



# National Service Specification for NHS Abortion Care

November 2022

Key principles for commissioning, evidence-base, expected standards  
and template specification

[Template in Word version available from: [policy@rcog.org.uk](mailto:policy@rcog.org.uk) and at [www.bsacp.org.uk](http://www.bsacp.org.uk),  
[www.rcog.org.uk](http://www.rcog.org.uk) & [www.fsrh.org](http://www.fsrh.org)]

# Forward

The Royal College of Obstetricians and Gynaecologists (RCOG), the Faculty for Sexual and Reproductive Healthcare (FSRH) and the Faculty of Public Health (FPH) are delighted to welcome this national service specification for abortion care. We extend our grateful thanks to everyone who has been involved in producing this much needed document, which will make it easier for providers and commissioners of abortion services to ensure women and girls can get the care they need, when they need it, wherever they happen to live.

Abortion care is an essential part of our health service – a third of women across the UK will access abortion care in their lifetime. It is, therefore, crucial that abortion services are put on a more sustainable footing, so women and girls, now and in the future, can be confident that the care they need will be available. It is also vital that variations in standards of care are driven down, so all women can expect to access high quality care, wherever they live.

This national service specification will help achieve this. It provides a resource for commissioners that includes the latest guidance and experience from clinical experts, to help ensure abortion care is commissioned using evidence-based principles. It is grounded in the core values of the NHS, including the choice framework and the need to implement sustainable, cost-effective care pathways, reflecting the drive for world-class commissioning in the NHS.

Importantly, the specification also encourages collaboration between all those involved in abortion care. Real collaboration will allow commissioners, the NHS and independent sector providers to create a truly patient-centred approach, an approach that responds to the needs of women, as well the needs of the sector and health services. In addition, this will help reduce the stigma still associated with abortion by ensuring services are commissioned and delivered in line with other essential healthcare services.

We strongly recommend this national service specification to commissioners and look forward to seeing the positive improvements in the quality and sustainability of abortion services we feel certain it will achieve.

Dr Edward Morris  
President, RCOG

Dr Janet Barter  
President, FSRH

Professor Kevin Fenton  
President, FPH

Abortion is a core healthcare service that underpins women's health and wellbeing. It is the most common gynaecological procedure provided by the NHS, with an estimated one in three women needing one in their lifetime. However women face many barriers when trying to access abortion care in the UK. Only a few NHS Trusts in England provide surgical abortion at later gestations and in Scotland, Wales and Northern Ireland there is no provision for surgical abortions at later gestation.

The RCOG abortion taskforce believes the system of commissioning for abortion care has resulted in poorer standards of care for women. There are marked variations across the UK, with women accessing abortion in many areas being denied the rights they should expect from the NHS constitution and choice framework and which would certainly apply if they were accessing any other healthcare service. Failure to fund services adequately and in line with high standards has resulted in disinvestment, reinforces stigma and compromises the resilience of this essential, time critical healthcare. This national service specification offers commissioners and providers a powerful, evidence-based, practical resource that will ensure women can access quality, cost-effective services wherever they live. I am delighted to endorse it and hope it will be rapidly adopted throughout the NHS.

Professor Dame Lesley Regan

Chair, RCOG abortion taskforce

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N.B. Although most abortion care is provided to women, other people whose gender identity does not align with the sex they were assigned at birth can also experience pregnancy and abortion. For simplicity of language this document uses the term women, but this should be taken to also include people who do not identify as women but who are pregnant.

# Best Practice and Key Principles

## 2 Purpose and Aims

The purpose of this document is to improve the quality of commissioning and therefore provision of abortion care, and to improve access to best-practice services. The primary aims are to reduce variations in the quality of services, to improve resilience in the provision of this essential and time-sensitive healthcare that a third of women will need to access in their lifetime<sup>1</sup>, and to ensure that all women and people who are pregnant in the UK have access to evidence-based, quality abortion advice and care in line with existing national guidance.

### 2.1 Background

Abortion provision is essential, time-sensitive, healthcare. In England, abortion care is commissioned through integrated care boards (ICB) within integrated care systems (ICS) from 1<sup>st</sup> July 2022. 77% of all abortions in the NHS in England and Wales are provided by three national independent service providers (ISPs)<sup>2</sup> and 23% through NHS Trusts. For surgical abortions above 14 weeks there is very little provision through NHS Trusts. Providers have noted significant variations in the quality of service specifications, with failure to follow NICE guidance and quality standards or commissioning principles published by NHS England (NHSE). The Royal College of Obstetricians and Gynaecologists (RCOG) abortion taskforce, which includes representatives of all interested stakeholders, agreed that an exemplar service specification should be developed to reduce variations in quality, to provide an example of a high quality specification for benchmarking and to act as a resource for commissioners to prevent duplication of work.

The RCOG abortion taskforce believes the historical system of commissioning abortion care at sub-tariff prices has resulted in poorer standards of care for women. Whilst the ISPs have introduced innovation and maintained service provision, often in community-settings that remove pressure from the acute sector, NHS Trusts have become excluded from many contracts, resulting in a loss of skills and experience in NHS staff, poor provision for training and inadequate provision for complex and emergency cases. There has been a disincentive for providers to act collaboratively in the best interests of patients. The commissioning system has impacted on system resilience, and chronic under-resourcing and under-provision of services has placed women at risk of greater morbidity and distress, and limited their choices of procedure and location of care.

Surgical services, in particular, are at risk as sub-tariff rates have led to these becoming unsustainable. It has resulted in a loss of resilience in the provision of this essential, time-sensitive service. Sub-tariff prices are by definition set below NHS reference costs, which means that essential but more costly elements of the pathway such as safeguarding and later gestation care are not sustainable without commissioning change. Commissioning abortion care at sub-tariff prices has also led to needlessly complex arrangements where every element of care has to be costed and claimed, or not be commissioned at all, often resulting in core parts of abortion care being unobtainable in some areas (e.g. provision of oral contraceptives, availability of *Chlamydia* testing to high risk patients, availability of surgical services in the locality).

