NHS

NHS
Northamptonshire
Integrated Care Board

Service Specification – Termination of Pregnancy Services (TOPs) Northamptonshire

General Overview

Abortion is when a pregnancy is ended so that it does not result in the birth of a child. Sometimes it is called 'termination of pregnancy'. Terminations are performed medically or surgically. Both options are safe and effective and national guidance recommends a choice of methods where appropriate.

The Department of Health and Social Care have set out the guidance for the provision of termination services. The guidance sets out the framework within which Integrated Care Boards (ICBs) should commission termination services.

Most terminations in England and Wales are carried out by Independent Sector Providers under contract to the NHS (74%). These services typically operate from free-standing clinics and are staffed and equipped to provide abortion care for healthy patients or those with mild systemic disease. However, patients with significant co-morbidities and / or medical complications require management in an NHS hospital setting where there is a MDT with specific clinical expertise and access to diagnostics, therapeutics and blood, theatres and critical care.

An estimated 25 million unsafe abortions occur every year, making it one of the leading causes of maternal mortality and morbidity worldwide. Abortion-related deaths and morbidity are largely preventable by providing safe abortion care (performed in line with clinical best practice) and timely post-abortion care, as well as by access to contraception and comprehensive sexuality education (CSE).

Abortion need not be unsafe. Morbidity and mortality rates following abortion that is provided using best practice are lower than those that would be faced in an ongoing pregnancy and in childbirth. Surgical abortions provided according to evidence-based guidance are generally straightforward procedures and can be provided by a range of clinician groups in a variety of settings. In addition, with appropriate support, individuals can safely manage medical abortions at under 12 weeks of pregnancy themselves at home. As with many other medical procedures, adherence to best practice standards will ensure that the most effective and the safest services are delivered. This Best Practice Paper is designed to be used by health workers delivering abortion and post-abortion care.

The two methods of abortion are:

• **medical abortion**: the use of medications to end a pregnancy; the most commonly used medications are misoprostol alone or misoprostol in combination with mifepristone.

• **surgical abortion**: the use of transcervical procedures to end a pregnancy, including manual vacuum aspiration (MVA), electric vacuum aspiration (EVA) and dilatation and evacuation (D&E).

Terminations performed for foetal abnormality and women requiring specialist referral do not form part of this specification.

Aim

Evidence shows that the earlier women can access termination of pregnancy, the less the risk and the better the outcome is likely to be.

The aim of the service specification is to ensure that women seeking termination of pregnancy or discussion of their pregnancy options receive an early assessment appointment and can access impartial advice and support at that appointment, in surroundings which promote confidentiality and well-being, and which reflect any particular personal circumstances (e.g., if a service user is seeking a termination of pregnancy as a result of rape).

The objectives of the service are:

• To offer high quality, impartial support and advice to all service users who request an abortion, regardless of age, ethnicity, language, disability, religious or personal circumstances.

• To provide service users with access to an abortion as early as possible.

• To provide abortion methods clinically appropriate for a service user's gestation and clinical circumstances.

• To improve the sexual health of all service users through providing sexual health screening for Chlamydia and other sexually transmitted infections (STIs) for all age groups for patients from Northamptonshire.

• To provide information and advice on all methods of contraception and the supply of the full range of long-acting reversible contraceptive (LARC) methods.

• To work with local sexual health service provider/s to facilitate ongoing continuation of long-term contraception Northamptonshire residents. This may involve requests to patients to share patient contact details with sexual health service for follow up.

• To provide service users with appropriate information on post-abortion counselling services both prior to and after having a termination.

• To provide information and advice on all methods of contraception, and the supply of the full range of reversible contraceptive methods.

The service will provide the following for the population of Northamptonshire:

• Offer face to face appointments for all young people aged 18 and under.

• Offer telemedicine and face to face appointments for Service Users as clinically appropriate.

• Advice for unwanted pregnancy and referral for termination of pregnancy.

• Pre-and post-termination support and advice and contraception planning and implementation post-termination.

• Active Health promotion/prevention campaigns on Sexual Reproductive Health and HIV.

• Ensuring that contraception and sexual health advice, support and provision is available as part of all termination of pregnancy service care pathways.

• Reducing unintended and unwanted conceptions and repeat terminations of pregnancy in all ages by improving access to long-acting reversible contraception

• To improve the sexual health of service users through proactively signposting to local sexual health services for screening and treatment as appropriate for Chlamydia, other sexually transmitted infections (STIs) and HIV. and signposting to GPs for cervical screening as appropriate

• To improve the sexual health of service users through proactively offering sexual health screening and treatment as appropriate for Chlamydia and other sexually transmitted infections (STIs)

• To provide information and advice on all methods of contraception, (with particular emphasis on the promotion of LARC) and the offer of the full range of reversible contraceptive methods. Where The supply of contraception is not appropriate, the service user should be signposted to local contraceptive and sexual health services.

The new service will build on the existing work to provide a high-quality, accessible, legal and appropriate termination of pregnancy service while also promoting improved sexual health among service users and reducing repeat terminations and unintended pregnancies.

The services will be available to women registered with a GP in Northamptonshire and to women not registered with a GP but who do have a residential postcode within the Northamptonshire ICB.

The service is for the provision of abortion care to the female population of Northamptonshire.

The service relates to the provision of termination services to women with an unwanted pregnancy who request termination. It also describes how termination services will provide contraception and sexually transmitted infection screening and treatment services.

The abortion service shall comply with the Abortion Act 1967, as amended by the Human Fertilisation and Embryology Act 1990. Those seeking terminations that are under 16 years of age will comply with the guidelines stated within the service specification.

This specification outlines the service that NHS Northamptonshire require for terminations performed under the 1967 Abortion Act, and associated services, for all women registered with Northamptonshire ICB General Practitioners.

The specification does not include terminations for foetal abnormality, or evacuation of retained products of conception after partial or inevitable miscarriage.

We anticipate around 2,424 terminations a year to be provided, based on activity from previous years. Of these approximately 2,116 will be medical terminations and 308 surgical terminations. Around 2,300 of the total number of terminations will be below 13 weeks.

We anticipate letting this contract for three years subject to satisfactory performance monitoring.

Services should be provided in line with evidence of best practice, currently the standards set by the Royal College of Obstetricians and Gynaecologists

The Abortion Act (1967), policies and procedures

The Abortion Act requires that treatment for the termination of pregnancy must be carried out in an NHS hospital or in a place approved by the Secretary of State for Health and

Social Care.

The Care Quality Commission (CQC) regulates all healthcare activities including termination care. Providers must maintain acceptable service standards according to the CQC inspection framework.

The service must comply with the safeguarding legislation for children and adults, national policy.

