NATIONAL INSTITUTE FOR HEALTH AND   
CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1. Quality standard title

Abortion care

Date of quality standards advisory committee post-consultation meeting:   
14th October 2020

1. Introduction

The draft quality standard for abortion care was made available on the NICE website for a 4-week public consultation period between 21st August and 21st September 2020. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 20 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the quality standards advisory committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the committee as part of the final meeting where the committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the committee should read this summary alongside the full set of consultation comments, which are provided in appendices 1 and 2.

1. Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be to be for these to be put in place?

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.

Stakeholders were also invited to respond to the following statement-specific questions:

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?

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.

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.

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.

1. General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

* There was support for the quality standard but some areas need refinement.
* There were concerns that the quality standard does not reflect the changes in abortion care since the COVID-19 pandemic, specifically in relation to telemedicine, ultrasound as clinically required and early medical abortion at home. Some stakeholders indicated that the changes have led to improvements in care while others expressed concerns about the impact of the changes on women having an abortion.
* The quality standard should use the non-gendered term ‘people’ rather than ‘women’ to be inclusive.
* Clarify if the QS applies to England only or UK. Note that the option to take misoprostol at home during the pandemic is up to 11+6 weeks in Scotland.
* Make it clear that the law regarding abortion should always be complied with.
* The Royal College of Obstetricians and Gynaecologists guidance during the COVID-19 pandemic is also relevant to statements 3 and 5.
* The quality standard should also reference the Department of Health and Social Care ‘Temporary approval of home use for both stages of early medical abortion up to ten weeks’.
* ‘Equality and diversity considerations’ should be reworded to ‘equitable access’ to reflect that it is intersectionality that leads to health inequality rather than individual characteristics.

### Consultation comments on data collection

* Individual providers are likely to have the systems and structures in place to collect data for their organisation.
* During the COVID-19 pandemic there has been increased sharing of data and information and there is interest in developing a national reporting system for key outcomes. A more formalised approach to a shared data set would be helpful.
* There was some concern that surveys of women who have had an abortion may be limited as not all women will participate.

### Consultation comments on resource impact

* There were concerns about current arrangements where abortion care is commissioned well below national tariff and the impact that has on patient choice and quality improvement and innovation. It was suggested that the quality standard places too much responsibility on service providers within this context.
* It was suggested that some of the quality statements will have resource implications that should be recognised as this will support the case for adequate funding.
* The emphasis in the quality standard on collaboration between providers and commissioners is unrealistic as it does not reflect existing funding and commissioning pathways.
* The quality standard could be helpful in holding contracting CCGs to account.

1. Summary of consultation feedback by draft statement
   1. Draft statement 1

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

### Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

* General
  + There was support for this quality statement and in particular the focus on self-referral.
  + It does not reflect the current context during the COVID-19 pandemic where telemedicine is the norm for early abortions.
  + Although joint working between commissioners and providers is important there are currently barriers that mean it is difficult to sustain (e.g. fragmentation of commissioning responsibilities, staff turnover, time pressures).
  + There was a concern that improving access could lead to pressure on women to make decisions that they are not ready to make.
* Rationale
  + Improving access reduces gestation at abortion which saves money due to reduced complication rates.
  + Should emphasise that having an abortion needs to be normalised.
* Measures
  + An additional measure on the availability of funding for travel and accommodation is needed as this is not being provided. Note that women who self-refer to abortion services are not eligible for the NHS Healthcare Travel Costs Scheme without a GP referral.
  + The measure on self-referral should be amended to ensure that the service provider can provide 2 signatures for the HSA1 form without expecting women to obtain a signature from their GP.
  + NHS hospital coding of gestation is categorised and does not include under 10 weeks as required for the outcome measure.
  + It would be preferable to use a different measure of lowered gestation at abortion as below and above 10 weeks is not clinically significant.
  + More timely sharing of routinely collected abortion data for the Department of Health and Social Care would support improved healthcare provision and reduce duplication.
  + There was a concern about the quality of data collection for the national abortion statistics.
* Audience descriptors
  + GP practices and sexual health clinics could help to reduce delays by giving women the self-referral details when they call for an appointment.
* Equality and diversity considerations
  + Should include safeguarding to prevent coercion including the option to have a face to face assessment.
* Resource impact
  + The cost implications of providing information in different languages should be recognised.

### Issues for consideration

* Should we progress this statement to the final quality standard?
* Would it be helpful to focus the statement e.g. on self-referral?
* In the current context, is it helpful to include telemedicine given that the recommendation is ‘consider’?
* Do we need to say anything else about funding for travel and accommodation if women who self-refer are not eligible for the NHS Healthcare Travel Costs Scheme?
* Should we keep ‘abortions performed under 10 weeks’ as an outcome?
* Do we need to say any more about safeguarding?
  1. Draft 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.

### Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

* General
  + There was general support for this statement.
  + There was agreement that choice of procedure should be provided during first and second trimesters but given current provision it is more likely that travel will be required during the second trimester.
  + More guidance on the requirements for an offer for surgical or medical abortion will be needed. For example, what is an acceptable travel distance or waiting time?
  + It is important to ensure that women are informed about the rate of complications for surgical and medical abortions.
* Statement
  + It would be helpful to consider gestation bands separately and to focus on areas where a lack of choice is having the most impact.
  + Surgical abortions should include a choice of local or general anaesthesia.
* Rationale
  + Locally should be revised to ‘as locally as possible’ given the constraints that exist in relation to lack of provision for later stage surgical and medical abortions.
* Measures
  + Remove ‘to local services’ from structure measure b).
  + Concern that the process measure will not be helpful.
  + Systems are not in place to record what women are offered and this would require investment.
  + There was concern about the value of surveys with women having an abortion as they tend to rank high satisfaction scores due to low expectations. As information about abortion is variable, they may not be able to identify if they received their ‘preferred abortion procedure’.
* Resource impact
  + There was a concern that the requirement for referral pathways to alternative local providers will encourage commissioners to move to Any Qualified Provider contracts which could have a negative impact on the willingness of providers to invest in services and provide the full range of services.
  + It should be recognised that providing local access to more specialised abortion treatments may not be feasible due to the cost and resource impact.

### Issues for consideration

* Should we progress this statement to the final quality standard?
* What do we mean by ‘local’ and is it realistic? Could it have unintended consequences for commissioning?
* Would it be helpful to focus on different gestation bands?
* Can we improve the process measure?
* Is there an alternative outcome that is not survey based?
  1. Draft statement 3

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

### Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

* General
  + More emphasis is needed to ensure women are not rushed to meet targets and can change their mind if they wish.
* Statement
  + There is a need to clarify which part of the pathway is included. Is assessment by a GP who refers to a specialist service included?
  + Should the time be expressed in weeks or working days?
* Rationale
  + There is currently no mechanism for recording the point at which the woman decides to have a medical or surgical abortion.
* Measures
  + Structure measure b) should be removed as local referral pathways are not appropriate for specialist abortion services.
  + There was support for providers to self-report data including waiting times to the next available treatment slot.
  + There was concern that collecting survey data for outcome b) could be difficult for some small-scale providers.
  + Would it be helpful to measure wait times separately for different treatment pathways such as early medical abortion and later gestation surgical abortion?

### Consultation question 4

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?

Stakeholders made the following comments in relation to consultation question 4:

* There was some agreement that the current focus on the time from decision to procedure is appropriate.
  + It will help to ensure that services are not under pressure to rush women into making a decision or to discharge them if they remain uncertain.
* Others felt that the current statement could make services worse by encouraging same-day treatment after a significant wait time to consultation.
* Waiting times to consultation have improved due to the interim legislation due to COVID-19 but that could change in future.
* The statement should include a target wait time to consultation as well as treatment waiting time as both are important.
* The focus should be on providing treatment within 2 weeks of referral to an abortion service to ensure resources are not focussed on one part of the pathway only.

### Issues for consideration

* Should we progress this statement to the final quality standard?
* Which part of the pathway should the statement focus on?
* Is it weeks or working days?
* Should we assume that the decision about medical or surgical abortion will be made at assessment?
* Do we need separate measures for different pathways?
  1. Draft 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.

### Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

* General
  + There was some support for this quality statement.
  + Is referral to a contraception service for those having an early medical abortion at home included?
  + It should be noted that a minority of women may choose to start contraception off licence prior to the abortion.
* Statement
  + It was suggested that the wording should be strengthened to ensure a more proactive approach rather than just asking women if they want information on contraception.
  + The wording should include long-acting reversible contraception methods.
  + ‘As soon as possible’ sounds vague and needs clarification.
* Rationale
  + It needs to be clearer if contraception includes only reversible methods or permanent methods as well.
* Measures
  + Structure a) on training should include more detail on what standard is expected, for example, the Faculty of Sexual and Reproductive Health qualifications or equivalent.
  + Outcome a) should focus on the ‘proportion of women who want contraception’.
  + There was concern that Outcome b) is not appropriate as it risks ignoring women’s choice in order to meet targets.
  + No current mechanisms are in place to collect this data.
* Audience descriptors
  + Commissioners need to ensure that funding is in place for abortion providers to provide contraception. Currently the assumption is that the method is provided at the time of the abortion and funding is only provided for the cost of the device. This is a barrier to providing LARC methods to women having an early medical abortion who require a separate appointment.

### Consultation question 5

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.

Stakeholders made the following comments in relation to consultation question 5:

* There was some support for retaining the focus on all women requesting an abortion to:
  + ensure that there is an emphasis on giving information and the woman’s choice
  + emphasise the importance of the conversation about contraception which is likely to increase uptake among those who may otherwise indicate that they do not wish to access contraception.
* Others suggested that it is more appropriate to focus on women who wish to access contraception.

### Consultation question 6

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.

Stakeholders made the following comments in relation to consultation question 6:

* There was some support for moving this statement from QS129.
* Others suggested the statement should remain in both quality standards.
* It was suggested that the wording of the statement in QS129 is better as it is clearer that it applies to all women.

*Women who request an abortion discuss contraception with a healthcare practitioner and are offered a choice of all methods when they are assessed for abortion and before discharge. (QS129 statement 3)*

### Issues for consideration

* Should we progress this statement to the final quality standard?
* Is it better to retain the focus on all women or to focus on women who wish to access contraception?
* How can we word the statement to ensure a proactive approach? Should we re-consider the wording in QS129?
* Do we need to define ‘as soon as possible after expulsion of the pregnancy’?
* Is referral to a GP or sexual health clinic excluded?
* Is there any specific training or accreditation that we can refer to in structure measure a)?
* Is outcome measure b) contraception uptake rate after abortion appropriate?
* Should this statement move from QS129 Contraception to the quality standard on abortion care?
  1. Draft 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.

### Consultation comments

Stakeholders made the following comments in relation to draft statement 5:

* General
  + There was some support for this statement.
  + The statement is out of date as it does not take into account the development of telemedicine abortion services as a result of the ability to take mifepristone at home during the COVID-19 pandemic, although it was recognised that the current legal framework is temporary.
  + It needs to be clearer what is allowed in relation to taking medicine and expulsion at home in line with the current approvals.
* Statement
  + It would be preferable to focus on giving women the option to take misoprostol at home rather than the option of expulsion at home as in reality most independent service providers are unable to offer inpatient expulsion.
  + It was suggested that simultaneous treatment should be removed from the statement as it is only needed when women need to take medication on licensed premises (currently not required). It was only relevant for a limited number of cases where a woman was unable to return to a provider for a second appointment. There was concern that simultaneous treatment results in inferior clinical outcomes and is not in line with the temporary approval during the COVID-19 pandemic for a two-stage process.
  + It would be helpful for the statement to include telemedicine.
* Measures
  + Systems are not currently in place to report the offer of treatment. It would therefore need to be provider self-report or survey based.
  + There was concern that data collection should not become a burden.

### Issues for consideration

* Should we progress this statement to the final quality standard?
* What should the statement focus on - expulsion at home, misoprostol at home?
* Should simultaneous treatment be removed?
* How can we reflect telemedicine given that it is a ‘consider’ recommendation?
* How can we futureproof the statement given the changing context?
  1. Draft statement 6

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

### Consultation comments

Stakeholders made the following comments in relation to draft statement 6:

* General
  + There was support for this statement.
  + The emphasis in the statement on giving advice on how to access support will not help to ensure that women are able to access timely and effective support when they need it, particularly if they require psychological therapies or counselling.
  + Women are often reluctant to access emotional and psychological support from their abortion provider and may need access to independent support.
* Statement
  + The wording should be amended to ‘care and support during and after the abortion’ to better reflect that clinical care is included as well as post-abortion counselling.
  + The wording should be amended to ‘clinical advice and support’.
* Measures
  + There was a concern to ensure that data collection does not become a burden.
* Audience descriptors
  + It is important that commissioners do not take a simplistic approach to providing support after an abortion as women are likely to access support from other local providers as well as their abortion service. NHS abortion services are not required to provide a 24-hour helpline.
  + Women may need to access support a long time after the abortion so it is important to ensure that information is provided in different formats including written and electronic so that it can be accessed when needed.

### Issues for consideration

* Should we progress this statement to the final quality standard?
* Do we need to amend the statement to make it clearer that clinical support is included?
* Is clinical support during an early medical abortion at home included?
* What can we say about support from other providers after an abortion?

1. Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

* **Information and support (including counselling) for women considering an abortion including options other than an abortion**
  + This is beyond the scope of this quality standard which is focussed on women who request an abortion. NG140 recommendation 1.1.8 indicates that women should not be required to have compulsory counselling or time for reflection before the abortion.
* **Telemedicine**
  + NG140 recommendation 1.1.9 covers this area and is included as source guidance for statement 1. As this is a ‘consider’ recommendation it would not be possible to use it for a separate statement on telemedicine.
* **Training for healthcare professionals**
  + NG140 recommendations 1.1.11 to 1.1.14 cover this area. Quality statements focus on actions that demonstrate high quality care or support, not the training that enables the actions to take place. This was discussed as an additional area at the prioritisation QSAC meeting but not progressed.
* **Testing for sexually transmitted infections including HIV**
  + The quality standard on sexual health (QS178) includes a statement on identifying people who may be at risk of sexually transmitted infections at key points of contact including abortion. This area was discussed at the prioritisation QSAC meeting but not progressed.
* **Routine follow-up for women who have had an early medical abortion**
  + NG140 recommendations 1.14.1 and 1.14.2 indicate that women should be offered the choice of self-assessment including remote assessment (for example by telephone or text messaging) as an alternative to clinic follow-up. They should also be provided with a pregnancy test to exclude ongoing pregnancy. These recommendations do not support the area suggested by the stakeholder. This area has not previously been discussed by the committee.

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# Appendix 1: Quality standard consultation comments table – registered stakeholders