### 3 Key Principles for Commissioning Abortion Care

- The specification should align with the principles set out by NICE<sup>3 4</sup> – that services offer evidence-based, cost-effective care that follow the core aims of:
  - Improving access
  - Minimising waiting times with no unnecessary delay
  - Giving choice of procedure & location
  - Ensuring privacy and convenience
  - Reducing stigma
  - Following evidence-based pathways that deliver safe and effective care
- Patients should expect services to be provided as close to home as they would be when accessing other pregnancy services such as for miscarriage or obstetric care. The principle should be that core abortion services (early medical abortion and surgical abortion up to 14 weeks' gestation) are managed across the same population footprint that is served by the nearest NHS Trust offering gynaecology care, with more complex care (e.g. later gestations or co-morbidities) being delivered by regional or, in the most complex cases, national centres.
- Adherence to the principles of both the NHS Choice Framework<sup>5</sup> and NHS payment system<sup>6</sup> is essential to ensure sustainability and resilience of this essential time-sensitive healthcare service.
- Patients needing an abortion are the same population as those seeking contraception, miscarriage care, booking for obstetric care etc., so the same quality principles should be applied. Service specifications should not stipulate additional requirements for abortion patients if those requirements are not routinely required for other services being offered to the same populations. Specifications should not be subject to historic prejudices that result in abortion patients becoming judged and stigmatised.
- All providers are registered by the relevant independent healthcare regulators (CQC in England, HIW in Wales) and are accountable to them for delivery of care to Fundamental Standards (CQC) and Health and Care Standards (HIW). There is no need to repeat the core standards required by CQC and HIW of all healthcare providers – doing so conveys the impression that the providers are not regulated, and also undermines the role of the regulators.
- Commissioning in England should follow the principles set out in the NHS Constitution<sup>7</sup> and NHS Choice Framework<sup>5</sup>. Patients should not be restricted in their choice of provider, and providers must ensure patients can receive the full range of services and must not “cherry-pick” cases so as to undermine local services. Where a provider does not provide a particular service within an ICS / Health Board area, the patient must be informed that they may need to travel to access this type of care and about all the alternative choices available locally. Providers should act collaboratively to ensure care pathways are seamless, and always put the patient's interests first by directing them to services that best fit their needs.
- Commissioning in England should follow the principles set out by NHSE & I in the national tariff payment system<sup>6</sup>, using the unit prices published in the national tariff workbook (annex A)<sup>8</sup>. If any

local variations in tariff are agreed, these must adhere to the rules set out in the national tariff payment system:

- The approach must be in the best interests of patients
- The approach must promote transparency to improve accountability and encourage the sharing of best practice
- The provider(s) and commissioner(s) must engage constructively with each other when trying to agree local payment approaches
- Any agreement must be submitted to NHSE within 30 days of agreement

## 4 Working Group & Reviewers

This specification was commissioned by the RCOG abortion taskforce, with the working party co-ordinated by the British Society of Abortion Care Providers (BSACP). The RCOG abortion taskforce advises College officers and the policy and public affairs department on issues related to abortion. It includes members of all key stakeholders, including officers of RCOG, FSRH and BSACP, and invited representatives from RCM, RCN, DHSC, NIO, BMA, GMC, NHSE, CQC, providers and commissioners. The BSACP is a specialist clinical society recognised by the RCOG to promote best practice, education, training and research in abortion care. This document was created in line with their processes, including peer and stakeholder review, using examples of established best practice and based on published evidence, including the guidelines and quality standards from the National Institute for Health and Care Excellence (NICE).

The working party is grateful to the following for their help with the development and review of the specification:

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Ed Dorman	RCOG abortion taskforce co-chair
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RCOG abortion taskforce	Representation as outlined above
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## 5 Summary of Changes

Version & Date	Section, Paragraph, Page	Change
1.0 – November 2022	-	New policy



# Service Specification Template for Abortion Care

<b>Service Specification No.</b>	
<b>Service</b>	Abortion Care
<b>Commissioner Lead</b>	
<b>Provider Lead</b>	
<b>Period</b>	
<b>Date of Review</b>	

## 1. Population Needs

### 1.1 National/local context and evidence base

A third of women in the UK will have an abortion by the age of 45<sup>1</sup>, with 25% of all pregnancies ending in abortion in both the UK<sup>9</sup> and worldwide<sup>10</sup>. Abortion care is an essential health need. In England and Wales there were 214,256 abortions in 2021<sup>2</sup>. Although abortion is a very safe procedure, with morbidity and mortality significantly less than the alternative of continuing with the pregnancy<sup>11</sup>, there is an exponential rise in mortality rate for every week of additional gestation after 8 weeks<sup>12</sup>. Whilst mortality is extremely rare, the corresponding increases in morbidity and complications with gestation affect greater numbers. NICE calculated that a reduction of one day in the average waiting time would save the NHS £1.6 million per year on procedure costs and treating adverse events<sup>3</sup>. Access to abortion is time critical not only to reduce complications, morbidity and cost to the NHS, but also to relieve the considerable distress that patients experience whilst waiting for an abortion.

NICE published its guidelines on abortion care in 2019<sup>3</sup> and the associated quality standards in 2021<sup>4</sup>. The key principles are those of improving access to abortion services, to ensure patients have choice and to deliver quality, cost-effective care. The recommendations and standards include the need to ensure there is no delay for patients in accessing care, that waiting times are kept to a minimum and that patients can choose both medical and surgical options. The guidelines emphasise that commissioners should work with providers, and that providers collaborate with each other and commissioners, to ensure that care is seamless and patients can access the care they require at a location and with a provider that is appropriate for their needs.

## 2. Outcomes

### 2.1 NHS Outcomes Framework Domains & Indicators

<b>Domain 1</b>	<b>Preventing people from dying prematurely</b>	
<b>Domain 2</b>	<b>Enhancing quality of life for people with long-term conditions</b>	
<b>Domain 3</b>	<b>Helping people to recover from episodes of ill-health or following injury</b>	✓
<b>Domain 4</b>	<b>Ensuring people have a positive experience of care</b>	✓
<b>Domain 5</b>	<b>Treating and caring for people in safe environment and protecting them from avoidable harm</b>	✓

### 3. Scope

#### 3.1 Aims and objectives of service

- The specification should align with the principles set out by NICE<sup>3 4</sup> – that services offer evidence-based, cost-effective care that follow the core aims of:
  - Improving access
  - Minimising waiting times with no unnecessary delay
  - Giving choice of procedure & location
  - Ensuring privacy and convenience
  - Reducing stigma
  - Following evidence-based pathways that deliver safe and effective care
- Patients should expect services to be provided as close to home as they would be when accessing other pregnancy services such as for miscarriage or obstetric care. The principle should be that core abortion services (early medical abortion and surgical abortion up to 14 weeks gestation) are managed across the same population footprint that is served by the nearest NHS Trust offering gynaecology care, with more complex care (e.g. later gestations or co-morbidities) being delivered by regional or, in the most complex cases, national centres.
- Adherence to the principles of both the NHS Choice Framework<sup>5</sup> and NHS payment system<sup>6</sup> is essential to ensure sustainability and resilience of this essential time-sensitive healthcare service.
- Patients needing an abortion are the same population as those seeking contraception, miscarriage care, booking for obstetric care etc., so the same quality principles should be applied. Service specifications should not stipulate additional requirements for abortion patients if those requirements are not routinely required for other services being offered to the same populations. Specifications should not be subject to historic prejudices that result in abortion patients becoming judged and stigmatised.
- All providers are registered by the relevant independent healthcare regulators (CQC in England, HIW in Wales) and are accountable to them for delivery of care to Fundamental Standards (CQC) and Health and Care Standards (HIW). There is no need to repeat the core standards required by CQC and HIW of all healthcare providers – doing so conveys the impression that the providers are not regulated, and also undermines the role of the regulators.
- Commissioning in England should follow the principles set out in the NHS Constitution<sup>7</sup> and NHS Choice Framework<sup>5</sup>. Patients should not be restricted in their choice of provider, and providers must ensure patients can receive the full range of services and must not “cherry-pick” cases so as to undermine local services. Where a provider does not provide a particular service within an ICS / Health Board area, the patient must be informed that they may need to travel to access this type of care and about all the alternative choices available locally. Providers should act collaboratively to ensure care pathways are seamless, and always put the patient’s interests first by directing them to services that best fit their needs.
- Commissioning in England should follow the principles set out by NHSE in the national tariff payment system<sup>6</sup>, using the unit prices published in the national tariff workbook (annex A)<sup>8</sup>. If any local variations in tariff are agreed, these must adhere to the rules set out in the national tariff payment system:

- The approach must be in the best interests of patients
- The approach must promote transparency to improve accountability and encourage the sharing of best practice
- The provider(s) and commissioner(s) must engage constructively with each other when trying to agree local payment approaches
- Any agreement must be submitted to NHSE within 30 days of agreement

### **3.2 Service description/care pathway**

Providers will offer a full range of abortion services, either themselves or in collaboration with other providers. The pathway will include provision of:

- Direct access to the service without need for referral. The rights of patients under the NHS Constitution<sup>7</sup> and Choice Framework<sup>5</sup> should apply equally to those who self-refer as it does to those referred via their GP. Patients should not have any restrictions in their choice of provider and can opt for a service that is not the most local (e.g. to access lower waiting times, choice owing to a past good or poor experience, to receive care in a different location – such as a student returning to their parents or a vulnerable patient moving away from an abusive partner, or where they need confidentiality and want to avoid being identified by somebody known to them who works for the local provider)
- Assessment by phone or video call [1.1.9]<sup>3</sup> or face-to-face according to preference, and treatment in a range of settings including in the community [1.1.10]<sup>3</sup> and through no-test telemedicine abortion where appropriate<sup>13 14</sup>. If patients prefer a face-to-face assessment, this should be available locally
- Medical or surgical abortion up to 24 weeks' gestation [1.6.1]<sup>3</sup>
- For early medical abortion, to have the option of expulsion at home [1.8.2]<sup>3</sup>
- Surgical abortion available at all gestations up to 24 weeks, with availability of local anaesthesia, conscious sedation and general anaesthesia [1.13.1]<sup>3</sup>
- These choices should be available to all patient groups, including young people (i.e. under 18 and those aged under 25 in local authority care)<sup>15</sup>
- Not all choices will be available at all locations, and travel may be necessary to access more complex care options (e.g. later gestation, general anaesthesia)

Commissioners, Health Boards and providers should ensure that there is minimal delay in the abortion process, and ideally [1.1.6]<sup>3</sup>:

- provide the assessment within 1 week of the request
- provide the abortion within 1 week of the assessment for women who decide to go ahead with an abortion

NICE calculated that a reduction of one day in the average waiting time would save the NHS £1.6 million per year on procedure costs and treating adverse events, and that a decrease of a week would save £61 per procedure or £11.5 million across all abortions<sup>16</sup>.

Patients should expect services to be provided as close to home as they would when accessing other pregnancy services such as for miscarriage or obstetric care. Core services (early medical abortion and surgical abortion up to 14 weeks gestation) should be available within the same local area as that served by their nearest NHS Trust offering

gynaecology care, with more complex care (e.g. later gestations or co-morbidities) being delivered by regional or, in the most complex cases, national centres.

Patients should not be restricted in their choice of provider, and providers must ensure patients can receive the full range of services and must not “cherry-pick” cases so as to undermine local services. Where a provider does not provide a particular service within an ICS / Health Board area, the patient must be informed that they may need to travel to access this type of care, including for any subsequent follow-up care, and about all the alternative choices available locally. Providers should act collaboratively to ensure care pathways are seamless, and always put the patient’s interests first by directing them to services that best fit their needs. Where care is transferred, providers should avoid the need for women to repeat key steps (such as returning to their GP for referral, or repeated assessments or investigations) [1.1.1]<sup>3</sup>.

### **3.3 Population covered**

All patients within the ICS / Health Board area. This includes patients with fetal anomalies.

### **3.4 Any acceptance and exclusion criteria and thresholds**

Providers will manage the onward referral of complex cases through agreed shared-care pathways. Where care is transferred, providers should avoid the need for women to repeat key steps (such as returning to their GP for referral, or repeated assessments or investigations).

### **3.5 Interdependence with other services/providers**

Providers will be expected to collaborate to ensure the interests of the patient are always the main concern. Providers will link with regional and national multi-disciplinary teams (MDTs) for complex cases using specialist commissioning arrangements where appropriate. Providers will have locally agreed shared-care pathways and transfer arrangements with local services including early pregnancy assessment units and inpatient gynaecology and obstetric services where such services do not exist within the provider’s own organisation.

Women having an abortion often have to travel at very short notice and may have difficulty arranging funds before the appointment. Upfront funding for travel and accommodation should be provided by commissioners for women who [1.1.4]<sup>3</sup>:

- are eligible for the NHS Healthcare Travel Costs Scheme and/or
- need to travel to a service that is not available locally

## **4. Applicable Service Standards**

### **4.1 Applicable national standards (e.g. NICE)**

NICE abortion care clinical guideline NG140<sup>3</sup>.

NICE quality standard in abortion care GQ199<sup>4</sup>

NICE Babies, children and young people's experience of healthcare clinical guideline NG204<sup>17</sup>.

### **4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)**

RCOG – Making Abortion Safe<sup>18</sup>, Coronavirus (COVID-19) infection and abortion care, Clinical Guidelines for Early Medical Abortion at Home – England<sup>19</sup>

WHO – World Health Organisation (WHO) Abortion Care Guideline, 2022<sup>20</sup>

### **4.3 Applicable local standards**

Providers must demonstrate robust and reliable systems for incident reporting and investigation (evidenced through CQC / HIW reports) and follow the NHS Patient Safety Incident Response Framework (PSIRF) and revised serious incident framework (England) or NHS Wales National Incident Reporting Policy (Wales). The mechanism for liaison within the ICS / Health Board is: *[insert local contact details and cross reference to local framework]*

Providers and commissioners should work in effective partnership to reduce health inequalities<sup>21</sup> and to progress the four strategic purposes outlined in the NHS priorities and operational planning guidance<sup>22</sup>:

- improving outcomes in population health and healthcare
- tackling inequalities in outcomes, experience and access
- enhancing productivity and value for money
- supporting broader social and economic development

Specific system priorities<sup>22</sup> applicable to abortion care include:

- Investing in the workforce
- Addressing health inequalities – using data and analytics to redesign care pathways and measure outcomes with a focus on improving access and health equity for underserved communities
- Exploiting the potential of digital technologies to transform the delivery of care and patient outcomes – achieving a core level of digitisation in every service across systems
- Making the most effective use of our resources – moving back to and beyond pre-pandemic levels of productivity
- Establishing ICBs and collaborative system working – working together with local authorities and other partners across their ICS to develop a five-year strategic plan for their system and places
- Responding to climate change, including having a board-level net-zero and green plan, with strategy to deliver carbon reductions