Staff appraisal and re-validation procedures must be in place to ensure that staff keep up to date with continuing professional development requirements as set down by their professional body and a Responsible Officer must monitor compliance with these standards.

NHS Centres must have in place governance arrangements to assure patient accessibility, clinical quality and patient safety. They must also ensure that effective policies and procedures are in place to minimise risk of infection and other complications associated with termination procedures

Access

Acceptability

The assessment appointment should be within clinic time dedicated to women requesting abortion.

Women and pregnant people should be informed about their options so that they can make an informed choice about their preferred course of action. Their choice should be respected without any unnecessary delay, as the earlier in pregnancy an abortion is undertaken the safer it is likely to be.

Waiting areas for clinical assessment should have sufficient seating to accommodate the number of women and their partner/friend/carer. Such areas should consider the comfort and privacy of those waiting for others as they may experience an extended wait during a consultation or procedure.

Women should be seen within half an hour of their appointment time, and flow through the clinic should be without undue delay.

All women should be offered a chaperone for any examination. If a chaperone is present a record should be made of the identity of the chaperone.

At no time during the assessment or procedure should women be shown an image or scan of the foetus, unless she specifically requests this.

In the absence of specific medical, social or geographical contraindications, induced abortion may be managed on a day care basis.

Women having second trimester abortions by medical means must be cared for by an appropriately experienced midwife or nurse. Ideally, they should have the privacy of a single room.

Where possible women who have not yet had an abortion should be kept separate from those who have already undergone the procedure. Women in the initial stages of recovery from anaesthesia should be given privacy as they pass through this stage.

All aspects of abortion care should be delivered in a respectful and sensitive manner that is person-centred and recognises women and pregnant people as the decision makers.

Follow up and contraception

NHS Centres will ensure that patients receive verbal and written information on discharge, and that any other service which provides the follow-up care is informed, subject to consent. Many patients want to begin a contraceptive method after a termination. Provision of contraception immediately after a termination is associated with greater uptake and continuation of use.

All patients must be able to discuss contraception and reproduction options with a trained healthcare practitioner and be offered a choice of all methods when they are assessed for termination and before discharge (refer to NICE guideline [NG140]: Abortion Care, 2019).

Population Needs

One in five pregnancies in England and Wales end by induced abortion. This equates to approximately 191,555 terminations in England each year. Of these, 74% are undertaken by ISPs and are exclusions from this specification.

Whilst there are limited data available that describes the number of patients with complex co-morbidities who require a termination of their pregnancy in an NHS hospital setting, data from two of the largest ISPs indicates this is likely to be between 2,500 to 3,000 people per year.

Disproportionately more people needing hospital placement for a complex termination are at a later gestational age compared to standard terminations nationally.

One ISP reported that 56% of hospital referrals are below 10 weeks' gestation compared to 80% for noncomplex cases nationally and that 6% of hospital referrals are referred at 20 weeks' gestation compared to 2% for non-complex cases. Some of the shift in gestation is the result of difficulty finding a suitable location for care, in some cases however, the medical condition itself may have led to a delay in the recognition of pregnancy.

Most people needing NHS centres services will require surgical abortion, and this may be the medically recommended method for many cases. Where clinically appropriate and preferred, a medical abortion may be offered. Feticide provided by an appropriately trained individual may be needed for medical inductions typically from 22 weeks of gestation.

Health Inequalities

At a national level, it is known that there is variation in sexual and reproductive health outcomes across each of the dimensions of health inequalities. Inequalities in uptake of or access to interventions can make inequalities in ill health worse. Some parts of the population will be affected by more than one area of sexual and reproductive ill health. Sexually

transmitted infections (STIs) are more likely to be diagnosed in young people, gay, bisexual and other men who have sex with men (MSM) and black and ethnic minorities.

Abortion rates vary by age. Abortion rates for those aged under 18 have declined over the last ten years in line with the successes in decreasing the rate of conceptions in this age group. The decline is particularly marked in the under-16 age group where the rates are less than a third of what they were in 2008. However, there is significant variation between local areas in the proportion of under-18 conceptions that end in abortion, ranging from 32% to over 70%. There is similar variation in the under-16s abortion proportion. This may reflect individual choice of young women, perhaps influenced by socio-economic factors, and/or differences in the ease of access to abortion services. Abortion rates have increased in the older age groups with the relative rate of increase being greatest in women over 35.

Health inequalities are not caused by one single issue, but a complex mix of environmental and social factors which play out in a local area, or place – this means that local systems have a critical role to play in reducing health inequalities. A number of resources have been developed to support local areas to explore the impact of changes to sexual and reproductive health service delivery – these can be found at www.fsrh.org/news/understanding-the-impact-of-sexual-health-and-reproductive/. A surveillance report showing the impact of the COVID–19 pandemic and response on prevention, testing, diagnosis and care for sexually transmitted infections (STIs), human immunodeficiency virus (HIV) and hepatitis in England has also been published www.gov.uk/government/publications/covid-19-impact-on-stis-hiv-and-viral-hepatitis

The provider will be expected to demonstrate how they will reduce health inequalities within the county, using the best available evidence/tools and expert knowledge.

Northamptonshire

Latest estimates put Northamptonshire's population at 753,278 people (all ages) in 2019 (ONS mid-year estimates), up from 747,622 in 2018 (or +0.76%) and 691,952 in 2011 (Census year) (or +8.86%).

The county has had above (national) average population growth in recent decades, to varying degrees across the county (see below table). In the past 10 years the population of Northamptonshire has grown by an estimated 10.2% versus a 7.84% England average. If we look back over the past 30 years, the growth gap is even greater with an estimated increase of 30.9% between 1989 and 2019 in Northamptonshire compared with 18.4% across England.

Most recently the highest rates of population growth have been in Corby, with a growth of 36% in the past 10 years, this is also high nationally with Corby having the 5th highest estimated growth of all 383 district/ unitary authority areas. All districts in Northamptonshire have increased in growth at a greater rate than the England average over the past 30 years.

Population size-GP Registered

Patients that are registered at GP practices in Northamptonshire aren't always resident within the county. Given the geographic layout of the county with borders to eight other upper tier authorities it is not unusual for patients registered at Northamptonshire GPs to live outside of the county or for county residents to be registered with a GP in a different local authority area, especially in more rural locations at the extremities of the county border or smaller communities close to an urban centre in a different area.

