1. SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	NCL ToPs Specification v1.3 (DRAFT) **NB THIS IS A DRAFT SPECIFICATION WHICH IS LIKELY TO BE AMENDED FOLLOWING FURTHER STAKEHOLDER FEEDBACK.**
Service	Termination of Pregnancy Services AQP
Commissioner Lead	Commissioning Lead CCG - Islington
Provider Lead	
Period	1st April 2018
Date of Review	31st March 2019

1. Population Needs

1.1 National/local context and evidence base

The purpose of a Termination of Pregnancy Service (TOP) – the 'Service', is to provide a choice of TOP methods which are timely and safe depending on the personal health, gestation and circumstances of the individual woman, to reduce repeat TOPs and unintended pregnancies and to promote better sexual health among women.

Providers of the Service (Providers) shall ensure that the overall Service is consistent, effective, comprehensive, legal and of demonstrably high quality. It shall respect the dignity, privacy, individuality and rights of women to exercise personal choice over their care and treatment. The service shall be provided in accordance with the grounds specified in the Abortion Act 1967 and amended by Section 37 of the Human Fertilisation and Embryology Act 1990.

This service model is based on the Royal College of Obstetricians and Gynaecologists (RCOG) Guideline on "The Care of Women requesting Induced Abortion" published in 2004 and updated in 2011 and current best practice. This specification shall be amended in line with any future guidance produced by the College.

The Providers of the Service will comply with safeguarding legislation (children and adults), national policy, multi-agency guidance and the commissioning CCG contractual requirements.

Commissioning Group Principles

This specification is designed for the residents of the following 5 CCGs within the North Central London region.

Barnet
Camden
Enfield
Haringey
Islington

Legal abortions: numbers by Clinical Commissioning Group, by age, 2016

Clinical Commissioning Group		Number of Abortions by Age							Number of Female residents by Key Child Bearing Age (15-44)
		Under 18	18-19	20-24	25-29	30-34	35 +	Total	
07M	NHS Barnet	41	90	325	333	289	313	**1391**	81,826
07R	NHS Camden	28	53	218	225	201	186	**911**	61,260
07X	NHS Enfield	62	115	432	415	332	328	**1684**	70,531
08D	NHS Haringey	41	118	380	418	274	266	**1497**	66,986
08H	NHS Islington	36	69	314	354	241	181	**1195**	65,259
Totals		**208**	**445**	**1669**	**1745**	**1337**	**1274**	**6678**	**345,862**

Ref(s):
https://www.gov.uk/government/statistics/report-on-abortion-statistics-in-england-and-wales-for-2016

https://data.london.gov.uk/dataset/office-national-statistics-ons-population-estimates-borough

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

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

2.2 Local defined outcomes

The expected outcomes for this Service, including improving prevention are:

1. Improved access to TOP services.
2. Reduction in the number of subsequent unplanned pregnancies among women.
3. Reduction in the numbers of subsequent TOPs among women, within a 3 year time frame without limiting access to those women.
4. Onward referral to Sexual and Reproductive Health services to include Contraceptive Services, GUM Services and HIV Services.
5. Reduction in the rate of pelvic infection among women.
6. Improved identification of women and girls with safeguarding concerns, including those at risk of harm through coercive sexual relationships, FGM, trafficking, and modern slavery.
7. Increased awareness of sexual and reproductive health including prevention of sexually transmitted infections and HIV, and onward transmission to partners.
8. Reduce the referral to treatment time for women referred to an alternative provider.
9. Increase ease of access to the service, in particular, for hard to reach groups (including those as defined by the Equality Act 2010).
10. Increase ease of access to information about what the service provides, in particular, for hard to reach groups.
11. Increase understanding of the different methods of contraception, including but not limited to the efficacy, side effects, risks and benefit of each method.