| **ID** | **Stakeholder** | **Statement number** | **Comments[[1]](#footnote-1)** |
| --- | --- | --- | --- |
| 1 | British Association for Sexual Health & HIV (BASHH) | General | There is no mention at all of STI (incl HIV) testing that we can see: this so that’s an obvious omission. NICE would know from previous guidance in recommending HIV tests and the joint BASHH/ British HIV association/RCGP guidance and from NICE that STIs would be significantly present in those requestion abortion (i.e. having had unprotected sex) and indeed HIV and such tests ought to form a standard part of care. |
| 2 | British Association for Sexual Health & HIV (BASHH) | General | The language of the document is gendered and not inclusive of those who do not identify as a woman and need abortion services. There is a qualifying statement saying 'women' is used for sake of simplicity. 'People' or a non-gendered term may be simpler. |
| 3 | British Association for Sexual Health & HIV (BASHH) | General | Equality and Diversity: Suggest the term 'Equitable Access' or something else that takes into consideration the intersectionality that leads to health inequality rather than an individual characteristic. |
| 4 | British Pregnancy Advisory Service (BPAS) | General | BPAS welcomes the introduction of a Quality Standard designed to implement the 2019 Abortion Care guidelines which we supported. However, we were disappointed to see that the Quality Standards as produced lacked the ambition with which abortion providers have acted and advocated since the Covid-19 pandemic. The baseline for high quality, accessible abortion care has been raised, but this is not something recognised by the Quality Standards. We advocated for the introduction of a NICE guideline on abortion care because we were acutely aware that across the country, particularly in areas with direct NHS provision, women were not receiving the standard of care to which they should be entitled. The introduction of this Quality Standard as it stands would undermine high quality, evidence-based developments to care for the foreseeable future. We hope that the Committee will consider revising their proposals to take into account the standard of care every woman in England should be able to expect. |
| 5 | British Pregnancy Advisory Service (BPAS) | General | Throughout the Quality Standard, there is a focus on collaboration between providers and different parts of the NHS and Independent Service Provider system which does not account for existing funding and commissioning pathways. We do not believe it is the role of a Quality Standard to mandate this by default outside the Guideline and current NHS organisational and funding structures. There is a substantial risk that some aspects of the draft Quality Standard will place an onus on providers to provide a service which is impossible under current arrangements, without fundamental changes from commissioners. The Quality Standard should, instead, be focused on providing the best possible care within the current ‘hard’ limitations of the law, funding, and structural arrangements. |
| 6 | Centre for Bio-Ethical Reform UK (CBR UK) | General | The purpose of our comments is simple. It is to restate the statements you pose, with the euphemisms removed. We hope by doing so that NICE, along with policy makers and members of the public will understand the true and real nature of the UK abortion industry.  In starting, we also wish to make clear that this consultation is not open. While the guidelines  claim they are for “commissioners, service providers, health, public health and social care practitioners and the public”, in reality they have been created by and for the interests of the abortion industry. This closed “feedback loop” is deliberately ignoring the growing weight of evidence and expertise from crisis pregnancy centres, post abortive councellors, researchers, scientists and pastors, not to mention post abortive women, that suggest current abortion practice is harming women and killing children.  A recent leaked [email from NHS england and improvements](https://christianconcern.com/wp-content/uploads/2018/10/CC-Resource-Misc-Judicial-Review-Abortion-200729-NHS-email-2.pdf) detailing catastrophic events directly caused by abortion-by-post measures including “hemorrhaging”, “resusitations” and “two maternal deaths”- should also be pause for reflection for NICE as an abortion regulator, and not be cast aside as [“scurrilous”](https://www.politicshome.com/thehouse/article/the-abortion-act-is-no-longer-fit-for-purpose-we-need-telemedicine-to-become-a-permanent-option-for-women) as one leading MP has attempted to do. |
| 7 | Christian Action Research and Education (CARE) | General | It is not clear whether this quality standard is intended to apply only in England or across the UK. We recommend that the scope is made clear. |
| 8 | Christian Action Research and Education (CARE) | General | We are concerned that there is no reference in the guideline to commissioner and providers operating within the law as required in England (or beyond if that is the scope for this quality standard)  RSOP1 (Required Standard Operating Procedures) states that “The Abortion Act 1967 regulates the provision of abortion services in England, Wales and Scotland. If an abortion is performed which does not comply with the terms of the Act then an offence will have been committed under the Offences Against the Person Act 1861 and /or the Infant Life (Preservation) Act 1929… The Department of Health and Social Care issued guidance on 23rd May 2014 which sets out its interpretation of the law on abortion (reproduced at Annex 2). All approved places must comply with this guidance.” [[2]](#footnote-2) In making it easier for women to access a termination, it must be clear that the law regarding abortion is complied with at all times. Abortion is regulated by the criminal law. Under the Abortion Act 1967, two registered medical practitioners must be of the opinion, formed in good faith, that the termination of pregnancy complies with one of the Grounds under the Act. Services must not be made more accessible by circumventing this requirement.  Services in England must meet the requirements of Regulation 20 of the Care Quality Commission (Registration) Regulations 2009.[[3]](#footnote-3)  Any use of medication for a termination must meet the requirements of the Human Medicines Regulations 2012.[[4]](#footnote-4)  Use of abortion pills at home must meet the approval requirements set out in England,[[5]](#footnote-5) and those set out in the rest of the UK is the scope is wider.  The authors of this Quality Standard cannot assume that those using it will be aware of the law and the legal framework surrounding abortion, particularly service users.  We recommend that commissioner and providers are reminded that while working towards these quality standards all the legal requirements set out above must be met. |
| 9 | Christian Medical Fellowship | General | The six statements call for easier access, faster assessment, wider choice of procedure and venue, better provision of contraception and support services after the procedure and perpetuation of the current Covid provision of early medical abortion at home without the need for medical assessment.  It is a charter for abortion providers. If implemented, it will further increase the already record levels of abortion in the UK. Data show that the number of abortions undertaken during ‘lockdown’ under the emergency provision is significantly higher than normal, a trend that will continue if those temporary provisions are made permanent.  The Christian Medical Fellowship opposes those measures intended to ‘streamline’ the process. We call for a seventh statement to be added, namely that every woman considering an abortion should receive non-directive information and support, that includes information about options other than abortion, from an independent advisor (not from an abortion provider simply ‘ticking the box’). This would introduce a necessary period for reflection before abortion, and also the opportunity for an advisor to uncover any coercive factors in play. The Covid emergency measures, by doing away with a medical assessment, remove the opportunity for women under coercion to come to light and receive help.  We appeal strongly for the quality standard statements to include as a requirement the provision of independent and non-directive information and support for all women considering an abortion. This must not be left to the abortion providers to supply; it is self-evident that those who profit from abortion cannot provide truly independent information and support. |
| 10 | Marie Stopes UK | General | We warmly welcome the introduction of Quality Standards to implement the 2019 Abortion Care Guidelines however given the recent approval order from the Department of Health and Social Care relating to early medical abortions brought in during the Covid-19 crisis, we recommend that they include standards, measures and outcomes in relation to telemedicine provision. For example:  • Evidence of healthcare commissioning groups and providers working together to provide access to abortion services via telemedicine.  • Proportion of abortions performed via telemedicine  • Evidence of telemedicine access supporting a discussion about the differences between medical and surgical abortion, including the benefits and risks, with women who request an abortion; and evidence of referral pathways to surgical services if this is the woman’s preferred method.    Introducing Quality Standards without recognising the transformational role that telemedicine has played in the provision of high quality, accessible abortion care in the UK would undermine the evidence from both providers and women seeking care, since the regulations changed in March.  The evidence is clear that the introduction of telemedicine has increased accessibility and reduced complications. It has increased choice for women, reduced costs to the NHS, and can often be safer for vulnerable groups.  Due to the introduction of telemedicine in March, approximately 25,000 women across the UK (7,000 clients treated by MS UK) have been able to access timely, high-quality care. After an analysis of our data comparing over 8000 services, we have found complication rates to be even lower with the new regimens used in telemedicine than in traditional pathways. Waiting times and gestations have significantly reduced, and the number of safeguarding cases we have identified has risen by 20%, meaning increased protection for vulnerable women. |
| 11 | Marie Stopes UK | General | The current draft places the responsibilities of service provision on providers (rather than commissioners) when current NHS organisational and funding structures, commissioning pathways and reimbursement rates to providers, can at times make provision of services extremely difficult, if not impossible.  We would suggest that the Quality Standards take a more pragmatic approach, providing the best possible care whilst recognising the limitations of current arrangements, including an obligation on commissioners to ensure that an appropriate funding model is in place. |
| 12 | Right To Life UK | General | We make some preliminary comments pertaining to most of what follows, particularly with respect to ambivalence and free, informed decision making.  Firstly, in a large proportion of patients’ experiences, there is no definite point at which a decision is firmly made. As specifically noted in several submissions for a previous consultation (<https://www.nice.org.uk/guidance/ng140/documents/consultation-comments-and-responses-2>), ambivalence is extremely common among patients seeking a termination, including up until and after the point of termination (as exhibited in the cases cited by evidence review O for those guidelines, among other studies, e.g. [Ingham et al., 2008, ‘Reasons for Second Trimester Abortions in England and Wales’, Reproductive Health Mattershttps://www.tandfonline.com/doi/full/10.1016/S0968-8080%2808%2931375-5](https://www.tandfonline.com/doi/full/10.1016/S0968-8080%2808%2931375-5) ).  Secondly, we note that the draft quality standard recognises the need to provide women with appropriate expectations regarding abortion: “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.” We suggest various ways in which this information could be more helpfully expanded below. |
| 13 | Royal College of Midwives | General | RCM welcomes the introduction of a Quality Standard designed to implement the 2019 Abortion Care guidelines which we supported. However, as a result of the introduction of Early Medical Abortion via telemedicine, the baseline for high quality, accessible abortion care has been raised. We hope that the Committee will consider revising their proposals to take into account these new developments. |
| 14 | Royal College of Obstetricians and Gynaecologists | General | The RCOG is pleased that NICE has recognised changes to the provision of abortion care during the pandemic. We agree that the new pathway for early medical abortion, which can be provided for eligible women via telemedicine, supports Statement 1, but also supports Statement 3 and Statement 5. |
| 15 | The Faculty of Sexual & Reproductive Healthcare | General | Information to note  Option to take misoprostol at home is up to 11+6 weeks in Scotland. |
| 16 | British Pregnancy Advisory Service (BPAS) | Question 1 | Yes – the draft quality standard accurately reflects the key areas for quality improvement – particularly in relation to method of treatment and speed of access. However, we believe that within these broad options, the focus and specific content may need some work. We have included full comments below. |
| 17 | Christian Action Research and Education (CARE) | Question 1 | CARE recommends an additional quality standard: information about counselling services should be made widely available so that women have the opportunity to consider their options early in their pregnancy and after an abortion, as needed.  The Standard ought to note the importance of counselling in aiding women’s decision making and allowing women the opportunity to discuss their options, as indicated in several studies. In a study by Ingham et al (2005), the most common factor causing women to delay their abortion to the second trimester was ambivalence: 41% of women in the study were unsure about having an abortion and had ‘great difficulty’ in making the decision. Notably, delays caused by the woman’s indecision, were also compounded by responses of partners.[[6]](#footnote-6) In a study on ambivalence during early pregnancy[[7]](#footnote-7), the authors concluded that ‘The conflict of wanting or not wanting to have a child must be solved in the decision-making process that precedes the choice of whether to interrupt a pregnancy or carry it to full term. The time limit for this decision making process is reduced by the medical abortion methods now available.’ The study notes that ‘Hasty early abortions as well as delayed abortions create problems and should be avoided.’ It does not appear the committee has considered the implications of the former, as the guidelines only focus on speeding up the abortion process.  Another study[[8]](#footnote-8) in 1995 found that 30% of subjects were ambivalent about the decision to terminate when the abortion was due. Of the women who were ambivalent, they had less supportive partners than the non-ambivalent group and in 16% of these cases the partner made the decision for them. The study notes that ‘36% of the ambivalent women felt they had not received adequate information from their physician about their legal rights should they choose to continue with the pregnancy, and 47% indicated they would have changed their decision given different personal circumstances, including partner support or improved socioeconomic conditions.’ The authors conclude that ‘Counselling of abortion seekers is essential to reduce the element of doubt in the decision making process and mitigate post-abortion depression and regret.’ This indicates that care should be taken by medical professionals in how women are taken through the abortion pathway—women should not be rushed into making a decision regarding termination of pregnancy and should have the opportunity to discuss their concerns with a counsellor.  This proposed new Standard would be in line with RSOP14 which states: “counselling should be provided or refer women for support to make a decision if they request this.” RSOP14 also says, “Post abortion counselling should also be available for those women who require it. They should tell women that this support is available if they need it.” RSOP14 also requires that “For the minority of women who require formal, therapeutic counselling, services should have referral pathways in place with access to trained counsellors with appropriate expertise.” The counsellor should be independent of any particular abortion clinic so that there is no conflict of interest. [[9]](#footnote-9)  This Standard should also cover post-abortion counselling for the reasons set out under Statement 6. |
| 18 | Marie Stopes UK | Question 1 | Yes |
| 19 | Pregnancy Centres Network | Question 1 | Recent temporary changes in the law have changed the landscape around abortion provision and there are areas for improvement not covered by this draft. In view of the discussion around making the legal changes permanent, we feel that these areas are critical in order that the standard protects the interests of women.   1. Case studies – including those following the temporary change in the law during Covid. (see Comment 2 below)   These highlight vulnerabilities in the current practice which put women at risk.   1. Response to the prevalence and nature of domestic abuse.   Already it was known that 1 in 3 instances of abuse surface or get worse during pregnancy (see <https://www.bestbeginnings.org.uk/domestic-abuse>), and that at the root of an abusive relationship there are issues of control (see <https://womens-aid.org.uk/what-is-domestic-violence/> ) – in most cases the man exercising control over the behaviour of the woman. Police have introduced special contact methods because women may be unable to use a telephone to safely make a telephone call for assistance in this case. Consequently, a new key area for quality improvement not mentioned in this draft is to outline specific practices to ensure that the provider is not inadvertently complicit with a partner who is coercing a woman into terminating a pregnancy against her will. Care is needed to ensure that telephone abortion assessment is received by the patient in a physical space that is private and that she is not under coercion   1. Issues encountered around equality and diversity that are complicated and not immediately obvious, for example    1. Care needed when offering support for non-English speakers to ensure the translation is accurate for example, for example when an older female translator was engaged for a young pregnant woman whose cultural norm is obedience to elders    2. Care to ensure that patients are in a sufficiently robust psychological space to fully understand and evaluate medical information. |
| 20 | Royal College of Midwives | Question 1 | Yes. We are pleased that the draft quality standard recognises the key areas for quality improvement, particularly in relation to method of treatment and speed of access. |
| 21 | Royal College of Nursing | Question 1 | In light of the recent pandemic and subsequent adaptions to care, the Quality Standards now appear out of date because of recent developments in care, and thought should be given to reformulating them with new best practice on ultrasound scanning as clinically required and provisions for home Early Medical Abortion (EMA) to include mifepristone and misoprostol at home. |
| 22 | Royal College of Obstetricians and Gynaecologists | Question 1 | Yes. We are pleased that the draft quality standard recognises the key areas for quality improvement. |
| 23 | British Pregnancy Advisory Service (BPAS) | Question 2 | BPAS has in place the systems and structures to gather data on clients and treatment at both a national and local level. We have some concerns about some of the requested data collection and have included that with our responses to each Quality Statement |
| 24 | Care Quality Commission | Question 2 | Where “survey of women” is included as a data source, there needs to be recognition that this may be limited and not reflective of the complete service as not all women will complete a survey.  Independent health providers (IHP) are requesting some form of national reporting system for outcomes to be truly open / transparent re. failed abortion, ectopic, late gestation medical abortion etc. During Covid-19 we have seen increased sharing of information between NHS acute services, Independent health services and multiagency stakeholders. We suggest it may be useful to consider a more formalised approach to a shared data set to enable greater flows of information both data and qualitative. |
| 25 | Marie Stopes UK | Question 2 | Yes |
| 26 | Royal College of Midwives | Question 2 | N/A – As abortion care is delivered by different organisations, we would defer to their comments on the feasibility of the data requirements. |
| 27 | Royal College of Obstetricians and Gynaecologists | Question 2 | N/A – As abortion care is delivered by different organisations, we would defer to their comments on the feasibility of the data requirements. |
| 28 | British Pregnancy Advisory Service (BPAS) | Question 3 | Some of the quality statements have resource implications that should be recognised – but which will play an important role in enabling abortion providers to advocate for adequate funding for their service. |
| 29 | Care Quality Commission | Question 3 | Currently barriers exist to a fully collaborative approach; such as multiple clinical commissioning groups (CCG), any qualified providers (AQP) commissioning and commissioning well below national tariff (some independent health providers have informed us this can be as low as 40% under tariff for medical abortion and 50% under for surgical and we understand providers have raised this with the department of health as a concern). These all have a potential to impact patient choice, patient best interests and stifle quality improvement and innovation. |
| 30 | Marie Stopes UK | Question 3 | Not fully given current reimbursement rates and resource implications |
| 31 | Right To Life UK | Question 3 | In response to the aspect of question 3 which asks “Please describe any potential cost savings or opportunities for disinvestment”:  As we wrote in 2019 on the draft guideline Termination of Pregnancy, we propose that the cost-effectiveness of abortion as a medical procedure itself be evaluated. Given that cost-effectiveness is a key responsibility and interest of NICE, it is odd that the cost-effectiveness of abortion is assumed and cost-effectiveness of details of the service provision is the only element of cost-effectiveness. For most medical procedures, cost-effectiveness is analysed and those which are not cost-effective thereby generally have a prima facie mark against them when determining whether they should be publicly funded. Given that public funding of elective abortion is deeply controversial, a cost analysis is appropriate to help determine NHS spending policy. An additional reason for this is that it is an obvious area for saving: there appears to be no obvious health benefit to abortion (the standard medical indication given in 98% of cases is ‘mental health - not otherwise specified’ - [Abortion Statistics, England and Wales: 2016](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/679028/Abortions_stats_England_Wales_2016.pdf) - and yet it is widely agreed that there is no clear mental health benefit to abortion, as agreed by all major recent surveys on the topic). A considerable amount of NHS expenditure could thereby potentially be eliminated.  While it might be argued that some procedures are assumed to be ‘reasonable costs’ regardless of their demonstrable cost-effectiveness and regardless of their demonstrable health benefit, it is not clear who should be the arbiter of such proposals. Who decides that abortion should be immune from cost analysis, and on what criteria? Even if public policy turns out to be that it should be publicly funded regardless of demonstrable health benefits, it is surely of public interest to know in the first place whether it does indeed have health benefits, and whether these are cost-effective. We propose therefore that NICE provide a reasoned judgment, consistent with their conducting cost analysis for other procedures, for why termination of pregnancy should be exempt from such an analysis. For such an analysis is surely of interest in determining public policy on this question. |
| 32 | Royal College of Midwives | Question 3 | The RCM in conjunction with the Royal College of Obstetricians and Gynaecologists has expressed concerns that some clinical commissioning groups (CCGs) that continue to tender abortion care services well below tariff. These Quality Standards will be helpful in holding contracting CCGs to account, but consideration should be given to how CCGs meet their legal requirements to report against these standards when a variation has been agreed. |
| 33 | Royal College of Nursing | Question 3 | The focus on collaboration between providers is not something NICE can mandate as it does not fit with existing commissioning and funding pathways |
| 34 | Royal College of Obstetricians and Gynaecologists | Question 3 | The RCOG has continually expressed its concerns to NHS England /Improvement on some clinical commissioning groups (CCGs) that continue to tender abortion care services well below tariff.  We are concerned that these commissioning decisions have not been conducive to developing the collaborative care pathways that are needed, and have not borne responsibility for essential elements of sustainability such as training and delivery of best practice.  In particular, whilst many clinical commissioning groups (CCGs) contract outside of the Payment by Results (PbR) system and award contracts for abortion care via tender, none have followed the process as described in section six of “2019/20 National Tariff Payment System” [NHS England / NHS Improvement, 2019]. Specifically there have been no examples of registering local variations of price with NHS Improvement or its predecessors. This has meant that there has been no learning or scrutiny as to whether acceptable quality can be delivered within an agreed cost envelope, nor whether current published tariffs are not being used as they fail to reflect true cost or affordability.  This is a legal duty established by the Health and Social Care Act 2012, under section 116 subsection 3:  (3) Where a variation is agreed in accordance with rules provided for under  subsection (2), the commissioner of the service in question must maintain and  publish a written statement of—  (a) the variation, and  (b) such other variations as have already been agreed in accordance with  rules provided for under that subsection in the case of that service.  Section 6.1.1 of The National Tariff Payment System also states that “local variations, modifications and prices must be in the best interests of patients today and in the future”.  These Quality Standards will be helpful in holding contracting CCGs to account, but consideration should be given to how CCGs meet their legal requirements to report against these standards when a variation has been agreed. |