For further details on population go to:

Demography Update - 2020 (northamptonshire.gov.uk)

Quality Statement – Aim of Service

The aims of the service are to

• Ensure that people needing NHS care for safe termination are always able to access local termination services up to 23 weeks 6 days of gestation (regardless of the legal ground) including widely available information regarding termination and that it is easily accessible and in different formats i.e., languages and easy reading

• Provide rapid access to local, safe, effective and satisfactory terminations for individuals in routine termination services

• Maximise safety by providing local access to high quality expertise with access to multidisciplinary teams and acute peri-abortion care when needed

• Ensure that the quality of the care provided is nationally monitored and subject to a process of continued improvement (though a national dashboard)

• Participate in national data collection to improve understanding of service needs across the country to allow optimisation of outcomes and resources

The provider will be expected to share the following with the Integrated Care Board:

Patient Experience
Complaints
Staff surveys

Patient Safety
Incidents (moderate and above)
Duty of candour
Serious Incidents and Never Events
Learning from incidents (all levels of harm)
Will need to include future implementation of PSIRF

Clinical Effectiveness
Updates from NICE guidelines i.e., actions/learning
Staff appraisals and supervisions
Training
Quality Improvements

NHS Outcomes Framework Domains

Domain 1	**Preventing people from dying prematurely**	**Yes**
Domain 2	**Enhancing quality of life for people with long-term conditions**	**Yes**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**Yes**

Domain 4	**Ensuring people have a positive experience of care**	**Yes**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**Yes**

Integrated System Working

On 1 July 2022, Northamptonshire formally established a new statutory integrated care system. This is a new legal requirement not just for our county, but for the whole of England across 42 local areas.

An integrated care system is a partnership of local health and care organisations that come together to plan and deliver joined-up services and to improve the health of people who live and work in the area.

Our integrated care system is called **Integrated Care Northamptonshire**. It replaces and builds upon the partnership work undertaken over the last few years by Northamptonshire Health and Care Partnership.

Integrated Care Northamptonshire operates under the combined leadership of two statutory (legally required) bodies: NHS Northamptonshire Integrated Care Board (NICB) and Northamptonshire Integrated Care Partnership (NICP).

NICB is responsible for local NHS services, functions, performance and budgets. This body replaces the old NHS Northamptonshire Clinical Commissioning Group (CCG). It is made up of local NHS trusts (our two general hospital trusts and Northamptonshire Healthcare NHS Foundation Trust, our community and mental health service provider), primary care providers (including GPs), and local authorities.

NICP is a statutory committee made up of local health services, local government, the voluntary and community sector, as well as other public sector partners.

Together these bodies oversee the delivery of health and care services to ensure they meet the needs of local populations – for the county as a whole, at 'place' level (aligned with our unitary council boundaries), and even more locally in communities and neighbourhoods.

Further detail on NICS can be found at https://www.icnorthamptonshire.org.uk/ic

TOP services are also commissioned from NHS Providers at Acute Trust level, and communication between Providers may be required to assist individual case management.

Importantly, services may need to cross-refer or collaborate between other NHS Providers in relation to the confirmation of pregnancy and gestational age; the general medical examination to determine fitness for procedure; Screening for Chlamydia infection referral to integrated sexual health clinic, and partner notification; referral to the SARC (Sexual Assault Referral Centre) in cases of sexual assault; undertaking of blood tests for ABO, Rhesus group and antibodies, haemoglobin and haemoglobinopathy, if appropriate; and the provision of information and sign-posting about post-abortion support and contraception.

Appropriate follow-up care plans and discharge summaries should be made available as appropriate to assist follow-on care by other services.

A patient centred service enabled by consistent and continuous care between health professionals, with effective and efficient communication with patients, using standardised documentation and paperwork should be the goal.

The Provider will be expected to comply with the performance monitoring requirements of the Commissioner, and to maintain up-to-date records of the key Commissioner performance indicators in line with on-going related national programmes and initiatives, including waiting times to consultation; waiting times to treatment; monitoring of patient DNA profiles; monitoring of provider cancellation rates and in which case the commissioning organisation must be informed of all such cancellations; monitoring of repeat profiles; the universal pre-intervention offer of Chlamydia screening; complication rates; the offer and uptake of long-acting reversible contraception or referral to an appropriate location where practitioners are available and competent to fit such devices, by type of device; monitoring of referrals for safeguarding cases; the monitoring of alternative choices taken up and outcomes; referrals and/or signposting to other related support services as appropriate and documentation of same; co-operation with audits initiated directly or indirectly by the Commissioner or its partner agencies.

In order to improve the client experience, the Provider will be required to systematically seek user views on the design, delivery and evaluation of local service, and use the findings to inform service improvements.

Clinical staff undertaking abortions must be appropriately trained and experienced to RCOG, FFPRHC, NICE LARC, or other applicable standards. All clinical staff should have a DBS check. Clinical audit should be undertaken regularly. Professional and support staff should be involved in the audit of organisational care. Professional staff should undertake interdisciplinary clinical audit and receive clinical supervision, and ideally consider participation in external peer review processes.

Multidisciplinary continuous staff training involving working with a number of specialities should be standard encouraged. These specialities should include

a) Contraception Services

b) Obstetrics and Gynaecology

c) Genito-urinary Medicine (GUM)

d) Sexual Health Promotion

e) Primary Care

Systems should be put in place to enable the audit of components of the service as relevant to local planning and commissioning targets.

The information gathered through user involvement methods should be taken into account when reviewing standards as part of clinical audit.

Appropriately qualified counsellors/sexual health advisers should be available to provide Counselling in a timely fashion.

All units should have appropriate equipment and suitably skilled staff to ensure early access to accurate ultrasound scanning, for dating assessments and continuity of access to care as appropriate.

Interdependencies

Integrated care pathways should be established to enable those requesting abortion to also have their other sexual health needs addressed, including those for ongoing contraception and for diagnosis and treatment of STIs.

Referrals to the service from Primary care are dependent in the majority on patient registration with a General Practitioner.

Unregistered clients who reside within Northamptonshire, and who are entitled to NHS treatments, may also self-refer or be referred from specialists across other NHS tiers of provision such as NHFT or Gynaecology departments at Acute or Community Trusts.

Referrals for specialist GUM care, Cervical screening and breast cancer screening should be facilitated as appropriate.

In patients who refrain from proceeding, referral for antenatal/obstetric care at Primary or other appropriate level of care should be facilitated.

It may be necessary to liaise with the lead Clinician managing clients with underlying or chronic medical conditions, prior to, and post-procedure, in the interest of the continuing health and well-being of the client.

The confidential nature of the service should be emphasized, and provider contact numbers should be made available to patients so they can telephone to confirm their appointments and admission plans, if appropriate. Care should be taken to ensure that information is not shared with anyone else, including the woman's general practitioner, without her consent.