## **5. Applicable quality requirements and CQUIN goals**

### **5.1 Applicable Quality Requirements (See Schedule 4A-C)**

#### **Quality System**

- Evidence of a system that collects and reports patient outcome data within the organisation (including key parameters such as incident reporting, re-admission rates)
- Providers must demonstrate robust and reliable systems for incident reporting and investigation (evidenced through CQC / HIW reports) and follow the NHS Patient Safety Incident Response Framework (PSIRF) and revised serious incident framework or NHS Wales National Incident Reporting Policy
- CQC / HIW inspection reports and progress on action plans following inspections
- Patient-reported outcome measures that include key parameters such as the [NHS friends and family test](#) (“Overall, how was your experience of our service?”), that the patient could ask questions and raise concerns, and pain scores for procedures

#### **NICE Quality Standards**

The NICE quality standards for abortion contain a range of quality measures across six quality statements<sup>4</sup>. Local quality requirements should be clinically appropriate and realistically achievable<sup>23</sup> and be based on the NICE or other published standards<sup>3 4 24</sup>. As a general rule, focussing on a small number of key indicators is likely to be more effective than

requiring dozens of separate indicators to be monitored<sup>23</sup>. It is important for commissioners to bear in mind the burden which Local Quality Requirements may create for providers, in terms of service management and data collection and reporting, especially for national providers who report to all CCGs, ICS or health boards. Commissioners must ensure that any Local Quality Requirements which they propose (and the associated Local Reporting Requirements) will really add value [39.8]<sup>23</sup>.

As with Local Quality Requirements, commissioners are likely to find that a targeted approach with a limited number of well-chosen Local Reporting Requirements is the most effective approach<sup>23</sup>. The standard contract SC28.4 requires that commissioners must have regard to the burden their information requests will impose on providers and that they must be able to demonstrate the purpose which any new local information flow serves and the benefits which it yields. In the current context where NHS finances are under considerable stress, it is essential that commissioners are rigorous in reviewing the information burden they place on providers, ensuring that they only require information which they will actually use in practice, that the benefit from having the information is in proportion to the costs the provider incurs in collating it and that the information is not already being submitted via a different route [43.6]<sup>23</sup>.

Providers should report the following quality outcome measures to their ICSs / Health Boards to ensure the key elements of the NICE clinical guidelines and quality standards are measured. These should be reported annually as a minimum, but for larger services could be quarterly or monthly for priority measures such as waiting times.

#### **Access to abortion services**

- Evidence that women can self-refer to abortion services
- Proportion of abortions performed at under 10 weeks \* <sup>24</sup>

#### **Choice of abortion procedure**

- Evidence of local processes to support a discussion about the differences between medical and surgical abortion, including the benefits and risks, with women who request an abortion
- Proportion of women who had an abortion who were satisfied with their abortion care

#### **Waiting time for an abortion**

- Evidence of local arrangements to ensure that women who decide to go ahead with an abortion have the option to have the procedure within 1 week of assessment
- Proportion of women who decide to go ahead with an abortion who have the option to have the procedure within 1 week of assessment
- Evidence that next available appointment for assessment for abortion and for treatment (both medical and surgical) is within 1 week

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\* This is the single most important and informative outcome measure as it indicates whole system efficiency and is influenced by ease of access into services, referral processes, waiting times and access to treatment. This data has been available for decades through the annual abortion national statistics and can therefore be used to monitor longer term changes and to benchmark between areas.

### **Early medical abortion**

- Evidence of local processes to ensure that medical abortion at home is accessible for every suitable patient requesting it
- Evidence of pathways that offer a choice of both remote consultation or face-to-face where appropriate and chosen by the patient

### **Contraception**

- Evidence that the full range of reversible contraceptive options is available for women before discharge from an abortion provider, either on the same day as their abortion or as soon as possible after expulsion of the pregnancy
- Proportion of women having an abortion who want contraception who receive their chosen method before discharge

### **Support after an abortion**

- Evidence of local arrangements to provide care and support to women after an abortion, including referral pathways to counselling or psychological interventions
- Proportion of women who had an abortion who agree they were able to access care and support after the abortion if they needed to

#### **5.2 Applicable CQUIN goals (NHSE only - See Schedule 3E)**

None applicable to abortion services.

#### **5.3 Service Development and Improvement Plan**

The Service Development and Improvement Plan (SDIP, Schedule 6D) in England allows the parties to record action which the provider will take, or which the parties will take jointly, to deliver specific improvements to the services commissioned [41.1]<sup>23</sup>. NHSE normally set out national requirements for specific areas in which commissioners and providers should agree SDIPs for the coming year. Providers should report any that relate to abortion care to all their ICSs.

#### **5.4 Data Quality Improvement Plans**

Data Quality Improvement Plans (DQIPs) in England allow the commissioner and the provider to agree a local plan to improve the capture, quality and flow of data to meet the requirements of Schedule 6A and to support both the commissioning and contract management processes [43.14]<sup>23</sup>. GC21.6 requires each provider to undertake audits of its performance against the Data Security and Protection Toolkit, and these audits will be a valuable source of information about where data quality needs to be improved, including clinical information assurance and aspects of patient safety-related data quality. In particular, Assertion 1.7 of the Toolkit requires providers to have in place policies and processes to assure the quality of their data. Guidance specific to this assertion has been developed to support this and covers many of the points discussed in this section [43.19]<sup>23</sup>. Providers should report their DQIP audits to all their ICSs.

## **6. Location of Provider Premises**

### **6.1 The Provider's Premises are located at:**

Services should be available in the following localities:

[enter location to follow the principle that core services should be available to patients within the same travel time as their nearest NHS Trust providing obstetric and gynaecology services, more complex care within the NHS region and most complex cases at a national centre]

- Face-to-face assessment, ultrasound scanning, post-operative review, early medical abortion
- Surgical abortion under local anaesthetic or conscious sedation
- Surgical abortion under general anaesthetic up to 14 weeks' gestation
- Surgical abortion up to 18 weeks' gestation
- Surgical abortion up to 24 weeks' gestation

If a patient is referred to a provider who does not offer a service in one of these locations (via direct access or any other route), the provider must inform the patient of any more local services available, and that any assessment or follow-up care may necessitate additional travel.

A provider should not establish a new service in a location where a service is already provided unless they can demonstrate to the ICS / Health Board that there is a need and that to do so will not threaten the viability of existing services. Providers and commissioners should work collaboratively to ensure the best interests of the population. The overriding priority is to optimise access, waiting times and resilience whilst ensuring the services offered remain viable.

## **7. Individual Service User Placement**

Where suitable, clinically appropriate and in line with regulations in force at the time, care may be wholly or partly delivered in the patient's home. Providers will ensure access to help 24 hours a day, 7 days a week.

## **8. Applicable Personalised Care Requirements**

### **8.1 Applicable requirements, by reference to Schedule 2M where appropriate**

Where home care is not appropriate or where the patient prefers face-to-face consultation, in-person services will be available.

