a-shared-responsibility).

## 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 resource impact products for the source guidance to help estimate local costs:

* [impact on NHS workforce and resources, resource impact report and template](https://www.nice.org.uk/guidance/ng140/resources) for the NICE guideline on abortion care
* [costing report and template](https://www.nice.org.uk/guidance/ph51/resources) for the NICE guideline on contraceptive services for under 25s.

## Diversity, equality and language

Equality issues were considered during development and [equality assessments for this quality standard](https://www.nice.org.uk/guidance/indevelopment/gid-qs10084/documents) 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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