The necessary referral pathways should be defined between other potential referral destinations to ensure that the client experience is optimal. Arrangements should be in place to facilitate the care and management of under 16-year-olds/Minors, complainants of rape and sexual assault; victims of domestic violence, and other vulnerable groups such as those with a learning disability or sensory impairment.

Other essential referrals that will require clear pathways are between Safeguarding teams; Accident and Emergency; the Out of Hours service; Community Pharmacy outlets; School nurses; the Connexions service; the Youth service; and the website aimed at users.

Standardised, evidence-based information leaflets should also be made available in the appropriate and accessible formats.

Agreed follow up arrangements should be documented in the patients' records.

The GP and referring clinician (if different) should be informed of the following using a standard form, <u>if permission is given by client:</u>

- Date and method of abortion
- Screening tests done
- Antibiotic treatment
- Other medical problems
- Complications
- Referral to other services for contraception if not provided at the time of procedure for medical reasons

Arrangements should be put in place for those who need or request medical or psychological follow-up.

Relevant networks and screening programmes

Providers are required to update their competencies and practise in line with national department of health, NICE-National Institute for Healthcare and Clinical Excellence; BASHH; FSRH; the Royal Colleges; Teenage Pregnancy Reduction; Sexual Violence Reduction; Safeguarding of Vulnerable Children and Adults; and other relevant guidance as endorsed by the Commissioner.

The Provider will also participate in appropriate Clinical and Multi-disciplinary networks to support continuing professional development and improve the quality-of-service delivery. Such networks will include but not be limited to the Family Planning and Reproductive Health networks; Sexual Health Advisers' networks; Chlamydia Screening network; Gynaecology networks; Teenage pregnancy reduction and young people's networks; Safeguarding; Mental Health and Psychology networks; etc.

Expected Outcomes

- Improved access to termination of pregnancy
- Reduction in the number of subsequent unintended pregnancies among service users
- Reduction in the numbers of repeat termination of pregnancies among service users
- Reduction in the rate of pelvic infection or complications related to the procedure among service users
- Reduction in the rate of any subsequent sexually transmitted infections among service users
- Reduction in onward transmission of any existing STIs by service users
- Contribute to the reduction of under 18's conception rate
- Contribute to under 18's conception rate leading to abortions

Key National Evidence

NHS Abortions https://www.nhs.uk/conditions/abortion/

Abortion WHO https://www.who.int/news-room/fact-sheets/detail/abortion

Abortion Care NICE Guidance www.nice.org.uk/guidance/qs199/resources/abortion-care-pdf-75545790237637

Best practice in abortions RCOG 2022

https://www.rcog.org.uk/media/geify5bx/abortion-care-best-practice-paper-april-2022.pdf

National Institute for Health and Care Excellence. Abortion Care. NICE guideline NG140; 2019 [www.niceorg.uk/guidance/ng140].

Royal College of Obstetricians and Gynaecologists. The Care of Women Requesting Induced Abortion.

Evidence-based Guideline No.7. London: RCOG; 2011 [www.rcog.org.uk/en/guidelines-research-services/guidelines/the-care-of-women-requesting-induced-abortion].

World Health Organization. Abortion Care Guideline. Geneva: WHO; 2022. [https://www.who.int/publications/i/item/9789240039483]

World Health Organization. Clinical Practice Handbook for Safe Abortion. Geneva: WHO; 2014 [https://www.who.int/publications/i/item/9789241548717/].

The law and ethics of abortion

https://www.bma.org.uk/media/3307/bma-view-on-the-law-and-ethics-of-abortion-sept-2020.pdf

National Review of Abortion Services 2019

https://www.bpas.org/media/3121/national-review-of-abortion-services.pdf

Home use of both pills for early medical abortion up to 10 weeks gestation

https://www.gov.uk/government/consultations/home-use-of-both-pills-for-early-medical-abortion/home-use-of-both-pills-for-early-medical-abortion-up-to-10-weeks-gestation

Self-reported outcomes and adverse events after medical abortion through online telemedicine: population-based study in the Republic of Ireland and Northern Ireland

https://www.bmj.com/content/357/bmj.j2011

Standardizing abortion research outcomes (STAR): Results from an international consensus development study 2021

https://www.sciencedirect.com/science/article/pii/S0010782421002249 or https://www.contraceptionjournal.org/article/S0010-7824(21)00224-9/pdf

Effectiveness, safety, and acceptability of no-test medical abortion (termination of pregnancy) provided via telemedicine: a national cohort study 2021

https://obgyn.onlinelibrary.wiley.com/doi/10.1111/1471-0528.16668

Variation in outcomes in sexual and reproductive health in England

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/984393/SRH_variation_in_outcomes_toolkit_May_2021.pdf

What Good Sexual Health, Reproductive Health and HIV Provision Looks Like

https://www.adph.org.uk/wp-content/uploads/2019/10/What-Good-Sexual-and-Reproductive-Health-and-HIV-Provision-Looks-Like.pdf

Variation in outcomes in sexual and reproductive health in England. A toolkit to explore inequalities at a local level

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/984393/SRH_variation_in_outcomes_toolkit_May_2021.pdf

Guide to abortion statistics, England and Wales: 2021

https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2021/guide-to-abortion-statistics-england-and-wales-2021

Information about Abortion Care

https://www.rcog.org.uk/for-the-public/browse-all-patient-information-leaflets/information-about-abortion-care/

Local Evidence

Meeting the sexual and reproductive health needs of homeless individuals accommodated in Northampton hotels during the COVID-19 lockdown 2020

https://ukhsa.koha-ptfs.co.uk/cgi-bin/koha/opac-retrieve-file.pl?id=98bb6aac062b63d4bffc6c8097a0520a

Women's Health Strategy 2022

https://www.gov.uk/government/publications/womens-health-strategy-for-england

Service Delivery

The provision of a safe and effective abortion care service depends on everyone involved in the service ensuring that everything can be done to achieve best practice for safe abortion care. It is not enough for doctors, nurses and midwives to perform effectively if the facilities and tools that they need are not reliably available and if the service is not organised in a way that ensures safe and effective abortion care. Best practices for service delivery are listed below.

The service model is based on the RCOG Guideline Best practice in abortions RCOG 2022

https://www.rcog.org.uk/media/geify5bx/abortion-care-best-practice-paper-april-2022.pdf

The service specification will be amended in line with any future guidance produced by the College. While the ICB will endeavour to update this service specification in line with any new guidance as quickly as possible, it is expected that the Service Providers will work pro-actively to agree a speedy variation of the contract to take account of any new guidance ahead of the production of a revised service specification.

Access to services

1. Abortion services should be available to the fullest extent that the law allows. Healthcare providers should know what the law does allow in their country and be clear about the circumstances for which abortion is legal.