### **8.2 Information and Support**

Providers should offer information in a range of formats, for example video or easy-read written information, including information based on the experiences of women who have had an abortion [1.2.4]<sup>3</sup>. Patients should receive information about the differences between medical and surgical abortion (including the benefits and risks), taking account of the woman's needs and preferences. This should be done without being directive, so that women can make their own choice [1.2.2]<sup>3</sup>. Women should not be required to have compulsory counselling or compulsory time for reflection before the abortion [1.1.8]<sup>3</sup>. Providers should offer or refer women (e.g. to counselling services) for support to make a decision if they request this [1.1.8]<sup>3</sup>.

After the abortion, providers should explain to women [1.14.3]<sup>3</sup>:



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

Providers should be able to provide emotional support after abortions [1.14.5]<sup>3</sup>, including through signposting to confidential advice lines such as [Abortion Talk](#). Providers should provide or refer women for counselling if requested [1.14.6]<sup>3</sup>.

For women who have had a medical abortion up to and including 10 weeks' gestation with expulsion at home, providers should offer the choice of self-assessment, including remote assessment (for example telephone or text messaging) [1.14.1]<sup>3</sup>.

### **8.3 Confidentiality, Safeguarding and Consent**

Services should be sensitive to the concerns women have about their privacy and confidentiality, including their concerns that information about the abortion might be shared with healthcare professionals not directly involved in their care [1.1.18]<sup>3</sup>. Unless there is a statutory need to share information (e.g. to prevent harm where there is a safeguarding concern), services should not communicate with others without the express consent of the patient. For example, systems should not automatically send discharge letters directly to GPs. The Department of Health and Social Care (DHSC) and British Association for Sexual Health and HIV (BASHH) consider it best practice that sexual health services maintain their own patient record systems separate from other healthcare services [5.2]<sup>25</sup> / [5.5.3]<sup>26</sup>. The DHSC's policy is that people using sexual health services have assurance that information will not be included in shared patient records without their consent. Healthcare systems that use shared records should consider how they can reduce women's concerns that information might be visible to others not directly involved in their care.

Safeguarding is an essential part of abortion care and providers must have systems in place to screen, identify and manage safeguarding concerns. Providers should have specific procedures to manage vulnerable adults and young people and have a named safeguarding lead. Safeguarding is a fundamental standard of the regulators, to whom the providers are responsible in demonstrating quality systems, including effective liaison with external agencies and multi-disciplinary working.

Services should take account of the needs of young people and vulnerable adults. NICE recommends to "use flexible methods where clinically appropriate, agreed with the child or young person to deliver healthcare services (for example, telephone or video calls, digital media such as websites and apps) as alternatives to in person face-to-face services to help overcome access difficulties, such as travelling to appointments or relying on parents for transport" [1.10.10]<sup>17</sup>. Guidance from the National Society for the Prevention of Cruelty to Children (NSPCC) states that, "conversations, therapeutic sessions and meetings held via phone or video call can seem less intimidating and intense than face-to-face meetings in an office or practitioners visiting someone's home. This might be because children and families feel safer and more comfortable with remote support in a familiar environment, which can help them feel more able to open up about their emotions, experiences and situations"<sup>27</sup>. Where requested by the young person or vulnerable adult, or required for clinical reasons, face-to-face appointments must be available. The RCOG / FSRH / BSACP have issued guidance for commissioners, regulators and abortion care providers on implementing best practice on safeguarding young people accessing early medical abortion services<sup>28 29</sup>.

Informed consent is a fundamental standard of regulators and it forms part of the core standards of professional healthcare practice. Providers must be able to demonstrate effective systems that deliver the information a patient needs to make a decision in appropriate formats and to give informed consent for treatment, including the benefits, risks and alternative choices of the available options including no treatment. Patients must have opportunities to clarify any uncertainty, to ask questions and to raise concerns, and to receive information in a form that enables them to make an informed choice. There is no requirement for written consent, but there should be documentation that the patient has received adequate information, that they have understood it, that they have no further questions and concerns and that they have the capacity to give informed consent (including a record of assessing Gillick competence and applying Fraser guidelines where appropriate for young people).

#### **8.4 Infection Prevention & Control and Testing for Sexually Transmitted Infection**

Providers should have a named lead for infection prevention and control (IPC), with systems to ensure staff are trained and competent in IPC including use of prophylactic antibiotics in line with NICE guidelines, suitable environment and equipment, application of aseptic non-touch technique (ANTT) and sterile fields where appropriate. These measures form a standard part of CQC assessment.

Patients presenting for an abortion come from the same population as those requesting contraception or for miscarriage care. There is no evidence that they have significant differences in carriage rates for sexually transmitted infections (STI), including HIV, compared to age-matched sexually-active controls. Historic prejudice has resulted in policies that presume they are at higher risk, and this prejudice can have detrimental effects including reinforcing stigma, risk of “information overload” during an abortion consultation by having to spend time discussing screening where it may not be beneficial, distraction from the most important elements of abortion care (informed choice, treatment regimens, choices of contraception, etc.), and failure to target screening at higher risk groups.

Patients having abortion care should have the same access to STI testing, including HIV, as the general population (e.g. as would be offered in a new contraceptive GP appointment). The same policies should apply to all early pregnancy and contraceptive services and need to take a risk-based approach following current national guidance, modified by local public health intelligence based on specific local prevalence and risks. Where screening is offered, this should be using patient-centred approaches that includes access to clear information as to the benefits, using self-taken or postal services where appropriate and notification directly to the patient with onward referral for partner tracing.

#### **8.5 Contraception**

Women having an abortion who want contraception receive their chosen method before discharge, either at the time of their abortion or as soon as possible after expulsion of the pregnancy [NICE quality statement five]<sup>4</sup>. Commissioners should ensure there are no barriers to access and that providers are commissioned to provide all forms of contraception at the time of treatment, either within the national tariff or through a local variation. In England, the [indicative national tariff for 2022/3](#) includes provision of long-acting reversible contraception (LARC) in both surgical and medical abortion.

Commissioners and providers should ensure that the full range of reversible contraceptive options (depot medroxyprogesterone acetate [DMPA], contraceptive implant, intrauterine methods, oral contraceptives, contraceptive patches, vaginal rings or barrier contraception)

is available for women on the same day as their surgical or medical abortion [1.15.1]<sup>3</sup>. Where the implant is chosen, this should be offered on the day of surgical abortion or the day they take mifepristone [1.15.3]<sup>3</sup>, for intrauterine methods of contraception, these should be offered at the same time as surgical abortion or as soon as possible after expulsion of the pregnancy for medical abortion [1.15.4]<sup>3</sup>. Oral contraception, contraceptive patches, vaginal rings and barrier contraception should be provided at the same time as the abortion treatment.

NICE notes that ensuring that women can access their preferred method of contraception at the time of their abortion, or soon after, will reduce the risk of future unintended pregnancies and abortions<sup>4</sup>. It will improve the uptake of contraception and its continued use, as well as the woman's satisfaction with ease of access to contraception. However, providers must ensure that the discussion is collaborative and that women do not feel pressured into making a choice, as this can increase stigma and feeling of shame and failure in the patient, and can result in discontinuing later on<sup>30</sup>. Therefore quality measures should not be of pre-defined rates of uptake, but of availability of all forms of contraception at or immediately after abortion<sup>4</sup>.