| 35 | Pregnancy Centres Network | Question 7 | 1. CASE STUDIES DURING COVID    1. We have one case of a missed ectopic pregnancy due to the lady being sent abortion pills without a scan.    2. We've had three clients recently who've taken tablets at home. None have found this to be the straightforward process they expected.    3. Some women have described a desperate search for counselling support outside the medical setting, due to the stress they experience after finding they are pregnant. 2. CASE STUDIES BEFORE COVID…    1. Women seeking support following abortion very frequently say that they were not offered counselling before the procedure. Engagement with the local providers indicates that they are mistaken about that, and providers do offer the opportunity to access counselling support. This implies that the stress that is experienced while attending an assessment consultation means that many patients miss some of the information given during the consultation itself.    2. Women express real appreciation of the excellent care received from the abortion provider, but say they thought that if they revealed their concerns about the decision itself in that setting they would not be allowed to proceed.    3. Women attending centres with their partners are routinely offered separate counselling sessions as well as one together. Very typically the man is not supportive of the continuation of the pregnancy, and individual counselling can facilitate the woman to consider and own her own decision. Occasionally there are safeguarding concerns which are then followed through with appropriate disclosure and signposting.    4. A significant number of men contact independent pregnancy centres to find out where they can obtain an abortion for their wives/partners.    5. An articulate woman in her early 40s is unexpectedly pregnant. Her confidence is badly shaken when the GP asks her whether she wants to keep the pregnancy, and the opportunity to explore her thinking in a neutral environment enables her to evaluate this reaction and decide for herself accordingly.    6. A young woman makes and then postpones 4-5 appointments to terminate a pregnancy. She is from a culture which attaches deep shame to pregnancy outside marriage. Her partner wants to marry her but is hesitating, while she is desperate to marry quickly and continue with the pregnancy. Pregnancy centre staff offer a structure to help her process her decision and then ongoing support regardless of the outcome of the pregnancy.    7. A growing number of women coming to a centre following abortion who are experiencing suicidal thoughts, and requiring appropriate support for this before it is safe to offer counselling to them.    8. A woman attends a termination clinic with her husband, where the normal procedure is for a 15 minute session with a non-medical counsellor, held with the woman on her own to support her emotional health. Immediately she becomes tearful, saying he is insisting on the abortion and she is unwilling to go through with it. This information is very useful to the doctor who would normally have seen the couple together.    9. Many women demonstrate a tendency to prioritise the needs of family, or of other patients over their own. As a result when offered the choice between medication administered in the hospital and that administered at home may be motivated to accept the latter in order to accommodate family members or hospital staff instead of considering the best course of action for themselves. An non-medical point of contact within the clinic setting can provide the empowerment and self-awareness which will guard against this unhelpful outcome. |
| 36 | British Pregnancy Advisory Service (BPAS) | Statement 1 | We support this quality statement and the focus on self-referral |
| 37 | British Pregnancy Advisory Service (BPAS) | Statement 1 | Quality measures  We recommend an additional quality measure – ‘Evidence that funding is available for travel and accommodation where treatment outside the CCG area is necessary’. We understand that ‘upfront funding’ this is a ‘consider’ point from the guideline, but BPAS has over summer 2020 undertaken an FOI of all CCGs with regards to funding available for women needing to travel outside the area for abortion treatment. The Briefing Paper attached to this Quality Standard erroneously claims that women who access abortion services outside their local area can access the Healthcare Travel Costs Scheme (HTCS) when they meet the statutory qualifications. They cannot – as a direct result of recommendations from the NICE Guideline. The HTCS requires referral from a GP to be eligible for funding, and self-referral into specialist services is not covered. As a result, of the 135 CCGs in England, only 13 provide funding of any kind for women who need to travel for abortion care – either via reimbursement or upfront funding. As a result, women who need to travel for care and are unable to pay for travel or accommodation rely on Independent Service Providers to fund them from our charitable remit – an unacceptable solution given that abortion is essential and urgent healthcare. In order to ensure abortion care is accessible, based on new evidence, the Quality Standard should require commissioners to ensure that funding is available. |
| 38 | British Pregnancy Advisory Service (BPAS) | Statement 1 | Quality measures  We recommend an additional quality measure – ‘Evidence that the abortion service can provide both signatures for the HSA1 form without delay’. We are aware of some NHS services where self-referral is nominally in place (ie, there is a telephone number women can call to book an appointment with the termination of pregnancy service), but the service runs with one doctor and as such, women are expected to have a GP appointment not to be referred into the service but to obtain the initial HSA1 signature. Without this, women are turned away or asked to return at later date after another signature has been found. This leads to pressure on other health services, increases waiting times, and undermines the intention of self-referral. The existing quality measure (c) regarding self-referral does not adequately provide for these cases. (We know several NHS services in Wales have overcome this issue during COVID-19 with teleconsultations and obtaining in-service signatures before medication is posted out, but have no indication that this is the case for the relevant services in England.) |
| 39 | British Pregnancy Advisory Service (BPAS) | Statement 1 | Quality measures  Regarding (b), consideration should be given to the cost implications of providing full abortion information in different languages and methods, and translation services. These are an essential part of a sensitive service, but are not included in contracts and, for instance, translation of materials can easily cost tens of thousands of pounds. |
| 40 | British Society of Abortion Care Providers | Statement 1 | Rationale  Easy access also reduces anxiety and saves money.  We feel that removing practical barriers is not the whole story. Having an abortion needs to be normalised [Purcell C et al (2020): Toward normalising abortion: findings from a qualitative secondary analysis study, Culture, Health & Sexuality, DOI: 10.1080/13691058.2019.1679395]. |
| 41 | British Society of Abortion Care Providers | Statement 1 | Measures  Detailed measures of gestation are submitted to CMO/DHSC (under the regulations) which include gestation in weeks. In the NHS, hospital coding does not allow for this level of detail and has the following format: Less than 9 weeks / 9-14 weeks /14-20 weeks /Over 20 weeks. So, in fact identifying under 10 weeks for NHS providers is problematic. However, as indicated the data is already held nationally. Duplication of abortion data collection is a waste of NHS resources. We would like to see DHSC/CMO data “shared-back” to the individual abortion providers submitting it - in a reasonable time‑frame.  Measuring waiting times can be complex – not all women are ready to proceed or are certain of their decision when they make contact. They need the support of services – and services must feel no pressure to rush a patient’s decision. Therefore, we broadly support using gestation – however socioeconomic factors do impact on gestation at presentation and this needs to be considered.  A single point of access for the pregnant person to contact (central booking system) is ideal. |
| 42 | British Society of Abortion Care Providers | Statement 1 | Different audiences  Commissioners and providers rarely have opportunities to meet and work together. There has historically been confusion even about commissioning responsibility for abortion and the fragmentation of commissioning for women’s reproductive health care has been repeatedly identified as impacting negatively [https://www.fsrh.org/documents/womens-lives-womens-rights-full-report/].  An example is the Pan-London Joint commissioners/providers group; this took years of work to establish and only got widespread engagement with support from the London CCG Office – and since this support is no longer sustained the group is ‘at-risk’ of disbanding. Fundamentally, the barriers to joint working are that few NHS providers can make time to attend and most commissioners do not stay in post long enough to understand the issues. |
| 43 | Centre for Bio-Ethical Reform UK (CBR UK) | Statement 1 | NICE Statement 1: Healthcare commissioning groups and providers work together to make abortion services easy to access.  Reality of Statement 1: “Healthcare commissioning groups and providers work together to make killing unborn children easy to access”.  It goes without saying that access to institutions or medications that kill unborn children is never in the best health interests of the mother or child. In light of this why does such an “abortion service” (as your recommendations refers to it) need to be easier to access? As a healthcare regulator, seeking excellency, it seems incredibly surprising that your first statement should not only support but seek to increase access to a procedure that kills a human being.  If the [Hippocratic Oath’s](https://www.nlm.nih.gov/hmd/greek/greek_oath.html) promise to “cause no harm” is any foundation for the excellency that your organisation seeks to create, then abortion - an act that violently kills and or dismembers a human being - should be a last available resort, only for extreme cases that should be entered upon with much sobre thought and consideration. Not something you collaboratively seek to make easier.  Further down in your recommendations you suggest “consider providing abortion assessments by phone or video call, for women who prefer this”. This too seems an utter renegation of your core value. Excellency, at least traditionally understood, is something of “outstanding quality”. In regard to other medical procedures it infers careful assessment, background history, holistic and ethical considerations of consequence, in person support and follow up. Not to mention further study, research and data collection outside of patient experience. None of which is possible during “phone or video call” consultations.  [A large 2014 survey by Comres](https://comresglobal.com/wp-content/themes/comres/poll/Christian_Institute_Abortion_Survey_3rd_March_2014.pdf) confirmed 89% of respondents believe mothers should be seen by a registered doctor before an abortion. A wariness confirmed by a [2020 undercover investigation of new pill-by-post abortion measures](https://www.thetimes.co.uk/article/campaigners-accuse-abortion-clinics-of-breaking-law-with-diy-kits-nzgbn2m87) that showed how wide-open telemedicine is to abuse. Instead of trying to put the brakes on this practice NICE seeks to brainstorm how to make it easier. This is highly concerning and a clear divergence from your title.  “Care Excellency” as your prestigious organisation is named, means exactly that: “caring for human beings in an excellent way”, seeking expedient ways to kill them is the antithesis of such a goal. We therefore recommend:   * Healthcare commissioning groups consider ending contracts with organisations who kill babies and redirecting funds to organisations committed to helping mothers and their children in the long term through support groups, fostering and adoption schemes, healthy relationship training, nursery bursary schemes, single mum educational schemes and carefully vetted baby sitting initiatives. * Higher thresholds for procedures that kill unborn children including in-person consultations before and after, background checks, emotional counselling and holistic support. * Finally we recommend the introduction of mandatory NHS numbers before accessing services that kill children, so that longitudinal data can be gathered on the long term impacts of having their children killed, on women’s health. |
| 44 | Christian Action Research and Education (CARE) | Statement 1 | Rationale  We are concerned that the quality standard emphasis on improved access could lead to pressure for women to make decisions they are not yet ready to make.  We are aware that a few years ago, Marie Stopes was criticised for following up women who decided not to go forward with an abortion[[10]](#footnote-10) and that at the Maidstone clinic, “there was a culture that worked against patient choice.”[[11]](#footnote-11) While the Maidstone clinic is now rated good, it highlights there could be potential difficulties. The measures to monitor outcomes need to ensure that women can say no to an abortion or wait longer to make a decision; and that measurement does not lead to perverse incentives.  In addition, one study[[12]](#footnote-12) investigating the experiences of women who had obtained second-trimester abortions in England and Wales suggests that there are numerous factors causing delays. Significantly, the study found that much of the delay occurred prior to women requesting an abortion: half of the 883 women questioned were more than 13 weeks pregnant by the time they requested the abortion. The main reasons identified for delay included “uncertainty about what to do if they were pregnant, not realising they were pregnant, experiencing bleeding which may have been confused with continuing to have periods, and changes in personal circumstances.” The study’s authors also suggest this demonstrates that better education is needed for women to gain the earliest possible awareness of pregnancy, rather than merely dealing with the efficiency of services—a factor that does not seem to be addressed in the guidelines.  The study’s findings are particularly significant to recommendations regarding speeding up service delays. The authors note the following: “This study has found that, for all age groups and gestations, most reasons for delay are best considered “woman-related’’ – i.e. delays in suspecting and confirming the pregnancy and in deciding to have an abortion – rather than ‘‘service-related’’. This suggests, for England and Wales at least, limits on the extent to which policy changes directly related to early abortion services can be expected to reduce the proportion of second trimester abortions. This conclusion may come as a surprise; it has been a long-held assumption in the British abortion debate that making early abortion more accessible is the best way to reduce demand for second trimester procedures.” [[13]](#footnote-13)  These findings correlate with a 1996 paper which found that most women requesting second trimester abortions ‘did not present until a relatively advanced gestational stage. Only 13% of them could have been managed earlier through service improvements.’[[14]](#footnote-14) Similarly, a 2005 study by Marie Stopes International[[15]](#footnote-15) found that a small minority of women who had awareness of their pregnancy at an early stage either “denied this was the case” or only decided later that the pregnancy was unwanted due to changes in their circumstances. Many of these women found the decision to terminate “difficult and reported that it took them time to decide to proceed with it.” Ingham et all note that one conclusion from these studies is that “while accessibility of abortion services plays a part, it is only one part of the explanation for second trimester abortion.”[[16]](#footnote-16)  In this context, CARE recommends an additional quality standard: information about counselling services should be made widely available so that women have the opportunity to consider their options early in their pregnancy (see below). |
| 45 | Christian Action Research and Education (CARE) | Statement 1 | Quality Measures  Self-referral cannot be an option that circumvents proper medical examination, safeguarding nor the requirements of the law. We recommend that as per the recommendation of RSOP3, a woman’s GP should be notified if an abortion takes place, wherever possible[[17]](#footnote-17) to ensure that if a woman needs follow up care, her medical record is complete. We recommend that notification should be the default, with an option to opt out. |
| 46 | Christian Action Research and Education (CARE) | Statement 1 | Quality Measures  We are concerned about the data sources currently being used on abortions under 10 weeks.  Data Collection must be rigorous. Interim abortion statistics published, documenting abortions in England & Wales from January to June 2020, show an increase in number of abortions compared with the equivalent period in 2019 which is in line with the increase of the past few years; and a decrease in the average gestation at which abortions are conducted. However, claims that this demonstrates the success of the telemedicine service by demonstrating broader and more timely access for service users are problematic as these statistics are not supported by strong data collection protocols.  The data collection methods used to produce the interim abortion statistics have serious deficiencies in the following regards:   * + In the case of abortions without in-person clinic appointments, the statistics rely entirely on the client’s self-assessment of gestation which needs to be below 9 weeks and 6 days to access telemedicine, leading to an inevitable incentive to state a gestation that is below this limit. The emergency conditions created by the Covid-19 pandemic led to the decision that, in the context of clinic closures and increased risk associated with travelling due to the prevalence of Coronavirus, providing early medical abortion without confirming gestation by ultrasound was considered preferable with low relative risk. This is not the same as asserting that statistics, which assume accuracy of self-assessed gestation, provide sufficiently robust evidence upon which to base further policy recommendations.   + There is also no means to confirm, in cases where telemedicine packages were posted to clients, that the abortion was completed as planned. Minutes from the NICE prioritisation meeting regarding abortion care quality statements note that “[t]here is no routine follow-up for women having an early medical abortion.”[[18]](#footnote-18) BPAS advice on their ‘Pills by Post’ service states that “[y]ou will NOT be contacted by BPAS to find out if your treatment has worked.”[[19]](#footnote-19)   + The lack of routine follow-up also makes it uncertain that complications following ‘at-home’ abortions will be captured by the interim abortion statistics. The data which informs these reports only captures outcomes prior to discharge from the abortion provider, and therefore presumably does not routinely document actual outcomes following postage of the telemedicine abortion package. Whilst 24-hour support lines are available, this does not mean all women who experience complications, or simply change their mind about proceeding with an abortion will call them. Particularly in cases of serious complications one might expect the opposite, it seems reasonable to expect that women might first present at A&E, at which point it is unlikely that notifying the abortion provider would or should be their priority. Moreover, given the stigma that is regularly cited, it is not certain that a woman presenting with complications would disclose use of mifepristone/misoprostol at the point of care, thus if there were serious complications, these may never be linked to medical abortion.   We recommend improved data collection protocols are needed to determine actual outcomes following the dispatch of home-use treatment packages, particularly paying attention to frequency and severity of medical complications, client satisfaction, and the acceptability of disposing of fetal remains at home as well as indications the fetus was at the gestation estimated. |
| 47 | Christian Action Research and Education (CARE) | Statement 1 | What the quality statement means for different audiences  We recommend that, for the duration of the temporary approval in view of the Covid-19 pandemic, there should be specific training for practitioners on remote consulting prior to being involved in care via telemedicine where there is no in-person clinic visit, to:   * ensure any concerns about abortion are addressed; * ensure the client is referred for an in-person examination where uncertainty about gestation and medical contraindications exist; * confirm that the abortion falls within the grounds under the Abortion Act 1967; * ensure an abortion is medically and legally appropriate; * identify and respond appropriately to issues of coercion or abuse/safeguarding issues, recognising the potential for abuse in a situation where a woman is unable to leave the house due to quarantine etc; * ensure confidentiality.   CARE continues to be concerned about the potential for abortions carried out under the telemedicine regime to be outside of the 9 weeks and 6 day limit (see our comments under 5) and for the potential for abusive situations to be missed (see our comments under 9). |
| 48 | Christian Action Research and Education (CARE) | Statement 1 | What the quality statement means for different audiences  We raise again concerns about the statement “Health and social care practitioners do not allow their personal beliefs to delay access to abortion services”, which we did in our previous submission to NICE on the Draft Guideline on Abortion, which is now Guidance NG140. The need to provide access to services must be balanced with the rights of healthcare professionals who wish to exercise their right to conscience. Conscience is protected under section 4 of the Abortion Act 1967, Article 9 of the European Convention on Human Rights, Resolution 1763(2010) of the Parliamentary Assembly of the Council of Europe[[20]](#footnote-20) and the Equality Act 2010. Healthcare professionals should follow the relevant guidance, e.g., the GMC Guidance and General Pharmaceutical Guidance.[[21]](#footnote-21)  We recommend this is changed to: Healthcare professionals should follow professional guidance on matters of conscience if they object to providing access to termination of pregnancy services. |
| 49 | Christian Action Research and Education (CARE) | Statement 1 | What the quality statement means for different audiences  We are concerned that the Quality Standard should ensure that women are given accurate information on the risks of termination. Following Montgomery v Lanarkshire Health Board [2015] UKSC 11,[[22]](#footnote-22) women must be made fully aware of all material risks involved in a procedure, however small, and alternatives should be discussed with the patient before the procedure.  RSOP12 states that “Women must be given impartial, accurate and evidence-based information (verbal and written) delivered neutrally covering the following:   * 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 (to include potential side effects, complications and any clinical implications)” [[23]](#footnote-23)   There is nothing in this Standard which recommends information covering adoption and motherhood. We recommend that this is included to comply with RSOP12 as part of our proposed additional quality standard (see below). |
| 50 | Christian Action Research and Education (CARE) | Statement 1 | Equality and diversity considerations  We are concerned that while this standard is seeking to make abortion easier to access, it does not address adequate safeguards for coercion for women who might seek an assessment by phone or video call.  Page 8 of the standard and page 3 of the Equality Impact Assessment states that “[p]roviding 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.” This fails to acknowledge the important fact that coercion in the context of pregnancy can be to abort a pregnancy, as well as to continue a pregnancy, and then fails to consider whether some women may be more vulnerable to coerced abortion in the absence of a requirement to see a provider in person, especially during the pandemic (see also our comments below at comment 14). Telemedicine is a gift to abusive partners who are coercing women to abort against their will because it removes the need for their partner to attend a clinic where the fact that they desperately do not want an abortion is more likely to become apparent. [[24]](#footnote-24) [[25]](#footnote-25)  While telemedicine may help women coerced to continue a pregnancy access an abortion, since it provides a means whereby they can speak to clinicians without their partner’s knowledge, we are concerned that having abortion medication delivered to a residence which they share with an abusive partner may put them at increased risk. If their abuser is monitoring their post, the woman may be subject to further violence; moreover a residence shared with an abuser is not a supportive environment to undergo an abortion.  Neither of these scenarios seem “particularly beneficial” for the women involved.  In support of continuing telemedicine provisions, BPAS says that they have seen an increase in disclosures of domestic abuse via the temporary telemedicine service during the pandemic, which they say “seems to be attributable to women feeling more comfortable in disclosing abuse over the telephone from home.”[[26]](#footnote-26) As set out above, this will not be the case for all women and while women who are being coerced to continue a pregnancy might reveal this when they manage to access telemedicine abortion services when they will be, by definition, without an abusive partner, women who are being coerced to abort will, by definition be doing so in the knowledge of their abusive partner, and therefore will likely not disclose coercion for fear of the abusive partner who has compelled them to make the call. It is also unsurprising that there has been an increase in disclosures of domestic abuse at this time because the incidence of domestic abuse has risen dramatically during the pandemic, as has the profile of domestic abuse in the media.  BPAS has also said “Proportionally, we are more likely to encounter women who are planning to end their pregnancy without their abusive partner’s knowledge than a woman who has been coerced into attending a clinic.” [[27]](#footnote-27) Given those aborting against their will are unlikely to report that fact (see above), this statement seems impossible to confirm. A completely different research mechanism is required to determine the impact of the telemedicine service on true numbers of coerced abortions. Concerns raised by the BMA ARM which led to the overwhelming support of a motion in favour of examining the evidence base for remote consulting in GP surgeries and hospitals prior to long-term implementation of remote consultation equally apply to remote consultations for abortion.[[28]](#footnote-28) It is well documented that rates of intimate partner violence (IPV) amongst the abortion seeking population are higher than average,[[29]](#footnote-29) and the importance of non-verbal cues and the opportunity to be seen alone for vulnerable groups referenced in the debate on the former motion must also be addressed in the context of telemedicine abortion care. Ease of access must not come to the detriment of the safety of vulnerable groups, and the equality and diversity consideration has failed to take all scenarios into account.  We recommend that any equality and diversity consideration must take into account both women seeking abortion without a coercive partner’s knowledge, and those experiencing coercion to abort. The option of in-person clinic appointments must continue to be available alongside a telemedicine service, for the duration of the temporary approval, for those who wish to access them. It must also be demonstrated that women at risk of coercive abortion are still able to access face-to-face services where they may face partner/family pressure not to do so. |
| 51 | Doctors for Choice UK | Statement 1 | DfC supports the standards in efforts to reduce barriers to abortion care such as reducing wait times / allowing self-referral. We know that information for women and pregnant people seeking abortion care can be confusing and frequently misinformation is propagated by those who oppose abortion. We therefore wish to highlight that “barriers” to access arise from less tangible issues like stigma. Education of the general healthcare workforce in abortion helps to tackle stigma and so we were disappointed that there were not quality standards relating to the NG140 recommendations on training and workforce.  Joint-working between commissioners and providers is desirable but needs practical infrastructural support to be sustainably realised in practice. The fragmentation of reproductive health commissioning hampered collaboration. |
| 52 | Doctors for Choice UK | Statement 1 | Outcome a) Proportion of abortions performed under 10 weeks.  DfC fully supports the quality standards to promote reduction of waiting-times since waits create unnecessary anxiety for many patients. The lower gestation at abortion also saves the NHS money and increases safety by reduced complication rates.  DfC notes that a below and above 10 week gestation is not a clinically significant distinction and would prefer to see a more broad and generic measure of reduced gestation at abortion.  We support calls for more transparency of the routinely collected (HSA4) abortion data - and more timely sharing of this - to actively support healthcare provision. This DHSC data is a rich resource but has little practical value to providers or commissioners as not shared-back in any meaningful or timely way. |