2. If a person requesting abortion fulfils the legal criteria, there should be no further restriction of access on grounds such as age, marital status or the number of previous abortions.

3. Abortion is safer the sooner it is done. Services should be able to meet the local demand for abortion so that people can have their abortion as early as possible and as close to home as possible.

4. As the equipment and space required for a safe abortion service are similar to those needed for routine women's healthcare and contraception services, efforts should be made to provide safe abortion services in a wide range of health facilities and in an integrated manner.

5. All healthcare providers should be trained to provide safe abortion care in line with their skills and licences. This can help spread the workload and improve the skills of all providers of women's healthcare, thereby enhancing access to and increasing the safety of abortion care.

6. Integrating abortion services within mainstream maternity and women's health services minimises the stigma associated with abortion care for both patients and providers.

7. Where abortion services are provided but there is no provision for emergency or specialist care, there must be robust and timely pathways for referral.

Information provision

1. There should be local arrangements in place for providing information to women and pregnant people and to healthcare providers on routes of access to safe abortion care.

2. Services should ensure that written, objective, evidence-guided information is available in a way that is understandable to all people considering abortion. Information should be available in a variety of languages and formats.

3. Women and pregnant people should have access to objective information and, if required, counselling and decision-making support about their pregnancy options. However, there should be no requirement for compulsory counselling or mandatory time for reflection before an abortion.

Information for health workers providing abortions

Medical abortion

Before 12 weeks of pregnancy
If mifepristone is available, it is best practice to use it in combination with misoprostol as it is more effective than misoprostol alone, shortens the time taken to complete the abortion (the induction to-abortion interval), reduces side effects and decreases the rate of ongoing pregnancy. There is no lower limit of pregnancy duration at which medical abortion can be performed.

Medical abortion in the first 12 weeks can be safely managed by most people at home, is as safe and effective as infacility treatment, and can be more convenient and private for people.

The most effective regimen is mifepristone 200mg orally, followed 24–48 hours later by misoprostol 800 micrograms taken by the vaginal, buccal or sublingual route.
• If expulsion of the pregnancy has not occurred within 4 hours, a further 400 micrograms of misoprostol should be taken by the vaginal, buccal or sublingual route.
• If misoprostol is provided for use at home, additional doses should be provided in case they are required. This is especially important to consider for pregnancy durations of over 9 weeks as the effectiveness of a single dose of 800 micrograms of misoprostol starts to decline from then onwards.

If mifepristone is not available, use misoprostol 800 micrograms taken by the vaginal, buccal or sublingual route, followed by misoprostol 400 micrograms every 3 hours until the pregnancy has passed.

12–24 weeks of pregnancy

At 12 weeks or more, medical abortion is usually undertaken in a medical facility. However, there is no evidence indicating that out-of-facility medical abortion is unsafe.
If mifepristone is available, it should be used in combination with misoprostol as it shortens the induction-to-abortion interval, reduces side effects and decreases the rate of ongoing pregnancy.

The most effective regimen is mifepristone 200mg orally, followed 24–48 hours later by misoprostol 800 micrograms vaginally, buccally or sublingually, followed by misoprostol 400 micrograms vaginally, buccally or sublingually every 3 hours until abortion occurs.

Where mifepristone is not available, use misoprostol 800 micrograms followed by misoprostol 400 micrograms every 3 hours until abortion occurs.
The uterus is more sensitive to misoprostol as pregnancy advances, and therefore, in pregnancies over 24 weeks, lower doses of misoprostol should be used and increased intervals between misoprostol doses may be considered, especially for people with uterine scars.

Pain management for medical abortion

Analgesia (pain relief) should always be offered.

• Nonsteroidal anti-inflammatory drugs (NSAIDs) are recommended either prophylactically or at the time that cramping begins.

• Non-pharmacological pain management measures (e.g., hot water bottle/heat pad) may be helpful.

• Pain increases with pregnancy duration so narcotic analgesics may be required when other pain management measures are insufficient. Epidural anaesthesia can also be used, where available.

Surgical abortion

Before 14 weeks of pregnancy

Surgical abortion before 14 weeks can be performed using vacuum aspiration (electrical (EVA) or manual (MVA)).

Vacuum aspiration involves evacuation of the contents of the uterus through a plastic or metal cannula, attached to a vacuum source. EVA employs an electric vacuum pump. With MVA, the vacuum is created using a hand-held, hand-activated, plastic 60ml aspirator (also called a syringe).

• MVA aspirators accommodate 4–12mm cannulas.

• There is no lower limit of pregnancy duration for surgical abortion.

• It is best practice to inspect aspirated tissue at all durations of pregnancy, to confirm that the pregnancy has been fully removed.

• During vacuum aspiration, the uterus should be emptied using only a suction cannula (and forceps if required). The procedure should not be routinely completed by sharp curettage.

14–24 weeks of pregnancy

Surgical abortion between 14 and 24 weeks can be performed using dilatation and evacuation (D&E).

D&E requires preparation of the cervix using osmotic dilators or pharmacological agents, and

evacuating the uterus using long forceps and vacuum aspiration with cannulas. It is the safest and most effective surgical technique after 14 weeks, as long as skilled, experienced providers are available.

Vacuum aspiration can be used up to 15–16 weeks of pregnancy with larger bore suction tubing and cannulas up to 16mm in diameter.

Dilatation and sharp curettage (D&C) is an obsolete method of surgical abortion and should not be used.

Cervical preparation before surgical abortion

Cervical preparation should be used for all patients as it reduces the risk of incomplete abortion and makes dilation easier. It may cause some bleeding and pain before the procedure. If osmotic dilators are used, consider inserting them the day before the abortion, especially if pregnancy duration is 19 weeks or greater.

Before 12 weeks of pregnancy:

• mifepristone 200mg orally, 24–48 hours before the procedure, or

• misoprostol 400 micrograms sublingually, 1–2 hours before the procedure, or

• misoprostol 400 micrograms vaginally or buccally, 2–3 hours before the procedure.

12–18+6 weeks of pregnancy:

• combination of mifepristone and misoprostol*

(using above regimens), or

• osmotic dilators plus either mifepristone or misoprostol, or with both mifepristone and misoprostol (using above regimens in all cases).

19–24 weeks of pregnancy:

• osmotic dilators plus either mifepristone or misoprostol, or with both mifepristone and misoprostol (using above regimens in all cases).

Pain management for surgical abortion Analgesia should always be offered.

• In most cases, analgesics, such as NSAIDS, local anaesthesia and/or conscious sedation, supplemented by verbal reassurance, are sufficient.