### **Schedule 3 – Payment**

The national tariff payment system is a set of prices and rules to help commissioners and providers of NHS care provide best value to their patients. Commissioning in England should follow the principles set out by NHSE in the national tariff payment system<sup>6</sup>, using the unit prices published in the national tariff workbook (annex A)<sup>8</sup>. It is essential that abortion care follows these principles both to maintain quality of care, but also to ensure sustainability and resilience of this essential time-sensitive healthcare service.

In the event that any local variations are agreed, these must adhere to the rules set out in the national tariff payment system<sup>6</sup>:

- The approach must be in the best interests of patients
- The approach must promote transparency to improve accountability and encourage the sharing of best practice
- The provider and commissioner(s) must engage constructively with each other when trying to agree local payment approaches
- Any agreement must be submitted to NHSE within 30 days of agreement between commissioners and provider

The unit prices in the national tariff include all elements of care for each episode (outpatient consultation or admission). If local variations are agreed, these need to ensure all additional components that would otherwise be contained in the unit prices are costed, including:

- Follow-up consultations (e.g. if patient ambivalent or is complex)
- Safeguarding and multi-disciplinary referrals
- Counselling
- Pre-operative assessment
- Unbundled tariffs such as ultrasound scanning
- STI testing
- Provision of contraception and LARC
- Post-operative management
- Re-admission and re-treatment

- Market forces factor
- Future service development and investment
- Training

The RCOG abortion taskforce believes the historic system of commissioning abortion care at sub-tariff prices has resulted in poorer standards of care for women. Whilst the ISPs have introduced innovation and maintained service provision, often in community-settings that remove pressure from the acute sector, NHS Trusts have become excluded from many contracts, resulting in a loss of skills and experience in NHS staff, poor provision for training and inadequate provision for complex and emergency cases. There has been a disincentive for providers to act collaboratively in the best interests of patients. The commissioning system has impacted on system resilience, and chronic under-resourcing and under-provision of services has placed women at risk of greater morbidity and distress, and limited their choices of procedure and location of care.

Surgical services, in particular, are at risk as sub-tariff rates have led to these becoming unsustainable. It has resulted in a loss of resilience in the provision of this essential, time-sensitive service. Sub-tariff prices are by definition set below NHS reference costs, which means that essential but more costly elements of the pathway such as safeguarding and later gestation care are not sustainable without commissioning change. Commissioning abortion care at sub-tariff prices has also led to needlessly complex arrangements where every element of care has to be costed and claimed, or not be commissioned at all, often resulting in core parts of abortion care being unobtainable in some areas (e.g. provision of oral contraceptives, availability of *Chlamydia* testing to high risk patients, availability of surgical services in the locality).

Providers and commissioners should follow the principles set out in the System Collaboration and Financial Management agreement (SCFMA) [3.18]<sup>23</sup>:

- collaborative behaviours expected of both parties
- open book accounting by, and financial transparency between, the parties
- mechanism for management of the aggregate financial position of the parties to achieve and maintain the system financial improvement trajectory for the ICS

Nothing within any SCFMA agreed locally must compromise patients' rights to choice or seek to prevent or deter NHS bodies from complying with their responsibilities under the various regulations which govern procurement and competition within the NHS (including the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 and the Public Contract Regulations 2015) [3.19]<sup>23</sup>.

[The Health and Social Care Act 2022](#) replaced the NHS Act 2012. It defines the "Triple Aim" as its main objective. It proposes a common duty for NHS bodies that plan and commission services and that provide services to oblige them to consider the effects of their decisions on:

- the health and wellbeing of the people of England
- the quality of services provided or arranged by both themselves and other relevant bodies
- the sustainable and efficient use of resources by both themselves and other relevant bodies

These provisions aim to encourage these bodies to not only continue a culture of working in the best interests of their immediate service users and organisations, but also on public

health and prevention for the wider population, and will include working together strategically with other relevant bodies and the public. The Triple Aim should help align NHS bodies around a common set of objectives, thus supporting the shift towards integrated local health and care systems which have strong engagement with their communities.

## **9. Regulation and Legal Considerations**

The Abortion Act 1967 (as amended by the Human Fertilisation and Embryology Act 1990 and Health and Care Act 2022) states that an abortion is legal if it is performed by a registered medical practitioner (a doctor), and that it is authorised by two doctors, acting in good faith, on one (or more) of four grounds. This gives a defence against prosecution under the Offences Against the Person Act (OAPA) 1861 and the Infant Life (Preservation) Act 1929.

The Abortion Act 1967 requires that treatment for the termination of pregnancy (now usually termed “abortion”) must be carried out in an NHS hospital or in a place approved by the Secretary of State for Health and Social Care. In granting any approval where care is delivered outside an NHS Trust, the Secretary of State considers a set of core principles:

- Ensure compliance with all legal requirements
- Provide the best quality of care for patients
- Provide sound management, organisational and clinical governance arrangements

The independent healthcare inspectorates (Care Quality Commission (CQC) in England, Healthcare Inspectorate Wales (HIW) in Wales) register the service provider of the regulated activity (in this case termination of pregnancy) once they can demonstrate that they meet the requirements of registration. Providers must adhere to the [fundamental standards of the CQC](#) or [health and care standards of NHS Wales](#) which are assessed and published in regular inspections of each registered facility. These standards include delivering person-centred care, dignity and respect, consent, safety, safeguarding from abuse, proper premises and equipment, good governance, fit and proper staff and duty of candour.

Independent service providers will need to comply with the [Required Standard Operating Procedures \(RSOPs\)](#) as part of the approval process (this is not required of NHS Trusts as they are already approved under the Act). The RSOPs take account of legal requirements and best practice. Approval can be removed at any time if evidence of non-compliance with the RSOPs comes to the attention of the DHSC.

Clinical staff are accountable to their professional regulators, as well as to their employer, in upholding professional standards including having the necessary training and competencies, complying with continuing professional development, appraisal and revalidation, their duty to always put the care of the patient first, and the responsibility to follow national guidelines.

## **10. Access and Choice – NHS Standard Contract**

Commissioners should not restrict access to a sole provider. Providers in England operate under the terms of the NHS Standard Contract<sup>23</sup>. This states that it is important for patients

that providers of NHS-funded services accept referrals from all appropriate sources. The Contract (full-length) includes a specific requirement on providers (SC6.8.2) to accept every referral, regardless of the identity of the responsible commissioner, where this is necessary to enable a patient to exercise his/her legal right of choice of provider. This applies whether or not the responsible commissioner for the patient affected is a party to a written contract with the provider [42.4]<sup>23</sup>. At the point of referral, patients have the legal right to choose any clinically appropriate provider (the specific legal entity) in England which has been commissioned by at least one NHS commissioning body, to provide the particular service required [25.20]<sup>23</sup>. As well as the requirement to uphold the right of choice of provider, ICBs also have a more general duty, set out in legislation and guidance (including the NHS Act, NHS standing rules, NHS choice regulations, NHS constitution as well as being within the constitution of ICBs), to enable patients to make choices in respect of the care provided to them. In this context, ICBs “should in principle welcome, rather than seeking to resist, the expansion of available choices for patients, so long as this is managed in an appropriate way” [25.20]<sup>23</sup>. Where patients have a legal right of choice of provider, any Prior Approval Scheme which simply restricts that choice is void and cannot be used to restrict payment for activity carried out by the provider [42.10]<sup>23</sup>.