3. Scope

3.1 Aims and objectives of service

Aims

The Provider of the Service shall:

- Provide a consistent, effective, comprehensive, accessible, legal and appropriate TOP service to women, as early as possible and in consideration of personal circumstances.
- Provide a quality service informed by the Royal College of Obstetricians and Gynaecologists Guideline for the "Care of Women Requesting Induced Abortion" (the RCOG Guideline 2011), the MEDFASH standards for sexual health services and current best evidence. Deviations from the RCOG guideline shall be notified in writing and agreed with the commissioner.
- Provide a choice of TOP methods, clinically appropriate for the woman's gestation and clinical circumstances. This information, both written and verbal, shall be provided in an objective and non-judgemental way, which allows the woman to make her own choices. Staff shall respect the woman's decision. Respect and sensitivity shall be offered to women accessing this service irrespective of their circumstances, including age or repeat TOP.
- Ensure that risk of infection and other complications are minimised.
- Ensure that opportunities for contraceptive information and supply, and sexual health screening are maximised.
- Develop and implement improved access and patient care pathways to primary, community and acute providers.
- Prevent avoidable harm with robust processes for identifying risk and communicating and embedding learning from experiences.
- Ensure that staff (including counsellors) are well informed about procedures, efficacy rates, relative risks and are able to support women to make informed choices about

the method of TOP and future contraception.

- Increase sexual and reproductive health awareness among people accessing the provider site and women accessing the service.
- Identify and signpost women, who may be experiencing or may be at risk of domestic abuse, including other forms of abuse, to an appropriate service.
- Identify and report (as a crime) cases of Female Genital Mutilation (FGM) among women aged under 18 and signpost women of any age accessing the service who have experienced FGM to support as appropriate for the individual using an FGM Risk Assessment Tool and referral pathways.
- Offer face to face counselling services to women.
- Provide compulsory counselling service to women under 16 years.

Objectives

The Provider of the Service shall:

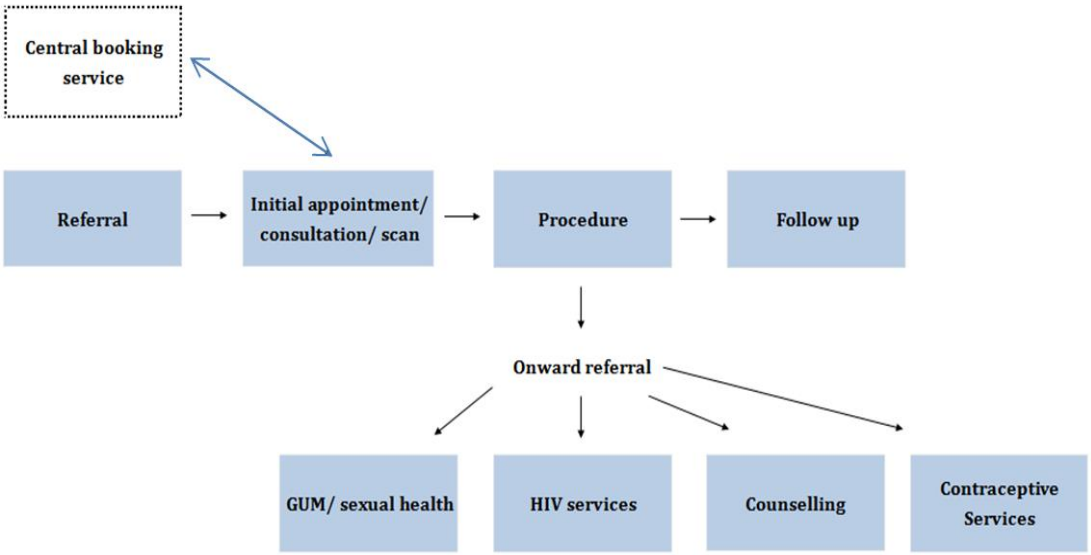
- Offer high quality, impartial support and advice to all women who request a TOP, regardless of age, ethnicity, language, disability, sexual orientation, religious or personal circumstances.
- Signpost women who, after the initial consultation, are undecided about TOP to appropriate services for support, advice and counselling.
- Provide women with access to a TOP as early as possible but procedures must be available up to the legal time limit.
- Provide a choice of TOP methods clinically appropriate for a woman's gestation and clinical circumstances.
- Improve the sexual health of women through providing sexual health screening and treatment as appropriate for Chlamydia, other sexually transmitted infections (STIs) and HIV.
- Provide information, advice and provision of the full range of effective contraception methods including Long Acting Reversible Contraception (LARC).
- Provide an assessment appointment within 5 calendar days of referral (which shall be prioritised in the case of a woman with a pregnancy at late gestation) and no later than 14 calendar days from referral. The procedure shall take place within 7 calendar days and no later than 14 calendar days from the time of decision to proceed, following the "late and complex medical cases pathway".