• General anaesthesia is not recommended for routine use in pain management for abortion procedures, as it has been associated with higher rates of complications, and with longer hospital stays, than local anaesthesia.

• Local anaesthesia, such as lidocaine given as a paracervical block, can be used to alleviate discomfort from mechanical cervical dilatation and uterine evacuation.

• Where conscious sedation is available, it should be offered with a cervical block.

• If general anaesthesia is used, consider intravenous propofol and a short-acting opioid (such as fentanyl) rather than inhalational anaesthesia.

• NSAIDS can be used to alleviate abdominal cramping caused by misoprostol given for cervical preparation.

Information for health workers providing care after abortions

People can experience a range of emotions after an abortion. Health workers should provide information on how to access emotional support after an abortion in case this is needed.

Health workers should ensure that individuals know what to expect following the procedure and where to get help if necessary. They should also ensure that everyone who wants a method of contraception is able to leave with their method of choice or know how and where to access it.

Safety, Confidentiality and Safeguarding

Confidentiality and safety are of paramount importance to women seeking to discuss their pregnancy options and undergo abortion. The aim of the service specification is to ensure that confidentiality can be maintained while also recognising the need on occasion to share information in the interests of patients, and to ensure that guidelines on dealing with young people under 18 are observed.

The Service Provider shall ensure that all staff are aware of and abide by the legislation on safeguarding children and should also ensure that staff are aware of and abide by the safeguarding local child safeguarding policies and procedures.

Patient Journey	Service Provision
First contact with healthcare providers and onward referral	Initial assessment 1. There should be a pathway to appropriate medical care for people with known significant medical conditions (e.g., heart disease) that require specialist abortion care in a hospital. 2. People presenting for abortion who are found to have a non-viable pregnancy also require contraception and sexual healthcare. 3. People requesting abortion but who subsequently decide to continue the pregnancy should be referred for antenatal care (together with all their relevant information). 4. Services should identify people who may be particularly vulnerable (e.g., some adolescents, those in controlling, abusive relationships, people addicted to drugs/alcohol, people with moderate/severe mental health problems) and refer/signpost them on to appropriate support services. Arrangements for the procedure To minimise delay, service arrangements should be such that an abortion can be provided as soon as possible, ideally on the same day as the assessment.

	2. The setting for abortion services (consultation rooms, procedure rooms and recovery rooms) should respect the need for clients' privacy and dignity
Treatment:	Whenever possible, offer individuals a choice of abortion method. Their choice will depend on their individual circumstances and how they feel about the different options. The following information should be provided to those requesting an abortion, in a clear, understandable, non-judgemental, and respectful way: • Abortion is a safe procedure for which major complications are rare at all pregnancy durations. • The choice of abortion methods available. • What will happen during and after the abortion. • What pain management options are available. • Side effects, risks and complications of abortion methods • How to be sure the pregnancy has ended for those having a medical abortion at home. • How to identify the need to seek urgent medical attention during or after the abortion. • The range of potential emotions experienced after an abortion. • Other available services, such as sexually transmitted infection (STI) screening, counselling • for those who need it and support for those experiencing, for example, sexual coercion or • domestic violence and abuse. • What contraception options are available and how they can be accessed. Those who are unsure about whether to continue the pregnancy or have an abortion should be offered counselling/decision-making support. Further treatment (e.g., blood transfusion, laparoscopy, laparotomy or hysterectomy) may be required, should any serious complications occur. There are several myths about the consequences of abortion. Individuals who express concerns can be reassured that there are no proven associations between having an abortion and subsequent ectopic pregnancy, placenta praevia, infertility, breast cancer or mental health problems. **It is best practice to invite a discussion about contraception at the initial consultation. If a contraceptive method is chosen, that method should be provided, where possible, at the time of the abortion.** **Young people**

Adolescents deserve the same amount of respect as everyone else accessing abortion care. It's important to remember how vulnerable a young person might feel when requesting an abortion, especially if it's their first-time seeking healthcare. If the law requires an adult to consent to their procedure, this should be clearly explained to the young person at the start of the consultation. While all adolescents should be encouraged to involve a trusted adult in their decision, if possible, do not insist on parents' authorisation unless it is a legal requirement. Staff should be trained to work with young people and create a young people friendly environment

Determining pregnancy duration

The duration of the pregnancy will influence the method of abortion and whether the abortion can take place at home or should take place in a clinical facility. Pregnancy duration can be assessed from the first day of the last menstrual period (LMP). Most people can determine the duration of their pregnancy with reasonable accuracy by LMP alone. Routine pre-abortion ultrasound scanning is unnecessary but, if available, should be used if there is clinically relevant uncertainty about the pregnancy duration or if there is a suspected ectopic pregnancy. In circumstances where the pregnancy duration cannot be assessed by reliable LMP and where ultrasound scanning is not available, an abdominal examination can help determine pregnancy duration when it is over 12 weeks. A bimanual examination can be performed if the practitioner is still not sure of pregnancy duration after an abdominal examination and the information gained would change clinical management

Contraindications and extra considerations

Medical Abortion
There are few contraindications to medical abortion:

- known or suspected ectopic pregnancy
- previous allergic reaction to mifepristone or misoprostol • severe uncontrolled asthma*
- chronic adrenal failure*
- inherited porphyria. *

* Mifepristone should not be used as there is a theoretical risk of exacerbation of the underlying condition but use of misoprostol alone could be considered.

Extra consideration and additional care planning might be necessary for those:
• on long-term steroid therapy – theoretically, since mifepristone is a glucocorticoid receptor antagonist, it might inhibit the action of the steroid therapy and exacerbate the underlying condition; seek specialist input on whether dose adjustments to a corticosteroid regimen are required