| 53 | Doctors for Choice UK | Statement 1 | Measures  DfC feels strongly that self-referral should be an option and are pleased this is within the measures.  Ideally - of course - a nationally-run single‑point‑of‑access system, such as the My Options helpline within Eire run by the Health Service Executive (https://www2.hse.ie/services/unplanned-pregnancy-support-services/my-options-freephone-line.html) |
| 54 | Homerton University Hospital NHS Foundation Trust | Statement 1 | Homerton Abortion Care Service supports joint working of commissioners and providers to make abortion services easy to access.  Our service lead worked to develop the Pan-London Joint commissioners/providers group including obtaining support from the London CCG Office (2014/15) to sustain regular meetings. This was difficult in the context of abortion commissioning often being poorly understood as a result of fragmentation of reproductive health commissioning responsibility.    We would point to a lack of agreed, acceptable process around joint-working between commissioners and providers as being problematic. We know that, whilst the Independent Sector Providers (ISP) must make time, few NHS providers are incentivised to engage in joint working and commissioners rarely have experience in reproductive health issues. These and other issues make for significant barriers to joint working. Returning to the example of the Pan-London group, the withdrawal of support from the London Office for CCGs is now making it a struggle for the group to successfully continue. |
| 55 | Homerton University Hospital NHS Foundation Trust | Statement 1 | Outcome a) Proportion of abortions performed under 10 weeks.  Whilst we are fully in agreement with quality standards that promote reduction of waiting-times and the lowering of gestation at abortion that can result, but we feel that the 10 week gestation is an arbitrary (and perhaps unhelpful) delineation.  We note that reducing gestation at abortion not only reduces patient anxiety associated with wait times but also saves money because of reduced complication rates.  Further it is necessary to understand that allowing earlier access to abortion will also positively impact with some reduced demand on care from Early Pregnancy Unit with pregnancies that would otherwise have miscarried. |
| 56 | Homerton University Hospital NHS Foundation Trust | Statement 1 | Outcome a) Proportion of abortions performed under 10 weeks  We note that multiple factors impact on gestation at presentation and not simply wait times and and administrative barriers to care. Socio‑demographic variables impact on the gestation at initial presentation, so this needs to be considered as well.  Also the NHS coding system for gestation at abortion does not correlate with gestation above or below 10 weeks (since the categories are “Less than 9 weeks” / “9-14 weeks” /”14-20 weeks” /”Over 20 weeks”) hence identifying “under 10 weeks” for NHS providers is cumbersome.  Of course we already submit gestation data to DHSC/CMO as part of or legal requirement - and this is done even done within 14 days of the abortion procedure. There seems to therefore be a duplication of abortion data collection. Having a mechanism for providers to access (at least) \*their own\* DHSC/CMO data would avoid the duplication and associated wasted resources. |
| 57 | Homerton University Hospital NHS Foundation Trust | Statement 1 | Measures  We very much support that self-referral should be an option. A single point‑of‑access for the woman/pregnant person to contact (central booking system) is ideal. |
| 58 | Marie Stopes UK | Statement 1 | We propose an additional quality measure, ‘Evidence that the abortion service can provide both signatures for the HSA1 form without delay’. |
| 59 | Pregnancy Centres Network | Statement 1 | 1a) & b)  Joint working, including with independent crisis pregnancy centres, will improve outcomes by ensuring that centres carry up to date information for their clients, while also enabling commissioning groups and providers to assess the contribution made to the clinical pathway by their local centre, incorporating these into the clinical pathway as appropriate.  Pregnancy Centres Network exists to resource those centres committed to best practice in non-directive support given in a supportive and affirmative environment. Such centres absolutely uphold the Statement that “Health and social care practitioners do not allow their personal beliefs to delay access to abortion services. |
| 60 | Right To Life UK | Statement 1 | Statement 1: Healthcare commissioning groups and providers work together to make abortion services easy to access.  Question 1: Does this draft quality standard accurately reflect the key areas for quality improvement?  The most important area for quality improvement is women’s safety and women’s access to information and support. While the quality standards rightly point out that earlier abortions are generally physically safer, the emphasis on this standard is disproportionate given the other relevant safety considerations. We aim to describe some safety considerations which could be added, as well as ways to ensure that women are fully informed before proceeding with an abortion.  While the quality standard emphasises the importance of ‘[making] information about abortion services (including how to access them) widely available’, there is no mention of the importance of discussion of other options, nor of the importance of ensuring women know the financial and other support available. A significant proportion of women have abortions for financial reasons, for example (<https://www.guttmacher.org/sites/default/files/article_files/2411798.pdf>), and a very large proportion of women in some countries have abortions for career reasons (Ibid.). Given this, it is important for women to know the financial and legal support available in order to make the freest choice possible. The quality standard already implicitly assumes that women do not have full information about all their options - hence statement 1 itself. Such information could include, for example, the NHS and government advice available regarding maternity and paternity benefits, pregnant employees’ rights, and so on (e.g. <https://www.nhs.uk/conditions/pregnancy-and-baby/maternity-paternity-leave-benefits/> and <https://www.gov.uk/browse/childcare-parenting/pregnancy-birth>). Polling shows that 84% of women agree that women under financial pressure to have an abortion should be given more support (<https://comresglobal.com/wp-content/uploads/2017/05/Where-Do-They-Stand-Abortion-Survey-Data-Tables.pdf>).  Likewise, this information is important given the relatively common ambivalence expressed among women seeking abortion. The significant minority of ambivalent women deserve serious consideration.  We also recommend that legal considerations be noted when informing women regarding access to abortion; women ought to know the circumstances under which abortion is legal (or not) so that they can make an informed judgment.  Below, we also describe some of the other important safety and informational considerations which ought to be audited. |
| 61 | Right To Life UK | Statement 1 | The QS recommends that abortion providers “consider providing abortion assessments by phone or video call, for women who prefer this”:  This quality standard opens up a variety of risks to women which are widely acknowledged, as has been demonstrated particularly by recent events related to telemedicine provision of abortion pills. Specifically, there are at least 4 particular concerns:   1. The lack of ultrasound provision for ruling out an ectopic pregnancy. Despite claims from some quarters that the abortion regimen would likely treat an ectopic pregnancy, this is not backed by good quality data, and already in the UK we have seen ruptured ectopics (it is not clear how many) as a result of telemedicine abortion provision (see the [leaked email from a Regional Chief Midwife](https://christianconcern.com/wp-content/uploads/2018/10/CC-Resource-Misc-Judicial-Review-Abortion-200729-NHS-email-2.pdf): <https://christianconcern.com/wp-content/uploads/2018/10/CC-Resource-Misc-Judicial-Review-Abortion-200729-NHS-email-2.pdf> ). 2. The lack of ultrasound provision for verification of the gestation (and lack of physical examination to verify this more crudely). Again, this has led to demonstrably unsafe situations for women in the UK since the start of telemedicine provision, as well as multiple significant breaches of the law, including a significant number of telemedicine abortions performed well after the safety limit (and the abortion of babies up to 30 weeks’ gestation), as well as at least one murder investigation for a live born baby.   Media reports from May found that a woman received both sets of abortion pills through the post at 28 weeks’ gestation, 18 weeks beyond the provision’s limit and 4 weeks’ beyond the legal time limit for abortion provision. The same reports noted that investigations into eight further cases where women have received both sets of pills beyond the 10 week limit have begun.  The safety considerations from a failure to verify gestational age are also significant from the perspective of informed consent. Without verifying the gestational age, it is impossible for a woman to know the risks involved. As is well known (and highlighted in the quality standard), abortion at a later gestation is associated with significantly greater risks, which women ought to be aware of before undergoing the abortion. This is obviously impossible if she does not know the gestation. This is a significant worry given that the ACOG report only half of women accurately recall their LMP (<https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/05/methods-for-estimating-the-due-date> ).  For example, the complication rate after a medical abortion before 14 weeks’ gestation is 70 out of 1000 compared to a rate of 130 out of 1000 after 14 weeks’ gestation. A Finnish study of 18,000 pregnant women over three years found an 8% rate of surgical evacuation for medical abortion failures in the first trimester, and an almost 40% surgery rate in the second trimester (see: [https://academic.oup.com/humrep/article/26/4/927/627865)](https://academic.oup.com/humrep/article/26/4/927/627865). This clearly would make a significant difference to the informed consent required for an abortion.   1. Home abortion (which presumably is legitimised by this quality standard - if not, that should be made clearer) may be associated with an increased complication rate. A large Swedish study from 2018 found a significant increase in the rate of complications over time, which the authors concluded ‘may be associated with a shift from hospital to home medical abortions.’ (<https://bmcwomenshealth.biomedcentral.com/track/pdf/10.1186/s12905-018-0645-6>) 2. The lack of safeguards concerning women in domestic abuse situations. It is clear that an in-person consultation ordinarily provides an extremely important safeguard against coercion. The Marie Stopes FAQ (<https://www.mariestopes.org.uk/frequently-asked-questions/>) itself says:   ‘I'm being pressured into having an abortion - what should I do?  The decision about whether to continue or end the pregnancy is yours to make. This might not be the same decision your partner, friends or family would make.  If you feel that you're being pressured into having an abortion, please let us know. We will not provide treatment unless you are certain of your decision. As part of an abortion appointment you would have a private consultation before treatment, away from any person who has accompanied you to the clinic. You can talk to our team in private and let them know what you are experiencing.’  Clearly the (informal) quality standard described by a leading abortion provider here is not possible in the case of phone or video assessments, and thus provides a safeguarding risk acknowledged by abortion providers themselves. Importantly, a recent legislative attempt to extend provision of telemedicine abortion to domestic abuse victims failed partly on the grounds that it would in fact make such women vulnerable to further abuse. See in particular the comments from the Chair of the Justice Select Committee, Sir Bob Neill:  ‘The only other issue that I would raise from my experience as a criminal practitioner is that, on more than one occasion, I found instances where part of the abuse had been to force the victim to have an abortion. The irony is that reliance on a telephone call to procure the means of doing that does not give the safeguard of knowing who is standing next to the victim when she makes the telephone call. I have certainly seen instances of that in practice, as other criminal practitioners will have done.’ (<https://hansard.parliament.uk/Commons/2020-07-06/debates/CEAE6941-5DC8-4F76-9377-3DE3ED0F3553/DomesticAbuseBill)>  Polling data from the UK also support the necessity of an in-person consultation with a doctor, specifically for this reason. 77% of women said that doctors should be required by law to verify in person that a patient seeking abortion is not under pressure from a third party (<https://comresglobal.com/wp-content/uploads/2017/05/Where-Do-They-Stand-Abortion-Survey-Data-Tables.pdf>). Given this broad agreement from abortion providers, the Government, and women themselves, that seeing a doctor in person is the best way to avoid women being pressured by abusers into abortion, it is frankly remarkable that - seemingly on no substantial evidence base and ignoring entirely the evidence presented here - the draft quality standard claims that women experiencing abuse and coercion are better served by telephone consultations.  While official data are yet to be published, this is in fact a reason for withholding the recommendation until the results of the emergency provision for telemedicine abortion assessments during the coronavirus pandemic have been properly evaluated and the safety of telemedicine provision verified. The aforementioned leaked e-mail showed unusually serious and frequent consequences of abortion in the UK linked to the telemedicine service, including 2 maternal deaths within a few weeks in one region alone. |
| 62 | Right To Life UK | Statement 1 | On the recommendations to “consider upfront funding for travel and accommodation for women who are eligible for the NHS Healthcare Travel Costs Scheme and/or need to travel to a service that is not available locally” and to “make information available about any upfront funding for travel and accommodation”.  We reiterate here our comments above regarding the reasonably frequent financial (and very frequent career) reasons for abortion and the need to ensure that women have access to comprehensive information regarding financial assistance and employment rights available to continue the pregnancy if she so desired. We note that this information is not routinely provided and there are no measures in place to encourage the relaying of this information.  The draft quality standard notes, “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.”  As we wrote in 2019 in the consultation on the draft guideline Termination of Pregnancy:  ‘It is of paramount importance that there is no pressure for conscientiously objecting doctors to engage with such training. And it is doubtful that it should be considered the ‘default’ given that the majority of doctors ‘would not perform’ the overwhelming majority of abortions (Gleeson et al., 2008, ‘Medical students’ attitudes towards abortion: a UK study’, Journal of Medical Ethics: only 37% would perform if ‘child unwanted’; 38% would perform if the foetus was at risk of serious disability; 46% if foetus guaranteed to have serious disability). This is especially important since there is evidence that conscientiously objecting doctors are liable to performing them due to pressure within work ([Strickland, 2011, ‘Conscientious objection in medical students: a questionnaire survey’, Journal of Medical Ethics](https://jme.bmj.com/content/medethics/38/1/22.full.pdf) <https://jme.bmj.com/content/medethics/38/1/22.full.pdf> , shows a significant discrepancy between those who have an objection to the procedure and those who would refuse to perform it). In particular, there is evidence that Muslim doctors are particularly pressured to go against their religious beliefs (significant anecdotal evidence provided by the British Islamic Medical Association; see also Strickland 2011, which shows a big discrepancy between ‘conscientiously objects’ and ‘would not perform’ for Muslims in particular).’  We also note comments provided by the British Islamic Medical Association (BIMA) along similar lines in the previous consultation. This should be noted at least in the section for ‘Equality and Diversity Considerations’ given that they were some of the central concerns highlighted by the BIMA. |
| 63 | Royal College of General Practitioners | Statement 1 | An additional measure of best practice could be the number of GP surgeries who know that women can self-refer to abortion services in their local area. Many women wait for a GP or sexual health clinic appointment and then again for onward referral for a termination, slowing down the pathway. If, on trying to book an appointment, the reception team offered the patient a GP or sexual health appointment to discuss options, or a self-referral number, it may improve access and reduce delays to the service for women. Local education and dissemination of information to community GPs and sexual health clinics could be measured to ensure the information had been disseminated and received. |
| 64 | Royal College of Midwives | Statement 1 | We support this quality statement. |
| 65 | Royal College of Midwives | Statement 1 | Quality measures  The Briefing Paper attached to this Quality Standard claims that women who access abortion services outside their local area can access the Healthcare Travel Costs Scheme (HTCS) when they meet the statutory qualifications. Unfortunately, this is not accurate. The HTCS requires referral from a GP to be eligible for funding, and self-referral into specialist services is not covered. According to BPAS, of the 135 CCGs in England, only 13 provide funding for women who need to travel for abortion care. As a result, women who need to travel for care and are unable to pay for travel or accommodation rely on Independent Service Providers. In order to ensure abortion care is accessible the Quality Standard should require commissioners to ensure that funding is available  In addition, we are concerned that there continues to be no national commissioning contract for complex surgical abortions, nor for any abortions in general, meaning the Independent Service Providers have different individual contracts with every CCG. This leads to a postcode lottery and makes standardising quality more difficult. |
| 66 | Royal College of Midwives | Statement 1 | Quality measures  We are aware that there are some NHS services where self-referral is nominally in place, but in some the service runs with one doctor and as such, women are required to get a GP appointment to obtain an initial HSA1 signature. Without this, women are turned away or asked to return at later date after another signature has been found. This leads to pressure on other health services, increases waiting times, and undermines the intention of self-referral. The existing quality measure does not adequately provide for these cases. |
| 67 | Royal College of Nursing | Statement 1 | Data source  The data provided was explicit illustrating how healthcare commissioning groups and providers can work together to make abortion services easy to access. Discussions around reducing barriers to access are helpful.  Useful to see the information provided by the RCOG around restoration of gynaecological services following COVID 19. A good addition is the document provided by the Department of Health and Social Care ‘Temporary approval of home use for both stages of early medical abortion up to ten weeks’. |
| 68 | Marie Stopes UK | Statement 1- Question 3 | Cost of providing information in different languages and translation services. |
| 69 | British Pregnancy Advisory Service (BPAS) | Statement 2 | We support this quality statement and the effort to ensure that women have a choice about what treatment option they receive. |
| 70 | British Pregnancy Advisory Service (BPAS) | Statement 2 | Rationale  We are concerned about the use of the word ‘locally’ in regards to abortions up to 23+6 weeks. It has to be recognised that later abortions are specialised procedures that require an experienced clinical team to provide safe services. Nationally, there are, as a best estimate, around 15 surgeons who provide surgical Ground C abortions up to the legal limit. It is unrealistic, as a result, to expect that all women can access her choice of procedure locally up to the legal limit. This is similarly true with medical abortion, where late medical procedures are such an unpopular choice of procedure that Marie Stopes does not provide it at all, and BPAS provides from only one clinic. Lack of willingness to provide up to the limit, staff time, and ward space mean that similarly only one NHS hospital across the UK provides Ground C medical abortions up to the legal limit. We support the efforts to ensure accessibility, but believe that ‘locally’ should be reframed to ‘as locally as possible’. |
| 71 | British Pregnancy Advisory Service (BPAS) | Statement 2 | Rationale  As highlighted in our overarching comment above, we are concerned by the push to use referral pathways to ‘alternative local providers’. This presupposes a funding and commissioning system which does not exist. For instance, if a woman in Shrewsbury (a BPAS contracted area) wanted to access a service outside BPAS, her nearest NHS provider is 50 miles away, and her nearest Marie Stopes clinic is 80 miles away. A requirement to have local alternatives will push commissioners into Any Qualified Provider contracts, which have a negative impact on the willingness of providers to invest in services or to provide the full range of services. There is nothing in the NICE Guideline about a preference of a certain type of contract format, so we believe it is inappropriate to produce a Quality Standard which would require a certain type of contract to meet a basic standard of care. |
| 72 | British Pregnancy Advisory Service (BPAS) | Statement 2 | Quality Measures (Structure (b))  See comment above about the issue of referral to other local services. It is unrealistic in the current system to expect this to happen, especially as women progress through pregnancy and the number of sites providing services dwindle. Recommend removing the words ‘to local services’. |
| 73 | British Pregnancy Advisory Service (BPAS) | Statement 2 | Quality Measures (Process)  We do not believe this data will provide any useful information. It presupposes a certain split between surgical and medical terminations which can be used to measure whether women were offered a choice. We believe that Outcome (a) is the correct option here, in that it measures women accessing the type of service they want. Regardless, the national abortion statistics already break down medical and surgical by CCG or gestation, so further data collection is unnecessary. We recommend this outcome measure is deleted. |
| 74 | British Society of Abortion Care Providers | Statement 2 | Rationale  Choice of procedure is fundamental [https://bsacp.org.uk/wp-content/uploads/2020/06/BSACP-Providing-Genuine-Choice-Statement-10062020.pdf].  Considering all gestation bands together is too broad. First and second trimesters should be considered separately. Patients (currently at least those under 10 weeks) should have a genuine/ local offer of medical or surgical treatment. Many services have switched so completely to medical abortion that surgical is either not offered at all or the offer is of poor quality i.e. neither timely nor local.  Second trimester cases should also be offered both options but it would currently be reasonable to expect that the chosen option may involve some travel as realistically many individual services cannot offer both options to maximum gestation at the present time.  We also feel that surgical abortions should be split into whether performed using local or general anaesthesia, as local anaesthesia can be an option that is highly acceptable to patients but is not always on offer. |
| 75 | British Society of Abortion Care Providers | Statement 2 | Measures  Systems are not in place to record what women actually get offered. Services would need to self‑report - or would require occasional small surveys of service users to effectively monitor this; it would be doable but requires some investment. Who decides what is an acceptable travel distance for the alternative surgical option? |
| 76 | Care Quality Commission | Statement 2 | There is an escalating risk of access to late gestation abortion which might not be fully reflected in the quality statement. For example, where 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) states in the rationale “To support women’s choice, it is important to ensure that they can access services locally and avoid lengthy travel times” this may not always be possible.  Access to local services for late gestation surgical termination of pregnancy (SToP) is not in place for various reasons (not feasible / financially viable / restricted by reduction in clinicians trained to perform late gestation).  There is also a need for the NHS to work more with independent health providers (IHP) to ensure that issues are addressed. |
| 77 | Centre for Bio-Ethical Reform UK (CBR UK) | Statement 2 | NICE 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.  Reality of Statement 2: Women who request to kill their unborn children should be given a choice between medical or surgical killing to take place up to and including 23+6 weeks’ gestation.  Again, it goes without saying that choosing how a mother has her child killed, should not be an option in a civilised society nor a recommendation for a regulator promoting medical excellence. The deliberate stopping of a human heart (which begins beating at 21 days) by harmful chemicals or surgical dismemberment is killing no matter which way you look at it. Even Ann Furedi, head of BPAS is clear on this point.  Testimonies of women who have killed their children by either medical or surgical methods tell of severe pain, blacking out, weeks of bleeding, regret, self harm, depression and suicidal thoughts. Or as one woman said “he didn’t just take my baby, he sucked the life out of me as well”. Although killing children by chemicals is often advertised as a more natural procedure which can be conducted in the safety of your home, [a Finish study in 2009](https://pubmed.ncbi.nlm.nih.gov/19888037/?fbclid=IwAR2mpVkeKSZvFKTWi3gRTef-EA_6Pfky3HZKPNcp3XOuIi5HuGWa0e0OMJo) of 40,000 women showed a four fold higher complication rate for medical abortion vs surgical abortion, including 6.7% rate of “incomplete abortion”.  Clearly the killing of an unborn child is traumatic and fraught with complications whichever way it is conducted. Hence the recommendation of a choice of procedure is irrelevant compared with the far higher consideration of trying to prevent the procedure from needing to happen in the first place. In light of this the term “choice” needs to be vastly expanded in meaning and application by NICE and society at large. If NICE is to uphold care excellency then it must be willing to implement holistic policies that provide patience far greater choice than just “which way do you want to kill your child”. These choices (or at least the sign posting to those that can provide them) should include financial support, emotional support, safe housing, medical support (if foreign national), employment, social care support, and fostering and adoption information.  In the mean time women must also be fully informed of the increased complication rates of medical abortion and the fact that many women experience symptoms far more severe than they anticipated. They should also be made aware of the existence of a growing weight of scientific research, currently flatly denied or ignored by abortion providers, includling the links between abortion and the following:   * [mental health problems](https://www.ncbi.nlm.nih.gov/books/NBK91749/) * substance abuse * placenta previa * endometriosis * [breast cancer](https://www.bcpinstitute.org/uploads/1/1/5/1/115111905/bcpi-factsheet-epidemiol-studies_2020.pdf)   In summary we recommend:   * The scope of choice is vastly expanded in such a way to actually care for these women and not just give them autonomy as to how they have their offspring killed. * That women accessing a procedure which kills their child, be fully informed as to possible health consequences of that procedure |