3.2 Service description/care pathway

Patient Pathway

The Provider of the Service shall provide TOP services to women of reproductive age referred to any approved Provider, giving greater access to appointments in a wider geographical location.

The generic patient pathway is outlined below:



* Central Booking Service will be in operation across every NCL CCG.

Within the generic overview provided above, there are six main pathways within the Termination of Pregnancy Service according to age/gestation/complexity:

- Under 18s
- Early Medical Terminations
- Early Surgical Terminations
- Mid trimester Medical/Surgical Terminations
- Late Surgical/Complex Termination

The above pathways summarise the totality of what can be provided under a TOP service, however Commissioners recognise that some Providers carry out procedures based on gestations levels; therefore, Providers will be requested to apply for the following pathways:

- Up to 10 weeks gestation
- Up to 16 weeks gestation
- Up to 24 weeks gestation

NB: Activity is provided in this format for the benefit of Providers. The CCGs in NCL are looking to commission Providers who are able to deliver services to meet the whole of the pathway. Activity provided by qualifying Providers will be monitored against the availability of gestational access across the sector.

In conjunction with the main pathway, specific additions to the individual pathways are as follows:

The Provider of under 18 year old TOP pathway shall ensure the following are in place and implemented:

- 'Spotting the Signs' pro-forma – the aim of this pro-forma is for TOP providers to identify young people who may be at risk or experiencing sexual exploitation.
- The under 18 pathway will be split into subsets according to age: under 13s, 14-16, and 16-18. These subsets have specific safeguarding guidance for providers outlined in the *Safety, Confidentiality and Safeguarding* below.
- Providers to be more prescriptive of referrals into support services for example, onward referral into contraceptive services for young women who are unable to choose a contraception method on the day, and compulsory face to face counselling for under 16s.

Early Medical pathway shall include:

- Follow-up/referral by the Provider into local contraceptive services for women requesting Long Acting Reversible Contraception (LARC) which is unable to be fitted on the day.

Early Surgical pathway shall include:

- Provision of patient accessible information relating to TOP procedure including the different types of anaesthetics for surgical terminations. Anaesthetics for this service include: local anaesthetic, conscious sedation, and general anaesthetic.

Mid trimester and Late Surgical (19-24 weeks), shall involve, for some providers:

- Close working with Acute Trusts where interventions are not suitable in community settings and may need to be transferred.

Complex care pathways shall involve, for some providers:

- Close work with a direct referral to Acute Trusts where interventions are not suitable in a community setting and a transfer/ referral for the provision of best care is necessary.

In all pathways. The Providers shall ensure that women have access to appropriate pain relief and that women are aware about the pain relief options available to them.

Medical Exclusions / Unsuitability of TOP under AQP Specification

In addition to the complex pathway, an exclusions list has been developed for this Service. The section below outlines 'complex' medical conditions under the Termination of Pregnancy Service - Any Qualified Provider (AQP) contract. Women with any of the conditions listed below are excluded from this Service, and require a TOP procedure to be carried out within NHS Acute care.

- **Anaemia** - this is not generally tested before the procedure but if the haemoglobin is tested and is known to be low (less than 8g/dl), alternative arrangements for TOP at an NHS Hospital is to be made.

- **Asthma** - uncontrolled by therapy, defined by hospital admission within last 3 months, oral steroids within last 3 months, recent change to medication without re-evaluation by GP or chest physician. (Wheezing on the day of the procedure will be a contraindication in both NHS and Independent sector).

- **Bleeding disorders** – haemophilia, Von Willebrand's disease, sickle cell disease.