## **11. Complex cases – Co-morbidities and Later Gestations**

Complex cases – patients with co-morbidities that prevent them being treated by independent service providers (ISPs) – are commissioned by specialist commissioning, in England through NHSE under their Women and Children’s Programme of Care. NHS England will provide a top-up to the tariff for terminations performed where patients present with medical complexity and / or significant co-morbidities that require NHS management. The top-up will only be available to named NHS providers commissioned in accordance with the service specification set out in schedule 2 of “NHS termination of pregnancy for patients presenting with medical complexity and / or significant co-morbidities”.

Commissioners should ensure specialist centres are available as locally as possible, to reduce delays and travel times for women with complex needs or significant comorbidities [1.1.15]<sup>3</sup>. Providers should develop pathways for women with complex needs or significant comorbidities to refer them to specialist centres if needed and to minimise delays in accessing care [1.1.16]<sup>3</sup>.

Later gestation cases need more specialist skills and resources. These services should be available within each region, or in the most complex circumstances nationally. Commissioners and providers should collaborate with regional MDTs to ensure that provision for later gestation and complex cases is integrated within the regional and national framework. Commissioners and providers should work together to ensure that women are promptly referred onwards if a service cannot provide an abortion after a specific gestational age or by the woman’s preferred method [1.1.1]<sup>3</sup>.

## **12. Dispute Resolution**

The dispute resolution procedure (GC14) requires the parties in dispute to try to resolve their differences by negotiation, escalating to senior managers and then board-level representatives as required<sup>23</sup>. If the dispute remains unresolved, the parties must refer it to mediation, under which the appointed mediator will attempt to facilitate the agreement of a satisfactory settlement of the dispute. If mediation fails to resolve matters, the dispute must be referred to an independent expert for determination. The expert’s ruling on the dispute will be binding on the parties [47.12-13]<sup>23</sup>.

### 13. Abbreviations

ANTT	Aseptic non-touch technique
BASHH	British Association for Sexual Health and HIV
BMA	British Medical Association
BSACP	British Society of Abortion Care Providers
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
DHSC	Department of Health and Social Care
DQIP	Data Quality Improvement Plan
FSRH	Faculty of Sexual and Reproductive Healthcare
GMC	General Medical Council
HIV	Human Immunodeficiency Virus
HIW	Healthcare Inspectorate Wales
ICB	Integrated Care Board
ICS	Integrated Care System
IPC	Infection Prevention and Control
ISP	Independent Service Provider
LARC	Long acting reversible contraception
NICE	National Institute of Health and Care Excellence
NIO	Northern Ireland Office
NHS	National Health Service
NHSE	NHS England
PSIRF	Patient Safety Incident Response Framework
RCM	Royal College of Midwives
RCN	Royal College of Nursing
RCOG	Royal College of Obstetricians and Gynaecologists
RSOP	Required Standard Operating Procedures
SCFMA	System Collaboration and Financial Management agreement
SDIP	Service Development and Improvement Plan
STI	Sexually Transmitted Infections
TOP	Termination of pregnancy
WHO	World Health Organization

### 14. References & statement on gender-inclusive language

References cited within this template are listed in full in the complete document “National Service Specification for NHS Abortion Care”, available from [policy@rcog.org.uk](mailto:policy@rcog.org.uk) and at [www.bsacp.org.uk](http://www.bsacp.org.uk) & [www.rcog.org.uk](http://www.rcog.org.uk).

Although most abortion care is provided to women, other people whose gender identity does not align with the sex they were assigned at birth can also experience pregnancy and abortion. For simplicity of language this document uses the term women, but this should be taken to also include people who do not identify as women but who are pregnant.

## 6 References

1. Stone N, Ingham R. Who presents more than once? Repeat abortion among women in Britain. *J Fam Plann Reprod Health Care* 2011;37(4):209-15. doi: jfprhc-2011-0063 [pii];10.1136/jfprhc-2011-0063 [doi] <https://srh.bmj.com/content/familyplanning/37/4/209.full.pdf>
2. Department of Health & Social Care (DHSC). Abortion statistics 2021: data tables. In: Department of Health & Social Care (DHSC), ed. Abortion statistics for England and Wales: 2021. London: DHSC, 2021. [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/1084078/Abortion-statistics-2021-data-tables.ods](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1084078/Abortion-statistics-2021-data-tables.ods)
3. National Institute for Health and Care Excellence (NICE). Abortion Care. In: National Institute for Health and Care Excellence (NICE), ed. NICE Guideline. London, 2019. [www.nice.org.uk/guidance/ng140](http://www.nice.org.uk/guidance/ng140)
4. National Institute for Clinical Excellence (NICE). Abortion care. Quality standard. In: National Institute for Clinical Excellence (NICE), ed. NICE Quality Standard. London: NICE, 2021. [www.nice.org.uk/guidance/qs199](http://www.nice.org.uk/guidance/qs199)
5. Department of Health & Social Care (DHSC). The NHS Choice Framework: what choices are available to me in the NHS? In: Department of Health & Social Care (DHSC), ed. London: DHSC, 2021. <https://www.gov.uk/government/publications/the-nhs-choice-framework/the-nhs-choice-framework-what-choices-are-available-to-me-in-the-nhs>
6. NHS England (NHSE). 2022/23 National Tariff Payment System. London: NHSE, 2022. <https://www.england.nhs.uk/wp-content/uploads/2020/11/21-22-National-tariff-payment-system.pdf>
7. Department of Health & Social Care (DHSC). Handbook to the NHS Constitution for England. In: Department of Health & Social Care (DHSC), ed. London: DHSC, PHE, 2021. <https://www.gov.uk/government/publications/supplements-to-the-nhs-constitution-for-england/the-handbook-to-the-nhs-constitution-for-england>
8. NHS England (NHSE). 2022/23 Annex A: The national tariff workbook. In: NHS England (NHSE), ed. National tariff payment system documents, annexes and supporting documents. London: NHS England, 2022. [https://www.england.nhs.uk/wp-content/uploads/2020/11/22-23NT\\_Annex-DtA-National-tariff-workbook.xlsx](https://www.england.nhs.uk/wp-content/uploads/2020/11/22-23NT_Annex-DtA-National-tariff-workbook.xlsx)
9. Office for National Statistics (ONS). Conceptions in England and Wales: 2019. London: ONS, 2021. <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/conceptionandfertilityrates/bulletins/conceptionstatistics/2019>
10. Bearak J, Popinchalk A, Ganatra B, et al. Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990-2019. *Lancet Global Health* 2020 doi: 10.1016/S2214-109X(20)30315-6 [published Online First: 07/23/2020]. [https://doi.org/10.1016/S2214-109X\(20\)30315-6](https://doi.org/10.1016/S2214-109X(20)30315-6)
11. Raymond EG, Grimes DA. The comparative safety of legal induced abortion and childbirth in the United States. *Obstet Gynecol* 2012;119(2 Pt 1):215-9. doi: 10.1097/AOG.0b013e31823fe923 [published Online First: 2012/01/25].