| 78 | Doctors for Choice UK | Statement 2 | Rationale  Choice of method of abortion is important for women and DfC is aware that there are geographical disparities in this so very much supports the QS2. It is not acceptable that some areas can only offer medical abortion and should a woman want surgical abortion she must travel out of her own locality.  DfC feels that commissioners will need more guidance from national bodies on what constitutes a genuine/real option of surgical or medical. We would also like to have seen a standard that promoted a choice of anaesthesia ensuring that local anaesthesia would therefore be available as an alternative to medical abortion or surgical abortion under general anaesthesia. |
| 79 | Doctors for Choice UK | Statement 2 | Outcome – measures  DfC is keen to see greater user‑involvement but we also know that most women who have abortion care have a low expectation (c/f the stigma issue surrounding abortion) and will rank high satisfaction scores for anything other than poor services as a result. Also, because public information about abortion is of variable, often poor, quality and the general level of public knowledge about methods is minimal service users may not really be in a position to truly identify they received their “preferred abortion procedure”. |
| 80 | Homerton University Hospital NHS Foundation Trust | Statement 2 | Rationale  We are very pleased to see a standard that supports choice of procedure.  However there is a need to focus on those situations/areas/gestations where lack of choice is having the most negative impact.   1. We have concerns that in other areas women in the 1st trimester are not offered an option of surgical abortion. Medical abortion has become the default - and this is not acceptable.   We would like to see some guidance to commissioners about what constitutes an acceptable option for surgical care – such as how far the woman must travel/how long she must wait etc.  We were also disappointed that the standards did not address the anaesthesia options for surgical abortion and would like to have seen a standard that promoted a choice between sedation/General anaesthesia versus Local anaesthesia.   1. We have concerns that in many other areas women in the 2nd trimester do not have a local option for surgical abortion - and this is not acceptable.   We would similarly wish to see guidance about what constitutes an acceptable travel distance / wait time. |
| 81 | Homerton University Hospital NHS Foundation Trust | Statement 2 | Outcome – measures  We are concerned that the proposed outcome measures are blunt and may not yield value. Whilst we support user engagement and involvement we hope it is acknowledged that most women accessing abortion care are simply “grateful” and express satisfaction because their expectations are low. Many are also not well-positioned to identify if they received their “preferred abortion procedure” since they often do not have awareness of the full breadth of clinically suitable method options. |
| 82 | Right To Life UK | Statement 2 | 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.  Page 9 of the draft quality standard notes that “[I]f clinically appropriate, medical and surgical abortion procedures are both safe and effective up to and including 23+6 weeks’ gestation . . . 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.”  On page 11, the draft quality standard recommends that: “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.”  Question 1: Does this draft quality standard accurately reflect the key areas for quality improvement?  This draft quality standard gives disproportionate emphasis to ‘consent’ without sufficiently emphasising the ‘informed’ element.  The complication rates for medical and surgical abortions are significantly different. A large Finnish study (<https://pubmed.ncbi.nlm.nih.gov/19888037/>) of over 42,000 women receiving abortions under 9 weeks’ gestation found that the rate of complications was 4 times higher for medical abortions than for surgical abortions. It is therefore not clear why surgical abortion is not the default or recommended option.  At the very least, the quality standard should be clear about the fourfold higher complication rate from medical abortion and that this is communicated to patients.  On a related note, a key step for women’s safety is collecting good quality data on an ongoing basis regarding complication rates and inpatient and ED admissions following abortion. This is particularly important to monitor the safety impact of policy changes over time. Given the aforementioned evidence that home abortions may be linked with an increased rate of complications (and indeed have led to at least 2 maternal deaths), it is of critical importance that the quality standard emphasises the data collection and outlines specific measures to ensure all complications are captured. This is necessary to preserve women’s safety. This data collection should also be centralised. |
| 83 | Royal College of Midwives | Statement 2 | We support this quality statement. |
| 84 | Royal College of Nursing | Statement 2 | Rationale  Women’s choice is important and good to see those who request an abortion are given the option between medical or surgical abortion to take place up to and including 23+6 weeks gestation. The use of local referral pathways for abortion care ensure that women are promptly referred to an alternative provider if their service is unable to provide their preferred method is an improvement. |
| 85 | British Pregnancy Advisory Service (BPAS) | Statement 2 – Question 3 | Providing choice of procedure has an associated cost, but there are ways of amending commissioning procedures particularly for NHS providers where the cost can be reduced. BPAS is already contracted by some NHS providers to provide treatment beyond their local NHS gestational limit, and further care could be provided for earlier gestations/specific types of treatment if commissioned or sub-contracted. As covered below, ‘local’ access to these more specialised abortion treatments is not a realistic prospect, and would pose a significant financial burden for training, hiring, theatre space, and full theatre teams. |
| 86 | Marie Stopes UK | Statement 2 – Question 3 | Whilst we fully support ensuring accessibility, ‘local’ access to more specialised abortion treatments, for example later abortions, is not always feasible. |
| 87 | British Pregnancy Advisory Service (BPAS) | Statement 3 | Quality Measures (Structure (b))  As per our comments above, we do not believe it is within the gift of the Quality Standard committee to determine the commissioning environment with regards to referral, and do not believe that ‘local’ is the best way to frame specialist services. We believe this quality measure should be removed. |
| 88 | British Society of Abortion Care Providers | Statement 3 | Rationale  There is no mechanism by which to record the point an individual patient says she is decided. This would need to be measured as ‘next available treatment slot’ averaged in some way. Services would need to self-report. |
| 89 | Centre for Bio-Ethical Reform UK (CBR UK) | Statement 3 | NICE Statement 3: Women who have decided to have an abortion should have the procedure within 1 week of assessment.  Reality of Statement 3: Women who have decided to have their unborn child killed should have the procedure within 1 week of assessment.  Yet again, once the euphemism “to have an abortion” has been removed and replaced with correct terminology, the question naturally rises: “Why in the world should women need to be fast tracked into killing their children?” This should never be the priority of anyone, let alone a supposedly sane and self proclaimed “excellence” regulator.  Now, a medical and emotional argument exists that claims the earlier you have your unborn baby killed the better and less stressful, hence waiting times or “contemplation periods” are highly criticised. However, with due regard to the reality of what an “abortion” is, being the ending of an innocent human life, and out of respect for the gravity of that decision, why should there be any pressure to accelerate that process? After all, unborn babies are not cancers that threaten the life of the patient and unlike cancers they are not the target of CQC’s ”reduce waiting time” programs. There is therefore absolutely no outside pressure to accelerate this process.  If anything the opposite is true. A large study by [Comres in 2017,](https://www.comresglobal.com/wp-content/uploads/2017/05/Where-Do-They-Stand-Abortion-Survey-Data-Tables.pdf) found that the majority of members of the public surveyed (77%), supported longer waiting times. If NICE were open to hearing from people outside of it’s feedback loop, it would be willing to reconsider the inclusion of this recommendation.  As it happens, this policy, like all industry targets and goals, will no doubt increase the pressure on women accessing abortion to go through with procedures without talking to friends or family, considering its full implications or assessing possible alternatives to killing their own unborn child.  In light of this we recommend:   * The abandonment of this unnecessary and potentially harmful target   An optional two week cooling off period in which women are encouraged to speak to someone they love and trust about their abortion and or seek alternative help |
| 90 | Christian Action Research and Education (CARE) | Statement 3 | What the quality statement means for different audiences  We are concerned that the requirement for service providers to ensure they have the capacity to provide abortions should not lead to doctors or other health professionals[[30]](#footnote-30) to be involved with abortions if they have a conscientious objection. As per the GMC guidance, practitioners who conscientiously object to abortion do need to ensure patients who do request an abortion have sufficient information to access abortion services in a timely manner,[[31]](#footnote-31) but effective service organisation should mitigate against this infringing upon conscience rights.  We recommend that it should be made clear in this document that doctors or other health professionals should be able to exercise their important right to conscience. |
| 91 | Christian Action Research and Education (CARE) | Statement 3 | Rationale  We are concerned this Quality Standard may place undue pressure on women to rush ahead with the termination, and may incentivise sub-standard care.  One study raised the former point: “The only concern related to the greater efficiency associated with establishment of a centralized referral service is that the shortened referral time may lead a small proportion of women to undergo an abortion they may later regret.”[[32]](#footnote-32) Although women need to be informed of the risks of delaying termination, it is important that this is balanced with information regarding the risks of going ahead with terminations—even at this stage where they are still deliberating. This recommendation also seems somewhat at odds with the RSOP guidance which states that if a woman is ambivalent (albeit following counselling) she ‘can be given a provisional appointment for admission but must be told that the procedure can be postponed or cancelled and that she remains free to continue with the pregnancy, if she so wishes.’ (RSOP14)[[33]](#footnote-33)  The validity of both concerns was highlighted by a CQC report on MSI Maidstone,[[34]](#footnote-34) published in 2017, which recorded that whilst “all patients had their treatment within seven working days from decision to proceed to termination of pregnancy” as per the, then Department of Health, recommendations, this came at significant cost:   * + “Time pressure and a very inflexible pathway led to patients being rushed and staff failing to see where their needs were not being met.” P13   + Staff reported a very target driven culture with a timed slot for each patient. All the registered nursing staff we spoke with felt patient care and safety were compromised by the need to, “Keep on top of the list”. P11   + Minutes dated 15 July 2015 recorded a company wide focus on ‘Do not proceeds’. Where a patient of less than 5 weeks and three days gestation had decided not to go ahead with the termination they were being called and offered a later appointment. P24   Note that this was documented as a ‘company wide’ focus demonstrates that this was not an isolated incident.  We recommend this quality standard should explicitly state that waiting time targets must not be achieved to the detriment of quality of care.  We recommend there should also be additional text for women who have decided not to have an abortion:  For women who would prefer to wait longer for a termination of pregnancy, there should be no pressure to have an abortion within a week. |
| 92 | Doctors for Choice UK | Statement 3 | Outcome – measures  DfC supports the use of decision to procedure time as an outcome measure. Although harder to monitor it acknowledges that a minority of women are not certain of their decision when they make contact with services and they need ongoing support. Services must never feel pressure to rush a patient’s decision-making nor discharge them if they remain uncertain. We would like services to be able to self-report average wait times rather than needing to produce hard-to-collate data on such wait-times. |
| 93 | Homerton University Hospital NHS Foundation Trust | Statement 3 | Outcome -measures  We appreciate the understanding shown of the complexity around waiting times (due to the fact that for a significant minority the initial contact with an abortion services is well before a decision to proceed with abortion has been made - or indeed may never be made. A good abortion service ensures that no patient feels “under pressure” and will support a patient through all of the pregnancy options).  However in looking for evidence / data source the proposal of a bespoke survey/audit raises concerns for us. Whose responsibility to survey and collect the evidence for this proposed data source? It is not feasible to ask NHS providers of small abortion services for bespoke pieces of evidence to show service quality on a frequent basis. We have concerns that, throughout these standards, data sources are proposed which may put excessive demands on NHS providers of small-scale abortion services if taken too literally by commissioners.  We would like to see services allowed to self-report measures e.g. an average such as the third ‘next available treatment slot’. |
| 94 | Leeds CCG | Statement 3 | Measure  The statistics from the link provided within the report on abortions before 10 weeks (page 14) haven’t been updated since 2015 – is this the wrong link? |
| 95 | Right To Life UK | Statement 3 | Statement 3: Women who have decided to have an abortion receive the procedure within 1 week of assessment.  Question 1: Does this draft quality standard accurately reflect the key areas for quality improvement?  While the quality standard is correct that earlier abortion is generally physically safer, the quality standard should also appreciate the substantive benefits of waiting for some women.  It has long been noted that the information presented, and the manner in which it is presented, can influence women considering abortion. For example, disability rights groups have consistently explained how the information regarding the ‘risks’ of a disabled child can amount to directive or even outright coercive abortion in the case of disability. Likewise, the quality standard recommends that ‘Healthcare professionals have a discussion with women who would prefer to wait longer for an abortion about the implications of waiting longer.’  This should be clarified: waiting longer can mean a slight increase in the risk of complications (these should be outlined specifically, since waiting one extra week does not typically increase the risk of complications by a very large amount, while waiting many weeks can increase the risk very substantially - these two should not be conflated). At the same time, it should also be noted that waiting can (even if not always) provide women with important extra time and more resources regarding alternative options. Polling shows that 77% of women support mandatory waiting periods (<https://comresglobal.com/wp-content/uploads/2017/05/Where-Do-They-Stand-Abortion-Survey-Data-Tables.pdf>). Evidence also suggests that the majority of women find the decision difficult, and at least a quarter find it ‘very difficult’ (Rocca et al. 2020, ‘Emotions and decision rightness over five years following an abortion: An examination of decision difficulty and abortion stigma,’ Social Science and Medicine, 248).  The CQC have previously noted ‘Time pressure and a very inflexible pathway led to patients being rushed and staff failing to see where their needs were not being met’ at at least one abortion clinic in the UK.  As we outlined in our previous submission and earlier in this document, many women are ambivalent about abortion even at the point of accessing services (and some are coerced). For this significant number of women, it is important that the benefits of waiting are clearly described. It is a simple fact that some women appreciate more time and consideration before proceeding with an abortion, and that this need is not always met at present. Ambivalence is universally agreed to be a risk factor for poorer mental health outcomes following abortion and so these women are especially in need of protection.  Additionally, as we wrote in 2019 on the draft guideline Termination of Pregnancy, “it was described that the committee had agreed that women should be given information on how to cancel their appointment or procedure, although this is not in the final guidelines. It is not clear that this would be standard procedure for a given operation or procedure… and so warrants particular mention here given the frequent ambivalence and reasonably common regret expressed by women undergoing abortions, especially given the emphasis in the guidelines of speeding the process along and carrying out the abortion as soon as possible.” |
| 96 | Royal College of General Practitioners | Statement 3 | * The statement should clarify this is 1 week from assessment by the clinician (e.g. a GP) who provides onward referral, or by specialist services who then perform the abortion. Delays occur at many stages of the pathway. E.g. Women may wait to access primary care/ sexual health appointments rather than directly approach secondary care/ abortion services. Delays are also found when waiting for initial assessment after contacting/ being referred to secondary care/ abortion services and there are then additional delays from secondary care/ abortion care assessment to treatment. It is unclear from this statement which part of the pathway is being monitored and clarification is requested. * It is essential that women are given the option of time to think about their choice after an initial assessment appointment and some will require more time to process their decision/ to access counselling. Success should not just be determined by high levels of completion of abortion within 1 week but by completion of the abortion once a fully informed decision has been made. Could the committee consider changing this statement to: “Women who have decided to have an abortion after time to consider their decision and/or appropriate counselling receive the procedure within 1 week of assessment” to ensure that all women are given the appropriate time to consider their options without pressure. |
| 97 | Royal College of Midwives | Statement 3 | As discussed above, Quality Statement 3 should be reworded to include a target wait to consultation as well as target wait to treatment. |
| 98 | Royal College of Nursing | Statement 3 | The focus of this quality statement quite rightly explains that women who have decided to have an abortion receive the procedure within 1 week of assessment. Not then having to wait for the abortion, this is a most important step and key part of the pathway.  However, currently this statement reads as though there is no time requirement to provide an assessment, just the time post assessment.  Suggest changing to: ‘treatment to be provided within two weeks of making a decision to have an abortion.’ |
| 99 | White Ribbon Alliance UK | Statement 3 | This statement could be paired with ensuring that the universal charter for respectful maternity care is upheld by health professionals who are supporting the process of abortion. The full charter, created by the Global Respectful Maternity Care Council, which advocates for respectful maternity care for all women and girls can be accessed here https://www.whiteribbonalliance.org/respectful-maternity-care-charter/ |
| 100 | British Pregnancy Advisory Service (BPAS) | Statement 3 – Question 4 | No – you have not focused on the most important part of the pathway. To be meaningful, the entire pathway from contact to treatment has to be included as per the Guideline. The way the statement is currently framed has the potential to worsen services – encouraging same-day treatment but after a significant pre-consultation waiting time during which the woman will have had no contact with the TOP service. We recommend that this quality statement is reworded to include a target wait to consultation as well as treatment. |
| 101 | British Society of Abortion Care Providers | Statement 3 – Question 4 | Waiting times for assessment have been short – and since telemedicine/coronavirus, very short – so probably yes, the decision/procedure interval is the more important one to focus on at the current time. |
| 102 | Care Quality Commission | Statement 3 – Question 4 | The important part of the pathway is access to treatment. Assessment can be done in multiple ways, including remotely, due to the recent interim legislation. This has led to improved consultation and assessment availability. However, delay between decision to treat and actual treatment can then occur and referral to other providers that may have capacity to treat sooner does not always happen. Therefore, a defined pathway from contact to procedure would seem to be more appropriate than a measurement simply of time from assessment to procedure i.e. initial contact - consultation - treatment all within 10 days.  We suggest consideration should be given to the terminology and use of “1 week”. RSoP / RCoG refer to working days, for example RSOP 11 wording “The total time from access to procedure should not exceed ten working days”.  This may also skew local data reporting if providers report in a different way.  A further suggestion would be to report separately current treatment pathways to enable an overview of where service provision is lacking and thereby quantifying and enabling targeted actions to improve i.e. reporting remote consultation early medical abortions (EMA) separately to later gestation surgical termination of pregnancy. |
| 103 | Leeds CCG | Statement 3 – Question 4 | A quality statement which was re-worded to ensure rapid access from self-referral to procedure would cover all parts of the pathway, and therefore mitigate against any resource being moved from increasing the speed of assessment to procedure at the expenses of referral to assessment. |
| 104 | Royal College of Obstetricians and Gynaecologists | Statement 3 – Question 4 | Partially. We recommend including the waiting time to assessment as a part of the statement, as defined by the NG140:   * provide the assessment within 1 week of the request * provide the abortion within 1 week of the assessment.   As minimising both waiting time periods is integral to the rationale of Statement 3. Data is available from providers to monitor waiting time to assessment as well as waiting time to treatment. |
| 105 | British Pregnancy Advisory Service (BPAS) | Statement 3- Question 3 | Under the current legal and clinical guideline system where mifepristone is allowed at home and care can be provided without routine scanning, waiting times can easily be met for EMA. However, changes to this framework have the potential to undermine the ability of providers to meet these targets – particularly in more rural areas where clinics may only operate one day a week as a result of local demand. |
| 106 | Pregnancy Centres Network | Statement 3- Question 4 | 1. A systematic review of the mental health outcomes of induced abortion by the Academy of Medical Royal Colleges and the National Collaborating Centre for Mental Health indicated that mental health outcomes improved when counselling support is offered regardless of the outcome of a pregnancy (See <https://www.aomrc.org.uk/wp-content/uploads/2016/05/Induced_Abortion_Mental_Health_1211.pdf> )   This research, the recent case studies, and the equality and diversity considerations outlined in the draft guideline itself, all indicate that there is a need to consider the waiting time for women before they obtain an assessment for abortion. All women benefit not only from support to access the assessment quickly, but also from emotional support that will empower healthy decision making at a stressful time.  Guidelines around protocols to improve communication and joint working between providers, health care professionals and the charitable sector will optimise the outcomes for vulnerable women. |
| 107 | Royal College of Midwives | Statement 3- Question 4 | Partially. We recommend including the waiting time to assessment as a part of the statement, as defined by the NG140:   * provide the assessment within 1 week of the request * provide the abortion within 1 week of the assessment.   As minimising both waiting time periods is integral to the rationale of Statement 3. Data is available from providers to monitor waiting time to assessment as well as waiting time to treatment. |
| 108 | Bayer plc | Statement 4 | We are concerned that the wording of quality statement 4 does not convey the urgent need to address record levels of unplanned pregnancy. The recently published 2019 abortion statistics for England and Wales reported the highest levels of abortion since the abortion act was introduced in 1967.1 In addition, 40% of women undergoing abortions in 2019 had had one or more previous abortions - this proportion has increased steadily from 34% in 2009. We therefore propose that the wording of quality statement 4 should be strengthened to ensure that information about contraception and all methods of contraception are offered to all women who request an abortion. Furthermore, the most effective forms of contraception are long-acting reversible contraception (LARC) methods as covered in the NICE clinical guideline on long-acting reversible contraception (CG30) 2019. Contraceptive discussions should therefore include LARC methods of contraception as covered in recommendation 1.1.1.1.  of that guideline: “Women requiring contraception should be given information about and offered a choice of all methods, including long-acting reversible contraception (LARC) methods.”  We also suggest with the introduction of quality statement 5 allowing women the option of an early medical abortion at home, statement 4 should be reworded to cover referral to a contraception service post abortion for these women so that they do not slip through the net.  Proposed wording for Quality Statement 4: Women who request an abortion are given information on contraception and offered a choice of all methods including long-acting reversible contraception (LARC) methods at the time of their abortion or as soon as possible after expulsion of the pregnancy. Women undergoing early medical abortion at home should be referred to appropriate contraception services.  Department of Health and Social Care. Abortion Statistics, England and Wales: 2019. <https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2019> |
| 109 | British Association for Sexual Health & HIV (BASHH) | Statement 4 | All women who need an abortion should be 'offered' contraception services vs. 'asked if they want information'. This is a more proactive approach to contraception while maintaining choice. many women may not indicate that they wish to access contraception, but after it has been discussed with them and their options laid out, may then choose to access a method. |
| 110 | British Association for Sexual Health & HIV (BASHH) | Statement 4 | We should point out that a significant minority of women are offered and may choose to start contraception, off licence, prior to TOP and that for some very vulnerable or high risk women, this may be preferable to waiting until time of/after TOP. |