	• on anticoagulant medication – anticoagulants may need to be stopped before abortion medications are administered and then restarted after the abortion • with a bleeding disorder, who may need care in a clinical setting rather than at home • with symptomatic anaemia, where the haemoglobin concentration should be measured and who may need additional care in a hospital setting. • with an IUD in place – the IUD should ideally be removed in advance of treatment; if the IUD cannot be retrieved, it is important to confirm that it is expelled during the procedure, by using imaging such as an abdominal X-ray after the abortion. **Surgical abortion** Surgical methods of abortion are contraindicated if the pregnancy cannot be removed through the cervix, for example due to an obstructing tumour. In the very rare case that a medical abortion is also not suitable in these circumstances, hysterotomy or gravid hysterectomy may be undertaken. Medical (or other) conditions and considerations can affect the choice of anaesthetic, indicate a need for the abortion to be undertaken in hospital, or require additional or specialised equipment. These include bleeding disorders and abnormal placentation, use of anticoagulant medication, and severe cardiopulmonary disease. A very high body mass index (BMI), distortion of the uterine cavity by fibroids or another anomaly, previous cervical surgery or type 3 female genital mutilation (FGM) can also make access to the cervix or pregnancy challenging. Procedure planning can include variations in patient positioning, use of longer instruments for evacuation, ultrasound guidance, and cervical preparation. **STI screening** It is best practice to undertake an STI risk assessment for everyone and conduct screening if appropriate, e.g., for chlamydia and gonorrhoea, which might be implicated in post-abortion infection, and for blood-borne viruses such as HIV and syphilis if such testing is available. This should be done without delaying the abortion. Administer treatment doses of antibiotics to those with signs or symptoms of an STI. Partners of individuals with an STI also require treatment; ideally, a system for partner notification and follow-up or referral would be in place. **Prevention of post-abortion infection** Prophylactic antibiotics are not required for medical abortion but should be used for surgical abortion as they have been shown to reduce the risk of infection following the abortion. However, surgical abortion should not be delayed if antibiotics are not available. The optimal regimen is not known but nitroimidazoles (e.g., metronidazole), tetracyclines (e.g., doxycycline) and penicillins have been shown to be effective.

	The following regimen can be considered for surgical (or incomplete) abortion antibiotic prophylaxis: • oral doxycycline 100mg twice a day for 3 to 7 days, starting within 2 hours of the procedure (there is evidence that a 3-day course is as effective as a 7-day course). **Blood tests** Pre-abortion assessment does not require routine blood tests. A determination of Rhesus blood status may be considered if the duration of pregnancy is over 12 weeks and anti-D is available. Measurement of haemoglobin concentration or other blood tests is not required unless there are good clinical indications for doing so, such as for those with symptomatic anaemia. **Contraception** Discussions about contraception should be sensitively initiated. Not all people will want to discuss contraception at the time of their abortion. Those who do should be offered information about all their contraceptive options, without any pressure to choose a particular method. Those who don't should be given information to take away Advice can be given on the greater effectiveness and duration of long-acting reversible contraception (LARC) methods (implants and IUDs) and of their safety, but no pressure should be put on clients to accept these methods. All contraceptive methods can be started at the time of a surgical abortion. All contraceptive methods except for IUDs can be started at the time mifepristone and/or misoprostol is taken for medical abortion. An IUD can be inserted following expulsion of the pregnancy after a medical abortion. Additional contraceptive precautions are not required if contraception is initiated immediately or within 5 days of an abortion. If sterilisation is requested, this should ideally only be performed after some time has elapsed after abortion. Individuals who request that tubal occlusion be performed at the time of an abortion should be advised of the possible increased failure rate and risk of regret. If a client's chosen method is not available, they should be provided with an interim, bridging method that they can start immediately, and they should be referred to a service where the preferred method can be provided. Anti-D If available, anti-D should be offered to non-sensitised RhD-negative individuals from 12 weeks of pregnancy and provided within 72 hours of the abortion. **Management of incomplete abortion**

	Post-abortion care can reduce the morbidity and mortality associated with complications of either miscarriage or incomplete abortion, including abortion that was performed unsafely. Options for management for incomplete abortion include surgical and medical methods of uterine evacuation. For those who wish to avoid another pregnancy, a contraception discussion should be offered, and the chosen method provided. Assessment Incomplete abortion should be suspected when a person of reproductive age presents with vaginal bleeding or abdominal pain after one or more missed menstrual periods. Ectopic pregnancy should be suspected if the uterus is small, the cervix is closed or there is an adnexal mass or tenderness. **Unsafe abortion** An abortion is unsafe when it is carried out either by a person lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both. In many settings it is important to distinguish between safe and unsafe abortion because the latter is much more likely to be associated with infection. Indications that an abortion has been attempted by unsafe methods include the presence of: • vaginal laceration cervical injury • uterine enlargement equivalent to a pregnancy of more than 12 weeks' duration • products of conception visible at the cervix or in the vagina • in patients with uterine injury, any of fever, significant lower abdominal pain, tenderness or abdominal distension • the presence of a foreign body in the vagina or cervix. Infection It is vital to identify those who may have an infection and to manage this urgently. Infection is much more likely, and much more likely to be severe, if the abortion has been performed unsafely. Clinical features suggestive of infection include: • temperature above 37.5°C • localised or general abdominal tenderness, guarding or rebound • unusual, unpleasant odour or pus visible in the cervical os • uterine tenderness. Features suggestive of sepsis and indicating the need for urgent intervention include: • hypotension • tachycardia • increased respiratory rate
Communication	Communicate information in a clear, understandable way. Providers should not impose personal values or beliefs on clients but focus on their needs and show empathy and respect for their reproductive decisions.

	Unless contraindicated, women and pregnant people should be offered a choice of abortion method. Clinical history taking should identify any health conditions that might affect eligibility for a particular method of abortion and any extra considerations that might affect the location of care and/or pre-treatment planning, including individuals with serious medical conditions who need to be referred for specialist care. Health workers should check that the person seeking an abortion is doing so voluntarily and is not being coerced into ending the pregnancy. They should also ask about sexual and domestic violence and abuse (physical and emotional) and be able to refer the person to appropriate support services. If the assessment is being conducted by telephone, video call or online, the provider should be confident that the person is able to speak privately without risk of being overheard. Health workers should be aware of the anxiety that clients may have about perceived negative and judgemental attitudes from healthcare providers. Health workers can help relieve anxiety, create a safe and respectful environment, and counteract abortion-related stigma by: • using welcoming words when they first meet the patient (making eye contact and smiling in face-to face meetings) • introducing themselves, explaining what the consultation will entail • structuring the consultation so that there is time to build up a rapport before exploring feelings about the pregnancy • giving clear, concise and accurate information and encouraging questions. • trying not to make assumptions and by using value-neutral, unbiased language • conveying how common abortion is. It is important that abortion eligibility by pregnancy duration is determined, that any contraindications to methods are identified and that post-abortion contraception is offered. Advice can be given on the greater effectiveness and duration of long-acting reversible contraception (LARC) methods (implants and IUDs) and of their safety, but no pressure should be put on clients to accept these methods. All contraceptive methods can be started at the time of a surgical abortion. All contraceptive methods except for IUDs can be started at the time mifepristone and/or misoprostol is taken for medical abortion. An IUD can be inserted following expulsion of the pregnancy after a medical abortion. Additional contraceptive precautions are not required if contraception is initiated immediately or within 5 days of an abortion. If sterilisation is requested, this should ideally only be performed after some time has elapsed after abortion. Individuals who request that