12. Bartlett LA, Berg CJ, Shulman HB, et al. Risk factors for legal induced abortion-related mortality in the United States. *Obstet Gynecol* 2004;103(4):729-37. doi: 10.1097/01.AOG.0000116260.81570.60 [doi];103/4/729 [pii] <http://www.ncbi.nlm.nih.gov/pubmed/15051566>
13. Academy of Medical Royal Colleges (AoMRC). Telemedicine and early termination of pregnancy - Academy Council statement. In: Academy of Medical Royal Colleges (AoMRC), ed. Statements. London: AoMRC, 2022. <https://www.aomrc.org.uk/statements/telemedicine-and-early-termination-of-pregnancy-academy-statement/>
14. Aiken A, Lohr P, Lord J, et al. Effectiveness, safety and acceptability of no-test medical abortion (termination of pregnancy) provided via telemedicine: a national cohort study. *BJOG* 2021;n/a(n/a) doi: <https://doi.org/10.1111/1471-0528.16668>  
<https://obgyn.onlinelibrary.wiley.com/doi/abs/10.1111/1471-0528.16668>
15. Royal College of Obstetricians and Gynaecologists (RCOG), Royal College of Midwives (RCM), Faculty of Sexual & Reproductive Healthcare (FSRH), et al. Safeguarding in abortion care – response to April 2022 position statement from NNDHP. In: Royal College of Obstetricians and Gynaecologists (RCOG), ed. Position Statements. London: RCOG, 2022. <https://www.rcog.org.uk/media/da5p1nmb/telemedicine-safeguarding-position-statement-rcog-rcm-fsrh-bsacp-may-2022.pdf>
16. National Institute for Health and Care Excellence (NICE). Abortion care. Evidence Review A - Accessibility and sustainability of abortion services. In: National Institute for Health and Care Excellence (NICE), ed. NICE Guideline NG140. London, 2019. [www.nice.org.uk/guidance/ng140](http://www.nice.org.uk/guidance/ng140)
17. National Institute for Clinical Excellence (NICE). Babies, children and young people's experience of healthcare. In: National Institute for Clinical Excellence (NICE), ed. NICE Guideline. London: NICE, 2021. <https://www.nice.org.uk/guidance/ng204/resources/babies-children-and-young-peoples-experience-of-healthcare-pdf-66143714734789>
18. Royal College of Obstetricians and Gynaecologists (RCOG). Making Abortion Safe. In: Royal College of Obstetricians and Gynaecologists (RCOG), ed. Centre for Women's Global Health. London: RCOG, 2022. <https://www.rcog.org.uk/about-us/global-network/centre-for-womens-global-health/making-abortion-safe/#:~:text=The%20Making%20Abortion%20Safe%20programme,and%20post%2Dabortion%20contraceptive%20services>.
19. Royal College of Obstetricians and Gynaecologists (RCOG), Royal College of Midwives (RCM), Faculty of Sexual & Reproductive Healthcare (FSRH), et al. Coronavirus (COVID-19) infection and abortion care. In: RCOG, ed. London, UK: Royal College of Obstetricians and Gynaecologists, 2020. <https://www.rcog.org.uk/globalassets/documents/guidelines/2020-07-31-coronavirus-covid-19-infection-and-abortion-care.pdf>
20. World Health Organization (WHO). Abortion care guideline. Geneva: World Health Organization (WHO), Human Reproduction Programme (UNDP - UNFPA - UNICEF - WHO - World Bank) 2022. <https://srhr.org/abortioncare/>
21. NHS England (NHSE). Core20PLUS5 – An approach to reducing health inequalities. In: NHS England (NHSE), ed. National Healthcare Inequalities Improvement Programme. Leeds: NHSE, 2022.

<https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/>

22. NHS England (NHSE). 2022/23 priorities and operational planning guidance. In: NHS England (NHSE), ed. NHS Operational Planning and Contracting Guidance. Leeds: NHSE, 2022. <https://www.england.nhs.uk/wp-content/uploads/2022/02/20211223-B1160-2022-23-priorities-and-operational-planning-guidance-v3.2.pdf>
23. NHS England (NHSE). NHS Standard Contract 2021/22. Technical Guidance. In: NHS Standard Contract Team, ed. London: NHS England, 2021. <https://www.england.nhs.uk/wp-content/uploads/2021/01/9-Contract-Technical-Guidance-2021-22-040121.pdf>
24. Lord J. Quality and abortion services. *Journal of Family Planning and Reproductive Health Care* 2017;43(1):16-17. doi: 10.1136/jfprhc-2016-101580 <https://srh.bmj.com/content/familyplanning/43/1/16.full.pdf>
25. Department of Health & Social Care (DHSC), Public Health England (PHE). Integrated Sexual Health Services. A suggested national service specification. In: Department of Health & Social Care (DHSC), ed. London: DHSC & PHE, 2018. [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/731140/integrated-sexual-health-services-specification.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/731140/integrated-sexual-health-services-specification.pdf)
26. British Association for Sexual Health and HIV (BASHH). Standards for the management of sexually transmitted infections (STIs). In: British Association for Sexual Health and HIV (BASHH), ed. Lichfield, Staffs: BASHH, 2019. <https://bashh.org/media/4429/bashh-standards-for-sti-management-2019.pdf>
27. National Society for the Prevention of Cruelty to Children (NSPCC). Delivery of virtual support and services to children and families. Key issues for practice. . In: National Society for the Prevention of Cruelty to Children (NSPCC), ed. London: National Society for the Prevention of Cruelty to Children (NSPCC), , 2021. <https://learning.nspcc.org.uk/media/2542/delivery-of-virtual-support-and-services-to-children-and-families.pdf>
28. Royal College of Obstetricians and Gynaecologists (RCOG), Faculty of Sexual & Reproductive Healthcare (FSRH), British Society of Abortion Care Providers (BSACP). Implementing the RCPCH guidance “Safeguarding guidance for children and young people under 18 accessing early medical abortion services”. In: Royal College of Obstetricians and Gynaecologists (RCOG), ed. Position Statement. London, 2022. <https://www.rcog.org.uk/media/okoiknws/rcog-implementing-the-rcpch-guidance-position-statement-sept-2022.pdf>
29. Royal College of Paediatrics and Child Health (RCPCH). Safeguarding guidance for children and young people under 18 accessing early medical abortion services Child protection resources. London: Royal College of Paediatrics and Child Health (RCPCH), ; 2022 [Available from: <https://childprotection.rcpch.ac.uk/resources/safeguarding-guidance-for-children-and-young-people-under-18-accessing-early-medical-abortion-services/> accessed 04/10/2022.
30. Brandi K, Woodhams E, White KO, et al. An exploration of perceived contraceptive coercion at the time of abortion. *Contraception* 2018;97(4):329-34. doi: 10.1016/j.contraception.2017.12.009 [published Online First: 2017/12/19].