| 111 | British Pregnancy Advisory Service (BPAS) | Statement 4 | We support this Quality Statement, but it has to recognise that it relies on this being a funded, commissioned service, which is not the current case. The onus cannot be placed on providers – it has to include an obligation on commissioners to ensure that an appropriate funding model is in place. |
| 112 | British Pregnancy Advisory Service (BPAS) | Statement 4 | Quality Measures (Outcome (a))  In line with the focus on women who have requested contraception (rather than all women), this should be reworded to say ‘proportion of women who want contraception…’. |
| 113 | British Pregnancy Advisory Service (BPAS) | Statement 4 | Quality Measures (Outcome (b))  We do not believe that this measure adds anything useful to the discussion around contraception. There are no national official figures for contraceptive uptake (only estimates), there is not requirement or expectation in the Guideline that a certain target percentage of contraceptive uptake has to be reached. Measuring this risks curtailing women’s choice in an effort to meet targets – if high quality care is measured by having x% of women receiving contraception, services will have to encourage patients to make a particular choice, rather than respecting their decision. It is out of line with the declared aims of both the Guideline and the Quality Standard. This measure should be removed. |
| 114 | British Society of Abortion Care Providers | Statement 4 | Rationale  It needs to be clarified whether contraception includes reversible methods only or permanent methods too. |
| 115 | British Society of Abortion Care Providers | Statement 4 | Measures  No current mechanisms are in place to collect the data. Could some joined-up thinking happen around the mandatory reporting from sexual health services (SRHAD data) and from abortion services if this is to be introduced? |
| 116 | Doctors for Choice UK | Statement 4 | Outcomes  DfC supports the focus on ensuring a genuine contraception “offer” rather than a measure with numerical targets. Patients must have an opportunity to access but an absolute right to decline and DfC wants to support providers in promoting genuine choice.  We feel that the outcome measure (a & d) looking at ensuring staff are “trained” in contraception need some greater detail to know what standard is expected. We would propose that the Faculty of Sexual & Reproductive Health qualifications or an equivalent certification is used as the standard.  We support the suggestion of moving this statement to QS129. |
| 117 | Leeds CCG | Statement 4 | “As soon as possible” sounds vague. Is this as soon as possible for medical reasons or as soon as possible for service design reasons (in which case these could be overcome by eg training nursing staff to deliver LARC). |
| 118 | Right To Life UK | Statement 4 | 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.  Question 1: Does the draft quality standard accurately reflect the key areas for quality improvement?  On the recommendation that service providers “give details of all contraceptive methods including:  • how the method works…”  We believe it is vital to ensure that, as part of this, doctors are informed and (as noted in our 2019 submission on the draft guideline Termination of Pregnancy), inform patients on the possible abortifacient mechanisms of certain contraceptives (in particular, copper IUDs, but for all those methods where there is evidence for or uncertain evidence regarding an abortifacient mechanism). Though this is not legally required, it is of essential importance for respecting the personal beliefs of patients (particularly Christians and Muslims) who object to abortion from fertilisation rather than the legal definition of implantation.” We note that only a small minority of obstetricians and gynaecologists agree with the view that pregnancy begins at implantation (<https://www.ajog.org/article/S0002-9378(11)02223-X/fulltext>. Most surveyed believed that pregnancy began at fertilisation. Given the (at least) significant debate on this question, and given the importance of the mechanism to many people (particularly religious minorities), it is crucially important that the anti-implantation mechanism of the copper coil (and perhaps other forms of contraception) is explained to patients. We note that the equality and diversity considerations note the importance of taking into account religion and culture - but given how overlooked this important consideration is, it is worth noting explicitly. |
| 119 | Royal College of Midwives | Statement 4 | We support this Quality Statement. |
| 120 | Royal College of Midwives | Statement 4 | Quality Measures (Outcome (b))  Measurement may risk curtailing women’s choice in an effort to meet targets – if high quality care is measured by having x% of women receiving contraception, services will have to encourage patients to make a particular choice, rather than respecting their decision. |
| 121 | Royal College of Nursing | Statement 4 | Rationale and equality and diversity considerations  This standard is paramount and considers, age, religion and culture which may affect which contraceptive methods women consider suitable.  Healthcare professionals should be educated to provide the appropriate information about all methods and allow the woman to choose the one that suits her best. Providing contraception swiftly after the abortion procedure as soon as possible improves uptake and increases personal satisfaction. |
| 122 | British Pregnancy Advisory Service (BPAS) | Statement 4 - Question 3 | There is currently no funding for standalone contraception services as part of abortion contracts – the assumption is that the method is provided at the time of the abortion, and thus funding is only provided for the cost of the device and not for clinician time or the appointment. This is a barrier to providing LARC methods to clients having EMA, where a separate appointment for fitting is required. Changing contracts to take account of this would have a cost implication. |
| 123 | Marie Stopes UK | Statement 4 - Question 3 | Current abortion contracts do not fund standalone contraception services, and funding is provided for the cost of the device and not for clinician time or the appointment. This can limit the comprehensive post abortion contraception counselling and service offered, for example, provision of LARC methods for medical abortion clients, where a separate appointment for fitting is required. |
| 124 | Royal College of General Practitioners | Statement 4 - Question 5 | * All women who attend abortion services should be offered contraception to ensure they are informed of all of their options. It is also essential that this can be provided by the service or that the information is passed by to their GP to take forward. Therefore this statement should be based on all women who attend for an abortion |
| 125 | Royal College of Obstetricians and Gynaecologists | Statement 4 - Question 5 | Quality statement 4 should focus on women who choose to receive information about contraception |
| 126 | British Pregnancy Advisory Service (BPAS) | Statement 4 – Question 5 | Re: framing. The current framing based on women who wish to access contraception is correct – in line with the NICE guideline, the focus has to be on the client’s choice. A 2017 paper based on BPAS data found that 85% of clients accepted contraceptive counselling, but only 51% chose to obtain the method from BPAS as opposed to a GP or specialist clinic. Applying the Quality Standard to all clients would not take into account client choice. |
| 127 | British Society of Abortion Care Providers | Statement 4 – Question 5 | We believe that the focus should be on those who indicate they wish to access contraception following their abortion. It cannot be right to include in the denominator those who are not in a relationship, who say they do not want contraception at the present time and those who wish to obtain their contraception from another provider. |
| 128 | Care Quality Commission | Statement 4 – Question 5 | It may be preferable to focus this on all women, to help ensure the most vulnerable know how to access contraception. It is important to reduce the year on year rise in this procedure in order to safeguard potential mental health issues that occur in this group of women receiving treatment. |
| 129 | Homerton University Hospital NHS Foundation Trust | Statement 4 – Question 5 | We are pleased to see that the focus is on those who indicate they wish to access contraception –and acknowledge the negative impacts of targets for method use/uptake.  We support use of measures that ensure staff are well-trained in contraception counselling and would see that provided by the Faculty of Sexual & Reproductive Health - or of equivalence to it - as the desired minimum. |
| 130 | Leeds CCG | Statement 4 – Question 5 | 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? – All women who are having an abortion, as it is the way that the conversation is held around contraception choices which is likely to maximise uptake amongst those who might not otherwise have indicated that they wish to access contraception. |
| 131 | Marie Stopes UK | Statement 4 – Question 5 | Focus this statement on women who indicate that they wish to access contraception following their abortion to ensure priority is given to client’s choice. Funding and provision should be made to provide LARC as soon as possible after the EMA given this is best practice and preferable for many women. |
| 132 | Pregnancy Centres Network | Statement 4 – Question 5 | Because of the importance of preventing future unwanted pregnancies, it is preferable to focus this statement on all women who are having an abortion, and to ensure that cultural issues which may affect uptake are discussed as part of follow-up care |
| 133 | Royal College of Midwives | Statement 4 – Question 5 | Quality statement 4 should focus on women who choose to receive information about contraception. |
| 134 | British Association for Sexual Health & HIV (BASHH) | Statement 4 - Question 6 | We prefer the statement in QS129 which says “Women who request an abortion discuss contraception with a healthcare practitioner and are offered a choice of all methods when they are assessed for abortion and before discharge” – this suggests it refers to all women and not just those indicating that they wish to access contraception. |
| 135 | Royal College of General Practitioners | Statement 4 - Question 6 | * The statement works well when included within the abortion guidance rather than in the contraception guidance and we agree should be moved here. |
| 136 | British Society of Abortion Care Providers | Statement 4 – Question 6 | We agree with the suggestion of moving this statement to QS129. |
| 137 | Care Quality Commission | Statement 4 – Question 6 | Disagree with proposal and feel that it should remain in both. Relevant to QS129 as the QS also includes emergency contraception and contraception post childbirth so provides clarity there rather than having to reference separately. |
| 138 | Homerton University Hospital NHS Foundation Trust | Statement 4 – Question 6 | We support the suggestion of moving this statement to QS129. |
| 139 | Royal College of Midwives | Statement 4 – Question 6 | Yes. However, care must be taken to ensure that choice regarding uptake of contraception is respected. |
| 140 | Royal College of Obstetricians and Gynaecologists | Statement 4 – Question 6 | Yes. However, care must be taken to ensure that choice regarding uptake of contraception is respected. |
| 141 | Bayer plc | Statement 5 | We support the inclusion of quality statement 5. |
| 142 | British Pregnancy Advisory Service (BPAS) | Statement 5 | We support the aim of this quality statement but believe it is out of date and does not take into account the substantially improved outcomes for women as a result of the development of telemedical abortion services during COVID-19.  It is currently legal for women in England undergoing Early Medical Abortion to administer both mifepristone and misoprostol at home up to 9+6 weeks’ gestation. This is a hugely positive development in line with NICE guidelines, and BPAS have provided more than 25,000 abortions in this way already. A Quality Standard written at the current time has to take account of the new evidence to ensure that services reflect current best practice going forward.  In the first quarter of BPAS’s Pills by Post service, compared to the same quarter in 2019:   * BPAS provided 16,910 Pills by Post treatments, which accounted for 80% of our total EMA caseload * In a service evaluation conducted 14-21 days after treatment, 99% of clients said they were satisfied or very satisfied with their experience with BPAS * 24.6% of clients received a scan prior to EMA treatment – a proportion which has risen to 33% in the months since * The median national waiting time to treatment for an EMA was 2 days – a reduction of more than 50% * Median gestational age at treatment across the service fell by a week from 7+4 weeks to 6+4 weeks * The risk of a continuing pregnancy fell by 75% from 1.12% to 0.28% * The risk of an haemorrhage requiring transfusion declined by 71% from 0.07% to 0.02% * Overall, the risk of major complications fell by 66% from 0.09% to 0.03%, and the risk of minor complications fell by 40% from 3.2% to 1.96% * The rate of incidences of women obtaining telemedical EMA beyond 10-weeks’ gestation stands at 1 in 2500, with a negligible risk of pregnancy being above 24 weeks * The rate of incidences of ectopic pregnancies being diagnosed post-treatment was 1 in 2800, with the majority of these detected quickly by the BPAS 24-hour aftercare team * There have been no maternal deaths linked with Pills by Post – any such reports are based on erroneous information.   The development of telemedical services has led to reduced waiting times, reduced reduced complications, and increased accessibility. It is the best method of care available to women seeking an Early Medical Abortion, and signifies a significant development since the NICE Guideline was developed. It is worth noting that the only reason this development had not been made before this point was the legal requirement to take mifepristone on a licensed premises – the requirement to attend a clinic was not a clinical requirement.  At the current time, the approval of mifepristone to be taken at home is time-limited, with a public consultation expected in autumn 2020. As a result, we suggest the following wording for an alternative Statement 5:  “Women having an early medical abortion are given the options available to them under the law for location of administration of abortion medication.”  This focuses on services providing the best possible clinical practice allowed by the law related to abortion (home use of mifepristone and misoprostol, or, in the event the mifepristone approval is revoked, misoprostol at home). |
| 143 | British Pregnancy Advisory Service (BPAS) | Statement 5 | If our previous comment regarding the re-writing of Statement 5 is not accepted, we propose a rewording of the proposed statement. The current framing focuses on home expulsion – despite the quality measures discussing misoprostol at home, and it requires the choice of simultaneous treatment when the clinical outcomes of simultaneous treatment are less good and it was used primarily as a way to ensure that women could access abortion care more easily when they were required to take all medication on licensed premises. In addition, the Independent Service Providers account for 72% of all abortions provided in England and Wales, but lack the capacity for inpatient expulsion of pregnancies. It would be impossible to maintain appointment and clinical capacity with women remaining in-clinic to pass their pregnancy. The framing of this statement indicates that women should be ‘offered’ expulsion at home, which indicates the requirement for a choice of inpatient expulsion – which is not possible under the current system. Although we believe the statement is better revised to include the potential for mifepristone at home, our second recommendation would be to reword the original statement to say “Women having an early medical abortion are given the option of misoprostol at home up to 9+6 weeks’ gestation.” |
| 144 | British Pregnancy Advisory Service (BPAS) | Statement 5 | Quality measures (Structure (b))  To align with our comment above, we recommend rewording this to say “Evidence of local processes to ensure that women having an early medical abortion are given the options available to them under the law regarding location of administration of abortion medication.” |
| 145 | British Pregnancy Advisory Service (BPAS) | Statement 5 | Quality measures (Structure (c))  As per our comments above, we recommend removing this as a quality measure. Simultaneous treatment has poorer clinical outcomes and is a suitable offer only where misoprostol at home is not appropriate. Given the focus in this statement on miso at home, simultaneous should not need to be offered. |
| 146 | British Pregnancy Advisory Service (BPAS) | Statement 5 | Quality measures (Process (b))  As per our comment above, we recommend rewording this as “Proportion of women having a medical abortion up to an including 9+6 week’ gestation who are given the options available to them under the law for the administration of abortion medication” |
| 147 | British Pregnancy Advisory Service (BPAS) | Statement 5 | Quality measures (Process (c))  As per our comment above, we recommend removing this as a quality measure |
| 148 | British Society of Abortion Care Providers | Statement 5 | Rationale  If the option of taking mifepristone at home remains long-term (this depends on a DHSC decision which is planned to be consulted on imminently) then interval v simultaneous timing in the facility is largely defunct. BSACP strongly supports making home administration of mifepristone a permanent option.  BSACP would like to see the option of having the whole treatment (not just the initial consultation) by telemedicine become part of QS5. [https://bsacp.org.uk/wp-content/uploads/2020/05/BSACP-Position-Statement-Remote-Consultations-16052020.pdf] Experience over six months of pandemic conditions has shown how beneficial telemedicine has been in terms of reducing the gestation of abortions [https://www.gov.uk/government/statistics/abortion-statistics-during-the-coronavirus-pandemic-january-to-june-2020] but also from the point of view of improved patient experience and the ability to carry out safeguarding [https://bsacp.org.uk/wp-content/uploads/2020/05/Submission-to-Health-Social-Care-Committee-on-Coronavirus-080520.pdf]. |
| 149 | British Society of Abortion Care Providers | Statement 5 | Measures  There are no systems in place to report what women actually get offered. Services would need to self‑report - or could be required to perform occasional small surveys of service users to effectively monitor this. Doing such audits and surveys requires time and effort; data collection in NHS services is often poor. We worry that if NHS services are asked to generate too many bespoke reports/audits on abortion care the impact of these demands can be excessively burdensome for these smaller-scale providers and some will simply withdraw from providing at all. Sustaining NHS provision alongside independent sector provision is recognised as being vital for more local care for women with co-morbidities and for sustainability of the workforce (as recognised by NG140). |
| 150 | Christian Action Research and Education (CARE) | Statement 5 | It needs to be clearer in this Standard what is allowed under the provisions for taking one or both pills at home and provision for women having an abortion at home after taking pills at a clinic or hospital.  We recommend that the language in this Quality Statement should be in line with the gestation limits set out in the approval for abortions at home both in the December 2018 and March 2020 (temporary) approval |
| 151 | Christian Action Research and Education (CARE) | Statement 5 | We note that the option for a simultaneous treatment is referenced on page 23 for pregnancies up to 9 weeks and 0 days gestation.  However in a Parliamentary Question answered on 27 May 2020 on the temporary arrangements under the coronavirus pandemic, the Government said “As part of their consultation prior to treatment commencing, women will be clearly informed that medical abortion is a two-stage process which requires the administration of Mifepristone followed by Misoprostol to successfully complete the procedure.”[[35]](#footnote-35)  The RCOG in their guidance for abortions during the pandemic also states that an effective abortion regime is a two-stage process.[[36]](#footnote-36)  We recommend that the language in this Quality Statement should be in line with the gestation limits and guidance set out in the approval for abortions at home both in the December 2018 and March 2020 (temporary) approval. |
| 152 | Christian Action Research and Education (CARE) | Statement 5 | Rationale  We note that the quality standard does not refer to the current temporary telemedicine regime, which unless extended will end at the latest on 30 March 2022. Page 1 of the document states that the final standard should be published in January 2021. As it is likely that this temporary measure will still be in place at that point, we recommend the standard should give appropriate advice for telemedicine, but with the recognition that the approval for this regime is temporary. In particular, we recommend that there should be clear guidance and training on telemedicine protocols for safeguarding, and follow-up to ensure there are no complications and data collection, as set out in our comments 5 and 6.  Our concerns about data collection were set out earlier. In particular, it is not clear whether the abortion itself took place, nor that the pregnancy was at the gestation estimated, nor whether there were complications after the pills were taken. This bears unfortunate resemblance to the case of postal coronavirus tests, where statistics were widely condemned and were latterly revised in recognition that posting a kit is not the same as verifying that is has been used.[[37]](#footnote-37) There may be no evidence of increased risk associated with telemedicine, and this service may have improved outcomes, but this must be thoroughly demonstrated prior to determining policy recommendations about how this quality statement may be met.  Further concerns about monitoring the safety of the temporary measures have come to light through the Department of Health and Social Care’s (DHSC) responses to recent Parliamentary Questions about the temporary service. Despite stating that the safety of the temporary measures is being closely monitored, the DHSC say that they do not hold data on the number of hospital admissions resulting from prescription of abortion pills since 1st April 2020.[[38]](#footnote-38) Whilst they note their awareness of a small number of incidents of concern,[[39]](#footnote-39) this response suggests an absence of systematic monitoring of one of the crucial measures by which safety outcomes could be assessed.  The Royal College of General Practitioners (RCGP) recommends that “[t]o ensure on-going continuity of care it is important that the central GP patient record is kept up to date and sharing of information regarding termination of pregnancy is the gold standard… This information does not always reach the GP making decisions regarding care when complications arise, or for contraception advice difficult.”[[40]](#footnote-40) Whilst confidentiality concerns may prevent women from wishing this information to be shared with their GP, this nonetheless demonstrates further concern that complications following abortion may not be linked to the abortion procedure, which may negatively impact ongoing care, and it also follows that the evidence provided for the efficacy and safety of the telemedicine service may be incomplete. |
| 153 | Doctors for Choice UK | Statement 5 | Rationale  Taking mifepristone at home has completely changed delivery of abortion care and had enormously positive benefits – improved safety and reduced cost (see RCOG Abortion Task force report Abortion care in the independent sector during the COVID-19 pandemic June 2020 – which has shown "average waiting time has halved since the approval order permitting the use of mifepristone at home, and the average gestation at the time of procedure has reduced by over a week in the same timeframe"). DHSC have planned a consultation on whether this should remain beyond the pandemic. It would be a disastrous retrograde step to reverse this. DfC believes it absolutely must remain long-term.  The simultaneous use of mifepristone and misoprostol - or the shorter interval regimens - were always a way of dealing with clinically restrictive regulations; so now with home use of mifepristone these are no longer relevant .  A standard around the total telemedicine care option would be a welcome revision (or addition) to part of the Quality Standard 5. |
| 154 | Homerton University Hospital NHS Foundation Trust | Statement 5 | Rationale  Simultaneous use of mifepristone and misoprostol was always a work-around of the regulations and so now is it basically defunct.  The option to take mifepristone at home has been “game-changing” within our service - and for whole population - and we feel it must remain long-term. We strongly support making home administration of mifepristone a permanent option.  Homerton strongly supports the total telemedicine option now available to so many service users and would really like to see this become part of the Quality Standard 5. |
| 155 | Homerton University Hospital NHS Foundation Trust | Statement 5 | Measures  Despite our wholehearted support for home use, we again wish to caution about proposed measures – and this caution applies to several proposed outcome measures in the standards where there are no current (or inadequate current) systems in place to report. We worry that demands for bespoke reports are burdensome. Smaller NHS providers might respond to such demands by ceasing provision altogether and this would be counter-productive. We know that a mixed-economy of NHS provision alongside independent sector provision is best and especially important to ensure women with co-morbidities can obtain local care – and for training the future workforce. |
| 156 | Marie Stopes UK | Statement 5 | It is currently legal for women in England to administer both mifepristone and misoprostol at home up to 9+6 weeks’ gestation. We would therefore suggest the draft either remove references to simultaneous treatment or make it clear that this would only now be necessary in a limited number of cases (e.g. where a woman travels to a provider but is unable to return for a second appointment). |
| 157 | Pregnancy Centres Network | Statement 5 | Equality and diversity considerations regarding medical abortion administered at home.   1. Many women do not keep a good record of the date of monthly period, leading to possible mistakes around gestation. 2. How to ascertain that an online or telephone assessment for an abortion is held in a place where the woman feels safe to be honest with the assessor. 3. Recent research demonstrates that miscarriage can result in Post Traumatic Stress Disorder. (see <https://www.nhs.uk/news/pregnancy-and-child/many-women-experience-post-traumatic-stress-anxiety-and-depression-after-pregnancy-loss/> ) Common sense suggests that abortion is likely to be accompanied by similar levels of stress. This supports the view that women will benefit from the clearly signposted provision of counselling support beginning when they are in the process of trying to access an assessment appointment for TOP, and continuing through and after the procedure. |
| 158 | Right To Life UK | Statement 5 | 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.  Question 1: Does the draft quality standard accurately reflect the key areas for quality improvement?  We have already explained some of the safety, safeguarding, and legal concerns that arise from home abortion, particularly in combination with telemedicine abortion. We therefore do not repeat those here but reiterate comment 4 of this submission.  Additionally, the Government is about to undertake a public consultation on ‘at-home’ abortions (see: <https://www.theyworkforyou.com/wrans/?id=2020-07-22.78913.h&s=abortion>). It is imprudent to move forward with a suggestion to increase the provision of home abortions before the results of this consultation.  In summary, we believe the draft quality standard should prioritise and focus on reducing complications suffered by women. Keeping hospital appointments for abortion assessments, supervising the use of both sets of abortion pills, and providing a full medical check-up before the abortion ensures that women have an opportunity to speak freely without external pressure, and guarantees medical oversight if complications occur.  We strongly support the inclusion of the outcome: ‘Hospital admissions for administration of early medical abortion’, but suggest that comprehensive data is included on these cases including gestation at which the abortion occurred, whether/which pills were taken at home, timing of the pills, and whether the patient attended an assessment in person or by phone/video consultation. We also suggest that the data clearly distinguishes inpatient and emergency admissions.  We support the recommendation to healthcare professionals that they explain the increased risk of simultaneous administration but recommend that whether this information is provided is also included as a measured outcome. |