	tubal occlusion be performed at the time of an abortion should be advised of the possible increased failure rate and risk of regret. If a client's chosen method is not available, they should be provided with an interim, bridging method that they can start immediately, and they should be referred to a service where the preferred method can be provided.
Post Procedure Care:	Information to provide after an abortion Clients should receive instructions about signs and symptoms that might indicate a complication that requires urgent medical help, including if they: • soak through two or more maxi-size sanitary towels per hour, for 2 hours in a row • develop an unusual, unpleasant-smelling vaginal discharge • develop a fever or flu-like symptoms after 24 hours • develop worsening pain, including that which might indicate an undiagnosed ectopic pregnancy (for example, if lower abdominal pain is one-sided, under the ribs, or goes up to the shoulders). Health workers should also provide information on signs and symptoms that might indicate an ongoing pregnancy for which clients should seek medical attention, including if they: • have no bleeding or only spotting or smearing of blood on sanitary towel or underwear in the • 24 hours after misoprostol for medical abortion • still feel pregnant 1 week after the abortion.
Monitoring:	Provider should record & audit: • Date of 1st contact with healthcare staff/referral • Date of 1st consultation and assessment • Date of TOP • Time from referral to assessment • Time from referral to TOP • Number and type of procedure • Maternal age • Gestational age • Usual form of contraception used • Use of emergency contraception • Number of women referred for active follow-up by sexual • health services. • Ethnicity • Religion **Patient Experience** A patient experience exercise is undertaken at least annually and appropriate to the service user to inform service development and improvements Patients are provided with information about termination of pregnancy, follow-up, and contraception

	All above data to be reported quarterly to the ICB contracting team via identified channels. Ad hoc surveys may be required, up to one a year, to enable sexual health services in Northamptonshire to develop according to need.
Service Exclusions:	Women presenting with foetal abnormalities - who would be continue to be treated by local Maternity services. Women with partial or inevitable miscarriages, who would continue to be treated by the gynaecology services Women presenting with medical complexity and/or significant co-morbidities requiring NHS treatment https://www.england.nhs.uk/publication/provision-of-nhs-termination-of-pregnancy-centres-for-patients-presenting-with-medical-complexity-and-or-significant-co-morbidities-requiring-nhs-treatment/
Special Circumstances:	Women with severe medical conditions - arrangements need to be put in place to ensure that medical backup is available for women with complex medical conditions who require terminations. See link above for further details on new national guidance for these. Young people attending for counselling or requesting termination should be treated in line with the Gillick & Fraser Guidelines on competency. Any child protection concerns should be reported to the Child Protection nurse in the ICB. https://learning.nspcc.org.uk/child-protection-system/gillick-competence-fraser-uidelines Interpreting services should be available for each stage of the process for those who need them. It is not acceptable to rely on family or friends for interpretation. Culturally sensitive services should be provided, including access to a female doctor if required. Services should be available for couples if needed and to include pregnant people who have LD.
General Conditions:	Staff will be appropriately qualified, accredited with relevant professional bodies and participate in professional development activities. There are clinical guidelines in place as per the service specification

Telemedicine

Telemedicine (telephone, video call or online) can be used for consultations for any kind of abortion.

Consultation by telemedicine also allows people to have a medical abortion (depending on stage of pregnancy) in their own home with remote support from the abortion provider. They

do not need to see a healthcare provider in person or visit an abortion clinic, unless there is a reason to do so (e.g., unsure of date of LMP, ectopic pregnancy risk, complex medical conditions) or they prefer an in-person visit. This model of care for medical abortion at home has been shown to be safe, effective and acceptable to clients and it improves access to abortion care, enabling them to be treated earlier in their pregnancy. Where eligible, people should always be given the option to choose this model of care.

The following abbreviations and acronyms have been used in this document:

Integrated Care Board (ICB)
Independent Sector Providers (ISPs)
Royal College of Obstetricians and Gynaecologists (RCOG)
General Practitioners (GPs)
Care Quality Commission (CQC)
Required Standard Operating Procedures (RSOPs)
Termination of Pregnancy (TOP)
World Health Organization (WHO)
National Institute for Health and Clinical Excellence (NICE)

Key Performance Indicators			
KPI 1	Initial Assessment	All service users should be offered an assessment appointment within 5 calendar days of referral or self-referral.	100%
KPI 2	Initial Assessment	Average waiting time for an assessment appointment should not exceed 5 days	Average wait time not to exceed 5 days
KPI 3	Time to Treatment	All service users choosing to proceed with a termination of pregnancy should be offered an appointment for the procedure within 7 calendar days after the decision to proceed has been taken	100%
KPI 4	Time to Treatment	Average waiting time for the procedure (measured from the time when the decision was taken to proceed) should not exceed 7 calendar days.	Average wait time not to exceed 7 days
KPI 5	Performance Measure	Number and proportion of termination of pregnancies carried out under 10 weeks, by maternal age and type of termination of pregnancy	Should not be below 70%
KPI 6	Performance Measure	Number and proportion of termination of pregnancies carried out over 10 weeks, by maternal age and type of termination of pregnancy	Should not be above 30%
KPI 7	Performance Measure	Number and proportion of repeat termination of pregnancies carried out by maternal age	
KPI 8	Contraception	All service users should be given contraception advice and supplies, including long-acting methods if requested by the service user.	% of service users given contraception advice - 100% % of service users given supplies or LARC
KPI 9	STI Screening	All service users should be offered and, if accepted, screened for chlamydia, gonorrhoea and HIV	% of service users offered screening - 100% % of service users screened
KPI 10	User Experience	A patient experience exercise should be undertaken at least annually to inform service development and improvements	

KPI 11	Safeguarding	All staff should be in date with Safeguarding Adults and Safeguarding Children's mandatory training	100%

Projected Activity Data 2022/23

Termination of Pregnancy Services (TOPS)	Northants 22/23 Activity M1 to M12
Consultation	
Consultation TOP (Including Telephone)	3,424
Total:	3,424
TOPS	
Early Medical Abortion (EMA)	2,667
Medical Abortion - up to 18 wks	0
Surgical Abortion LA	89
Surgical Conscious Sedation - up to 14 weeks	101
Surgical GA upto 14 Weeks	21
Surgical GA 15 Weeks +	0
Surgical GA - 15 wks to 18 wks	52
Surgical GA - 19 weeks +	21
Total:	2,951
Contraception	
Contraceptive Patch	6
Implant	49
Mirena	37
Jaydess	3
IUCD	34
Depo Provera	24
Coil Removal	0
Nuvaring	0
Contraception Oral (not emergency)	260
Contraception Oral Emergency (morning after)	247
Total:	660
Screening	
Chlamidya Test	376
Grand Total:	**7,410**