| 159 | Royal College of Midwives | Statement 5 | We support the aim of this quality statement but believe it would be beneficial to reframe the statement to take into account the substantially improved outcomes for women as a result of the development of telemedical abortion services during COVID-19. It is currently legal for women in England undergoing Early Medical Abortion to administer both mifepristone and misoprostol at home up to 9+6 weeks’ gestation. The development of telemedical services has led to reduced waiting times, reduced complications, and increased accessibility.  At the current time, the approval of mifepristone to be taken at home is time-limited, with a public consultation expected in autumn 2020. As a result, we suggest the following wording for an alternative Statement 5: “Women having an early medical abortion are given the options available to them under the law for location of administration of abortion medication.” This focuses on services providing the best possible clinical practice allowed by the law related to abortion (home use of mifepristone and misoprostol, or, in the event the mifepristone approval is revoked, misoprostol at home).  Additional evidence from BPAS:  In the first quarter of BPAS’s Pills by Post service, compared to the same quarter in 2019:   * BPAS provided 16,910 Pills by Post treatments, which accounted for 80% of our total EMA caseload * In a service evaluation conducted 14-21 days after treatment, 99% of clients said they were satisfied or very satisfied with their experience with BPAS * 24.6% of clients received a scan prior to EMA treatment – a proportion which has risen to 33% in the months since * The median national waiting time to treatment for an EMA was 2 days – a reduction of more than 50% * Median gestational age at treatment across the service fell by a week from 7+4 weeks to 6+4 weeks * The risk of a continuing pregnancy fell by 75% from 1.12% to 0.28% * The risk of an haemorrhage requiring transfusion declined by 71% from 0.07% to 0.02% * Overall, the risk of major complications fell by 66% from 0.09% to 0.03%, and the risk of minor complications fell by 40% from 3.2% to 1.96% * The rate of incidences of women obtaining telemedical EMA beyond 10-weeks’ gestation stands at 1 in 2500, with a negligible risk of pregnancy being above 24 weeks * The rate of incidences of ectopic pregnancies being diagnosed post-treatment was 1 in 2800, with the majority of these detected quickly by the BPAS 24-hour aftercare team   There have been no maternal deaths linked with Pills by Post – any such reports are based on erroneous information. |
| 160 | Royal College of Nursing | Statement 5 | Simultaneous abortion is now very rarely used, this was put in place so that women could access abortion in one visit, but it is not as clinically effective as interval. Women can now take medications at home so reference to simultaneous administration could be removed. |
| 161 | Royal College of Nursing | Statement 5 | Rationale  The provision here is to ensure that women having an early medical abortion up to and including 10+0 weeks’ gestation are given the option of expulsion at home. Clear guidance is given regarding the taking of mifepristone and misoprostol treatment. Healthcare professionals engaged in this work, enable women to make decisions about their care explaining pertinent issues and possible risks. We note the rationale for this standard, notably the reduction of hospital admissions. |
| 162 | Royal College of Obstetricians and Gynaecologists | Statement 5 | Consider reframing this statement to include the fact that it is currently legal in England and Wales to provide mifepristone at home (as well as misoprostol). The statement currently focusses on expulsion (i.e. the administration of misoprostol) when it could be expanded to refer to the importance of offering choice for the administration of both abortion pills at home. |
| 163 | British Pregnancy Advisory Service (BPAS) | Statement 6 | We support this Quality Statement, but recommend that the wording is amended to ‘care and support’ and to include ‘during and after the abortion’. These changes would reflect that this refers to clinical aftercare and not solely to post-abortion counselling. It is important to recognise that the vast majority of post-abortion contact comes from individuals with questions or concerns about treatment, rather than those who are seeking post-abortion counselling. Although Independent Service Providers are required by the DHSC’s Required Standard Operating Procedures to provide a dedicated 24-hour aftercare line, NHS services are not. Women are often given the number of the gynaecology ward, may have to present to A&E, or may have to wait to attend a GP for further care. Our 24-hour aftercare line receives different types of calls, but the majority are received during the abortion process rather than afterwards, covering eg pain, bleeding, administration. |
| 164 | British Pregnancy Advisory Service (BPAS) | Statement 6 | Quality measures (Structure (b))  We recommend that ‘support’ here is reworded to ‘care’, and to include ‘during and after the abortion’, as psychological support and counselling are already included in (a). |
| 165 | British Pregnancy Advisory Service (BPAS) | Statement 6 | Quality measures (Process)  We recommend that this is reworded to include ‘care and support’ and ‘during and after the abortion’ |
| 166 | British Pregnancy Advisory Service (BPAS) | Statement 6 | Quality measures (Outcome)  We recommend rewording this to include ‘care and support’ and to include ‘during and after the abortion’. |
| 167 | British Society of Abortion Care Providers | Statement 6 | Measures  As described above, audits or surveys of this would be hard to do and we have similar concerns about the impact of requiring bespoke reports. BSACP nevertheless does recognise and support this as an important element of good quality care. Women must know when and where they can go for aftercare. |
| 168 | Centre for Bio-Ethical Reform UK (CBR UK) | Statement 6 | NICE Statement 6: Women having an abortion are given advice on how to access support after the abortion.  Reality of Statement 6: Women having their unborn child killed are given advice on how to access support after their child has been killed.  Killing your child by abortion, in most cases, causes long term emotional and physical harm (cf. Studies).  While the harm of that decision can be concealed by [short term studies of post abortive women 1-5 years post procedure](https://www.guttmacher.org/gpr/2006/08/abortion-and-mental-health-myths-and-realities), eventually the cost of that decision catches up with them.l Understandably many don’t wish to seek this support from the place that performed the killing so instead require independent help. If NICE is truly committed to “Care Excellence” they should take seriously the offer of independent long term support. We recommend this be funded using money currently allocated to “in house” counselling, that by its very non impartial nature, cannot be trusted. |
| 169 | Christian Action Research and Education (CARE) | Statement 6 | As mentioned above, there is no routine follow-up for women accessing early medical abortion (though there is a 24-helpline), nor is abortion routinely recorded in the central GP patient record. For comparison, the NG126 on management of miscarriage says that women should be offered a follow-up appointment (1.1.4). The RCGP in their suggestions for improved abortion care said: “To ensure on-going continuity of care it is important that the central GP patient record is kept up to date and sharing of information regarding termination of pregnancy is the gold standard. If the GP knows a patient has had a termination of pregnancy, follow up can be provided to ensure psychological support is available.”[[41]](#footnote-41) In the case of a spontaneous miscarriage, recording in the central GP patient record would be routine when a woman has received medical care. (See our comments above about recording of complications during the temporary telemedicine arrangements).  Since it is not always automatic that an abortion is recorded on a medical record, women who experience complications following an abortion will be less likely to be identified. We recommend that this quality standard should require routine follow-up for women who have had an early medical abortion. |
| 170 | Christian Action Research and Education (CARE) | Statement 6 | Minutes from the prioritisation meeting held in August report that although some abortion providers offer counselling, there is no fast track into Improving Access to Psychological Therapies (IAPT) following abortion,[[42]](#footnote-42) so if a woman does not wish to access counselling provided directly by the provider (which in the case that her experience of abortion has been difficult would be understandable), she would be required to go through the usual IAPT referral mechanism, or depending on the level of complexity through standard referral mechanisms for secondary care psychological therapies, which are known to be fraught with lengthy delays. The meeting minutes acknowledged that accessing follow-up can be 'difficult'. Given the emphasis on improving access to abortion in this Quality Standard, there should be an equal emphasis on improving access to abortion counselling, both before an abortion (see our suggestion for Quality Statement 7) and after an abortion and to ensuring that the counselling is effective.  We are concerned that a requirement to provide women with advice on accessing support following an abortion is insufficient to ensure timely access to appropriate support. Whilst the commentary advises that commissioners should provide referral pathways, the briefing paper provided with the QS records on page 32, paragraph 4.6.4 that “[t]his area was not included in the resource impact assessment for NG140. It was not identified as an area that would have a significant resource impact (>£1m in England each year)”.  It appears that the emphasis is on providing information on how to get support/counselling rather than ensuring that the services that are received are timely and effective. This is not sufficient to meet the needs of women who require support. The evidence documents for the draft Abortion Guideline said there “was evidence that women may need support following termination of pregnancy for a number of reasons, including: dealing with isolation, negative feelings, milestones and the future, and to receive answers to specific questions and have someone validate their feelings.”[[43]](#footnote-43) And that "On some occasions it may be easier for women to be part of a system that guides them through managing their difficulties without them having to be asked if they want to be a part of it.”[[44]](#footnote-44)  According to the latest Annual Report on the use of IAPT services in England, in 2018-19, 1.09 million people started treatment within that period.[[45]](#footnote-45) Since the population of England is around 56 million,[[46]](#footnote-46) that equates to approximately 2% of the population. A 2011 Systematic review of mental health outcomes following induced abortion concluded that “it is important to consider the need for support and care for all women who have an unwanted pregnancy, because the risk of mental health problems increases whatever the pregnancy outcome.”[[47]](#footnote-47) It seems reasonable, then, to assume that at least 2% of women who have abortions may require counselling in the following year, that would be circa 4,000 women per year. That more women than men seek IAPT services also suggests this may be a conservative estimate.[[48]](#footnote-48) According to one paper the average course of low intensity IAPT costs c£500.[[49]](#footnote-49) If 4,000 women required an IAPT intervention following an abortion that would cost approximately £2 million. If the proportion of women requiring intervention was more than 2%, or if a higher-intensity intervention was required, the cost would be significantly higher.  We recommend that there should be a fast track option to receive independent post-abortion counselling, where needed, mindful of higher rates of complicating factors such as IPV in the abortion seeking population. We also recommend that Counselling should be part of this quality statement. |
| 171 | Homerton University Hospital NHS Foundation Trust | Statement 6 | Measures  Homerton recognise the importance good quality aftercare and ensuring patients know when and where they can get this.  Within our gynaecology and early pregnancy care services we see the reality of how women actually access after care post‑abortion from other providers as well as from our own abortion service and would caution commissioners and others in taking a simplistic approach.  Whilst we agree it is valid to make the measures proposed they will not give a full picture of care as women will frequently seek local care from another known (often NHS) service if their abortion provider is not in close proximity to their home. |
| 172 | Pregnancy Centres Network | Statement 6 | 1. The experience shared by Independent pregnancy centres across the UK is that many patients are reluctant to return to the premises where the pregnancy loss was initiated or where it took place to access emotional and psychological support after the event. 2. Many seek pregnancy loss support months or years after the event, while others seek this soon after they have lost a pregnancy. Some find one to one support following a programme tailored to the particular nature of the pregnancy loss is very helpful, while others find they benefit greatly from the dynamic of a guided support group. Therefore it is helpful if information about post abortion support is given in different formats – written and also electronic – so that they will be easy to find at a later date, should the need arise. |
| 173 | Right To Life UK | Statement 6 | Statement 6: Women having an abortion are given advice on how to access support after the abortion. Question 1: Does the draft quality standard accurately reflect the key areas for quality improvement? The draft quality standard correctly draws attention to the importance of post-abortion care and the possibility of physical and mental complications for vulnerable women. However, it is equally important that women are made aware of the potential psychological risks in advance in order to make a fully informed decision.  Regarding follow up care, previous NICE guidance on this topic noted in the evidence review that many women are unable to access follow up care (<https://www.nice.org.uk/guidance/ng140/evidence/o-support-after-abortion-pdf-248581907033>). Given the unusually quick access to a procedure women have in the case of abortion (with a target set here of 1 week), it is therefore grossly disproportionate that post-abortion support is sometimes not even attained at all. The NICE evidence review stated: ‘Low quality evidence from 3 studies (n=87) conducted in the UK and the USA reported that the availability of support decreases over time after an abortion for fetal anomaly, despite the desire for ongoing support, and that grief lasts longer than expected by the woman’. Specific outcomes should be recommended and measured to ensure that women receive the care they need after an abortion.  Given that the previous evidence review makes clear that women struggle in getting access to emotional support after abortion, the draft quality standard should be more robust in its directions, outlining the types of services specifically available, rather than simply noting this information can be collected locally.  Equally important for informed consent is the provision of accurate information regarding psychological risks. This is in fact required for informed consent and for quality care for women.  The quality standard attempts to cover this with the recommendation to ‘Explain that it is common to feel a range of emotions after the abortion’. This is simply too vague to properly inform women; it is true of almost any event in human life. There are specific risks - some much more serious and/or specific than a ‘range of emotions’ - associated with abortion.   1. 85% of women feel some negative emotions after an abortion (<https://pubmed.ncbi.nlm.nih.gov/19880932/>). 2. The majority of women feel some or very much sorrow, sadness, guilt, or disappointment. A large minority of women feel some or very much regret and grief. (<https://pubmed.ncbi.nlm.nih.gov/19880932/>) 3. A small minority of women meet the criteria for PTSD on abortion-specific symptoms alone (<https://pubmed.ncbi.nlm.nih.gov/10920466/>) 4. Multiple abortions are associated with anxiety (<https://www.aomrc.org.uk/wp-content/uploads/2016/05/Induced_Abortion_Mental_Health_1211.pdf>). Given that around 40% of abortions in the UK are repeat abortions, this is extremely salient to a large number of women. 5. Single abortions may be associated with a small increase in the risk of anxiety (the confidence interval is borderline significant) (<https://www.aomrc.org.uk/wp-content/uploads/2016/05/Induced_Abortion_Mental_Health_1211.pdf>) 6. Abortion is associated with an increased risk of suicidal behaviour compared to the voluntary continuation of an unwanted pregnancy (<https://www.aomrc.org.uk/wp-content/uploads/2016/05/Induced_Abortion_Mental_Health_1211.pdf>). Given that legal refusal of TOP is very uncommon in the UK, voluntary continuation of an unwanted pregnancy is the most appropriate comparison group.   The Montgomery v Lanarkshire ruling has clarified the standard in law requiring that patients are told of any outcomes they would reasonably want to know. It goes without saying that all of the above information is information which woman might reasonably want to know.  Notably, a recent undercover investigation by [Christian Concern](https://christianconcern.com/ccpressreleases/court-of-appeal-refuses-to-consider-sensational-evidence-of-diy-abortions-killing-women/) ([Court of Appeal refuses to consider sensational evidence of DIY abortions killing women - https://christianconcern.com/ccpressreleases/court-of-appeal-refuses-to-consider-sensational-evidence-of-diy-abortions-killing-women/](https://christianconcern.com/ccpressreleases/court-of-appeal-refuses-to-consider-sensational-evidence-of-diy-abortions-killing-women/)) found a startling lack of assessment of women seeking abortions through the British Pregnancy Advisory Service and Marie Stopes UK. Twenty fabricated applications successfully received abortion pills for home use despite the inclusion of fradulent information. The absence of pre-abortion care in this regard could easily facilitate the abuse of such telemedicine services by third parties including sexual abusers. Without proper pre-abortion care, vulnerable women may be privately coerced into abortion and such abuse remain concealed from medical professionals.  In addition, as noted in our 2019 submission on the draft guideline Termination of Pregnancy, we recommend screening for women particularly at risk of mental health problems following an abortion, as recommended in the RCPsych position statement ([Royal College of Psychiatrists statement on abortion and mental health](https://www.wthrockmorton.com/2008/08/20/royal-college-of-psychiatrists-statement-on-abortion-and-mental-health/) - <https://www.wthrockmorton.com/2008/08/20/royal-college-of-psychiatrists-statement-on-abortion-and-mental-health/> ). Indeed, it would be helpful to direct clinicians to resources and information regarding such screening so that they can carry this out properly, which seems to be lacking in the draft quality standard. We also recommend that for abortions carried out on mental health grounds, information is considered and documented regarding the woman’s risk factors for poor mental health outcomes, as well as a psychiatric history.  Furthermore, it is not clear if the draft quality standard will ensure women are fully informed of what is involved in expelling a dead foetus. As the draft quality standard notes that information on abortion services should be made widely available, all that abortion entails should be outlined so that the woman is fully informed before making a decision.  As we wrote in 2019 on the draft guideline Termination of Pregnancy:  The evidence reviews suggest that women were not prepared for the experience of delivering the dead foetus and appreciated detailed information on this. The need for detailed information is not adequately reflected in the draft guidance: it would be helpful for clinicians to know precisely what to include - specifically, that the foetus may well look like a human being, have identifiable body parts, may well move of its own accord, etc. It is also not clear what detailed information should be given regarding the nature of the procedure: not just what the woman experiences but also what the procedure involves in cases of medical and surgical abortions, particularly if there is a risk (as in medical abortions but also sometimes in surgical abortions) that the woman will see the body parts of the foetus.  As further noted in our 2019 submission, all the evidence in the evidence review is in favour of an opt-out system for emotional support after an abortion and this should not be limited to the period after pregnancy but should be an ongoing offer for those women who initially decline, and for those women who need ongoing support for an extended period of time.  Indeed, this is even implied by the guidance. However, it was claimed that such a system would be unreasonable because ‘some women do not feel they need support and may actually feel relieved after a termination of pregnancy and want to move on.’ This appears to make little sense, since such women can decline the offer of support very easily, and since the overwhelming weight of evidence regarding emotional support suggests that there is not enough, rather than that it is inappropriately offered (it is not clear whether there is any evidence at all of the latter, in fact). We therefore propose that such follow-up be offered as standard with an opt-out possibility for women who do not wish to have post-abortion support.  Such support should be offered routinely by abortion providers, in line with committee recommendations that it ‘is important that emotional support, and access to counselling if required, is available from termination of pregnancy providers as this would not require additional disclosure by the women in order to access support.’ Given the clear lack of access to support described by women, there is compelling reason to include such a mandate in the final guidance. The guidance should make clear that there is a recommendation of a formal requirement for abortion providers in this respect.  The evidence review says that “The committee noted that difficulties experienced by some women may require more intensive psychological therapy, which is often not available from termination of pregnancy services and that there can be difficulties providing referrals for these women; however, recommending pathways for referral was beyond the scope of this question.” However, it is unclear on what grounds this is outside the scope of the guidance.  We note the need of more intensive psychological therapy for some women and recommend that the quality standard outlines how this ought to be accessed and how its accessibility ought to be measured.  Finally, women should also be made aware of the negative experiences other women have from terminating after a foetal anomaly. As noted in our previous submission from 2019, given the detailed evidence review showing that women generally have very negative experiences of termination after foetal anomaly, it is worth giving women detailed information from evidence base regarding the experiences both of children born with certain conditions and of women who have given birth in such conditions (including for fatal foetal anomaly / life limiting conditions). For example, a recent study from Wool et al. ([Wool et al., 2018, ‘“I would do it all over again”: Cherishing time and the absence of regret in continuing a pregnancy after a life-limiting diagnosis’, Journal of Clinical Ethics](https://www.researchgate.net/publication/327990698_I_Would_Do_It_All_Over_Again_Cherishing_Time_and_the_Absence_of_Regret_in_Continuing_a_Pregnancy_after_a_Life-Limiting_Diagnosis) <https://www.researchgate.net/publication/327990698_I_Would_Do_It_All_Over_Again_Cherishing_Time_and_the_Absence_of_Regret_in_Continuing_a_Pregnancy_after_a_Life-Limiting_Diagnosis> ) found that the overwhelming majority (97.5%) of parents had no regret about their decision to continue the pregnancy in the case of FFA. Likewise, there is a particular study directly comparing the mental health outcomes of those having an abortion and those continuing a pregnancy in such a situation, showing that women have better mental health outcomes if they continue the pregnancy ([Cope et al., 2015, ‘Pregnancy continuation and organizational religious activity following prenatal diagnosis of a lethal fetal defect are associated with improved psychological outcome’, Prenatal Diagnosis](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4968036/) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4968036/> ). This should be conveyed to women in such a situation.  Likewise, it is worth giving women access to studies showing that children born with certain disabilities tend to be extremely satisfied with their lives. For example, Skotko et al. published a paper ([Skotko et al., 2011, ‘Self-perceptions from People with Down Syndrome’, American Journal of Medical Genetics Part A](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3740159/) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3740159/> ) showing that people born with Down Syndrome overwhelmingly value their lives and appreciate the opportunity to live.  By contrast, the negative experiences highlighted in the evidence review from women having abortions in such situations should be offered in comparison (e.g. the theme of experiencing the abortion as ‘torture’ highlighted in [Jones et al., 2017, ‘Women’s experiences of labour and birth when having a termination of pregnancy for fetal abnormality in the second trimester of pregnancy: A qualitative meta-synthesis’, Midwifery](https://pubmed.ncbi.nlm.nih.gov/28388456/) <https://pubmed.ncbi.nlm.nih.gov/28388456/> ). Even if this response is rare (which is not clear), it should be highlighted specifically to women as a rare but serious consequence. The language of a ‘range of emotions’ clearly does not adequately convey the severity of such responses to abortion. |
| 174 | Royal College of Midwives | Statement 6 | We support this Quality Statement but recommend that the wording is amended to ‘care and support and to include ‘during and after the abortion’. These changes would reflect that this refers to clinical aftercare and not solely to post-abortion counselling. According to BPAS, the majority of post-abortion concerns treatment, rather than those who are seeking post-abortion counselling. Although Independent Service Providers are required by the DHSC’s Required Standard Operating Procedures to provide a dedicated 24-hour aftercare line, NHS services are not. Women are often given the number of the gynaecology ward, may have to present to A&E, or may have to wait to attend a GP for further care. |
| 175 | Royal College of Nursing | Statement 6 | The standard importantly discusses women having an abortion are given full advice on how to access support after the abortion.  This statement, however, reads as though women only need support after an abortion, as in emotional support. Suggest the statement should be changed to access to “clinical advice and support”. |
| 176 | Royal College of Nursing | Statement 6 | Equality and diversity considerations  Considering equality and diversity issues (as with all the standards); it is good to note that information leaflets would be used, and that information would be taken from NICE’s guideline (2019) ‘Abortion Care’. |

## Registered stakeholders who submitted comments at consultation

* Bayer PLC
* British Association for Sexual Health & HIV
* British Pregnancy Advisory Service
* British Society of Abortion Care Providers
* Care Quality Commission
* Centre for Bio-Ethical Reform UK
* Christian Action Research and Education
* Christian Medical Fellowship
* Doctors for Choice UK
* Homerton University Hospital NHS Foundation Trust
* Leeds CCG
* Marie Stopes UK
* Pregnancy Centres Network
* Right to Life UK
* Royal College of General Practitioners
* Royal College of Midwives
* Royal College of Nursing
* Royal College of Obstetricians and Gynaecologists
* The Faculty of Sexual & Reproductive Healthcare
* White Ribbon Alliance UK

# Appendix 2: Quality standard consultation comments table – non-registered stakeholders

| **ID** | **Stakeholder** | **Statement number** | **Comments[[50]](#footnote-50)** |
| --- | --- | --- | --- |
| 1 | Individual 1 | Statement 2 | Surgical evacuation (D&E) is a surgically challenging procedure. I await responses from experts who continue to do this and NICE’s response to this. |
| 2 | Individual 1 | Statement 3 | Having met patients who change their mind even at the anaesthetic room prior to the procedure, keeping the target at 2 weeks seems to be a balanced target |

1. PLEASE NOTE: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees. [↑](#footnote-ref-1)
2. Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy (Abortion), Department of Health & Social Care, March 2020, pages 7-8, <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/874241/Procedures_for_approval_of_independent_sector_places_for_abortion.pdf>. [↑](#footnote-ref-2)
3. <http://www.legislation.gov.uk/uksi/2009/3112/regulation/20/made> [↑](#footnote-ref-3)
4. <http://www.legislation.gov.uk/uksi/2012/1916/contents> [↑](#footnote-ref-4)
5. <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/768059/Approval_of_home_use_for_the_second_stage_of_early_medical_abortion.pdf> [↑](#footnote-ref-5)
6. Ingham et al, *Op Cit* [↑](#footnote-ref-6)
7. Holmgren et al, ‘[Ambivalence during Early Pregnancy among Expectant Mothers](https://www.karger.com/Article/PDF/292586)’, Gynecol Obstet Invest 1993;36:15–20 [↑](#footnote-ref-7)
8. Husfeldt et al, ‘[Ambivalence among women applying for abortion](https://www.ncbi.nlm.nih.gov/pubmed/8533566)’, Acta Obstet Gynecol Scand. 1995 Nov;74(10):813-7. [↑](#footnote-ref-8)
9. Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy (Abortion), *Op Cit,* March 2020, pages 17-18. [↑](#footnote-ref-9)
10. <https://www.independent.co.uk/news/uk/home-news/abortions-marie-stopes-clinic-bonuses-persuade-women-investigation-a8012171.html> [↑](#footnote-ref-10)
11. Marie Stopes International Maidstone Centre Quality Report 02/10/2017, CQC, page 29 <https://www.cqc.org.uk/sites/default/files/new_reports/AAAF4825.pdf> [↑](#footnote-ref-11)
12. Ingham et al, ‘[Reasons for Second Trimester Abortions in England and Wales](https://www.sciencedirect.com/science/article/pii/S0968808008313755)’, *Reproductive Health Matters*, 2008, 16:sup31, 18-29, [↑](#footnote-ref-12)
13. Ibid. [↑](#footnote-ref-13)
14. George A, Randall S. Late presentation for abortion. *British Journal of Family Planning* 1996;22: 12–15 [↑](#footnote-ref-14)
15. Marie Stopes International. Late Abortion: A Research Study of Women Undergoing Abortion between 19 and 24 Weeks Gestation. London, MSI, 2005 [↑](#footnote-ref-15)
16. Ingham et al, *Op Cit,* 2008 [↑](#footnote-ref-16)
17. *Ibid,* page 9 [↑](#footnote-ref-17)
18. Quality Standards Advisory Committee 3 meeting, 6 December 2019, page 3, <https://www.nice.org.uk/guidance/gid-qs10084/documents/minutes> [↑](#footnote-ref-18)
19. <https://www.bpas.org/abortion-care/abortion-treatments/the-abortion-pill/remote-treatment/> - see section on After Treatment and Follow-up Instructions [↑](#footnote-ref-19)
20. <http://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-en.asp?fileid=17909> [↑](#footnote-ref-20)
21. <http://www.gmc-uk.org/static/documents/content/Personal_beliefs-web.pdf>; General Pharmaceutical Council: In practice: Guidance on religion, personal values and beliefs, June 2017, <https://www.pharmacyregulation.org/sites/default/files/in_practice-_guidance_on_religion_personal_values_and_beliefs.pdf> [↑](#footnote-ref-21)
22. <https://www.supremecourt.uk/cases/docs/uksc-2013-0136-judgment.pdf> [↑](#footnote-ref-22)
23. Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy (Abortion), March 2020, pages 16-17 [↑](#footnote-ref-23)
24. <https://www.independent.co.uk/news/uk/home-news/pregnancy-coercion-reproduction-abortion-a8834306.html> [↑](#footnote-ref-24)
25. The chair of the Justice Select Committee, Sir Bob Neill MP about his criminal law experience in this regard are relevant: ‘*The only other issue that I would raise from my experience as a criminal practitioner is that, on more than one occasion, I found instances where part of the abuse had been to force the victim to have an abortion. The irony is that reliance on a telephone call to procure the means of doing that does not give the safeguard of knowing who is standing next to the victim when she makes the telephone call. I have certainly seen instances of that in practice, as other criminal practitioners will have done.*’ July 6 2020, Hansard, House of Commons, col 719 [↑](#footnote-ref-25)
26. BPAS We Trust Women, Briefing on reforming abortion law to protect abuse victims. (Briefing for Domestic Abuse Bill 2020, no longer available online) [↑](#footnote-ref-26)
27. *Ibid* [↑](#footnote-ref-27)
28. <https://www.bma.org.uk/what-we-do/annual-representative-meeting/2020/arm-2020?rc=6698> [↑](#footnote-ref-28)
29. See e.g. <https://srh.bmj.com/content/41/2/128>, <https://www.researchgate.net/publication/230836996_Intimate_partner_violence_abortion_and_unintended_pregnancy_Results_from_the_WHO_Multi-country_Study_on_Women%27s_Health_and_Domestic_Violence>, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2901290/ [↑](#footnote-ref-29)
30. Rights to belief/conscience are protected under section 4 of the Abortion Act 1967, Article 9 of the European Convention on Human Rights, Resolution 1763(2010) of the Parliamentary Assembly of the Council of Europe and the Equality Act 2010 [↑](#footnote-ref-30)
31. GMC Guidance *Personal Beliefs and Medical Practice,* In effect from April 2013, <http://www.gmc-uk.org/static/documents/content/Personal_beliefs-web.pdf>

    General Pharmaceutical Council: In practice: Guidance on religion, personal values and beliefs, *Op Cit* [↑](#footnote-ref-31)
32. <https://www.ncbi.nlm.nih.gov/pubmed/1743956> [↑](#footnote-ref-32)
33. Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy (Abortion), March 2020, pages 17-18 [↑](#footnote-ref-33)
34. Marie Stopes International Maidstone Centre Quality Report 02/10/2017, CQC, page 29 <https://www.cqc.org.uk/sites/default/files/new_reports/AAAF4825.pdf> [↑](#footnote-ref-34)
35. <https://questions-statements.parliament.uk/written-questions/detail/2020-05-12/45957> [↑](#footnote-ref-35)
36. Coronavirus (COVID-19) infection and abortion care, Information for healthcare professionals, RCOG, Version 3.1, 31 July 2020, paragraph 2.4, page 15

    <https://www.rcog.org.uk/globalassets/documents/guidelines/2020-07-31-coronavirus-covid-19-infection-and-abortion-care.pdf> [↑](#footnote-ref-36)
37. <https://www.independent.co.uk/news/uk/politics/coronavirus-test-uk-target-daily-matt-hancock-news-cases-a9494821.html>

    See also section titled Tests sent to individuals at home or to satellite testing locations, <https://www.gov.uk/government/publications/coronavirus-covid-19-testing-data-methodology/covid-19-testing-data-methodology-note> [↑](#footnote-ref-37)
38. <https://questions-statements.parliament.uk/written-questions/detail/2020-08-28/81519> [↑](#footnote-ref-38)
39. <https://questions-statements.parliament.uk/written-questions/detail/2020-09-10/88252> [↑](#footnote-ref-39)
40. NICE Briefing Paper, Quality Standards Abortion Care, Appendix 2, page 82, suggestion 77 [↑](#footnote-ref-40)
41. Ibid [↑](#footnote-ref-41)
42. National Institute for Health and Care Excellence, Quality Standards Advisory Committee 3 meeting, 6 December 2019, *Op Cit* page 4. [↑](#footnote-ref-42)
43. Draft Evidence Review O for NG140, page 14 [↑](#footnote-ref-43)
44. *Ibid,* page 33 [↑](#footnote-ref-44)
45. <https://files.digital.nhs.uk/1C/538E29/psych-ther-2018-19-ann-rep.pdf> [↑](#footnote-ref-45)
46. See Table MYE1 <https://www.ons.gov.uk/file?uri=%2fpeoplepopulationandcommunity%2fpopulationandmigration%2fpopulationestimates%2fdatasets%2fpopulationestimatesforukenglandandwalesscotlandandnorthernireland%2fmid2019april2020localauthoritydistrictcodes/ukmidyearestimates20192020ladcodes.xls> [↑](#footnote-ref-46)
47. Induced Abortion and Mental Health – A Systematic Review of the Mental Health Outcomes of Induced Abortion, Including their Prevalence and Associated Factors, December 2011, Developed for the Academy of Medical Royal Colleges by National Collaborating Centre for Mental Health, London, 2011. [↑](#footnote-ref-47)
48. See House of Commons Briefing Paper 6988, for England: prevalence, services and funding, January 2020, page 16

    <https://commonslibrary.parliament.uk/research-briefings/sn06988/> [↑](#footnote-ref-48)
49. Muralikrishnan Radhakrishnan et al., “Cost of Improving Access to Psychological Therapies (IAPT) programme: An analysis of cost of session, treatment and recovery in selected Primary Care Trusts in the East of England region,” Behaviour Research and Therapy 51 (2013) 37e45, https://www.uea.ac.uk/documents/746480/2855738/Muralikrishan\_et\_al\_(2013)\_Cost\_of\_IAPT.\_An\_analysis\_in\_cost\_of\_session,\_treatment\_and\_recovery\_in\_East\_of\_England.pdf [↑](#footnote-ref-49)
50. PLEASE NOTE: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees. [↑](#footnote-ref-50)