- **High Body Mass Index** - Women with a BMI of 40 and above.

- **Cardiovascular disease** - previous myocardial infarction, congestive heart failure, uncontrolled angina defined by chest pain in the last 3 months. Congenital or acquired cardiac conditions such as valvular disease with or without pulmonary hypertension.

- **Cerebrovascular disease** - any history of cerebrovascular accident (CVA) or Transient Ischaemic Attack (TIA).

- **Chronic disease with systemic illness** – liver, renal, autoimmune.

- **Current anticoagulant therapy** - being treated by warfarin, low molecular weight heparin, or Direct Oral Anticoagulants (DOAC).

- **Hypertension** - systolic BP >160mm Hg and/or diastolic BP > 90mm Hg on 3 or more readings.

- **Lung Disease –** COPD and emphysema which is affecting pulmonary function.

- **Porphyria.**

- **Seizure disorder uncontrolled by therapy -** defined by women who have discontinued treatment without supervision, recent change in their treatment, or a new onset of unknown cause. 'Controlled' is defined as an absence of seizures for one year.

- **Thyroid abnormalities** especially hyperthyroidism.

Health care professionals referring women for abortion should check the medical history and if in doubt about any condition, should check with the Provider to ensure the woman is not delayed in the process.

Other conditions where additional and specific planning is required:

- Women on current corticosteroid therapy
- Insulin dependent diabetes
- Rheumatoid arthritis – currently treated with DMARDs, or corticosteroid therapy
- Cancer – women who have a current diagnosis, or undergoing treatment for cancer
- Conditions that can affect surgical abortion
- Fibroid uterus
- Multiple caesarean section or uterine scarring from myomectomy
- Congenital abnormality of uterus
- Thrombophilia (bleeding/clotting disorders) Venous thrombosis and pulmonary embolism – for women who have been recently diagnosed and currently undergoing treatment

For all pathways, Providers are required to work closely with sexual health, contraceptive, HIV, counselling, psycho-sexual, IAPT, secondary care, and drug and alcohol teams in the local area; this is to ensure Patients continue to receive required support after their procedure, with onward referrals made into these services where appropriate. In addition, Providers are required to sign-post women to resources in their local area, along with online support forums; ensuring women are fully informed of further sexual health, counselling and reproductive services they are able to access post termination.

For Women who fall outside of this specification either due to high complexity and/or late gestation period, the TOP procedure will be carried out by a designated specialist NHS Acute provider. The local providers pertinent to NCL patients are St. Georges, Kings College, Imperial College and Homerton Hospitals. For the purposes of billing and coding these will come under the standard PbR tariff within the relevant Acute or Specialist contract with the Commissioners. Access to the service may need to be referred from GP or other Acute/Local TOPs providers.

Access

Providers shall ensure that:

- Referrals into the Service shall include self-referrals and the Provider shall participate in any local centralised booking system where commissioned.

- Where a centralised booking system has been commissioned it is expected that all Providers, provide all their available appointments to the CBS to enable women to access the first available appointment which suits their needs.
- When developing referral pathways and criteria, care shall be taken to minimise the amount of bureaucracy needed for women to access a TOP (RCOG Chapter 6 recommendations)
- Flexibility of access, including evening and weekend clinics.
- Effective close working arrangements with local Early Pregnancy Units (EPUs) and the foetal medicine scanning departments to allow women to move from antenatal care into TOP services seamlessly.
- Services are provided in line with eligibility for NHS services. Eligibility criteria for women wishing to access an NHS-funded TOP shall be well-publicised and clear. In the first instance eligibility shall be agreed if a woman is registered with a GP in the listed CCG areas. NHS contractual and constitutional requirement states NHS funded services should be offered to unregistered patients (i.e. homeless). The funding of which is to be provided by the CCG borough where they are considered a resident.
- The Service offered is respectful and does not discriminate on grounds of age, gender, sexuality, ethnicity or religion. Services shall be accessible to the needs of women whose first language is not English and those with hearing, learning, visual or physical disability. A female doctor shall be available for women that request this (RCOG recommendation 2)
- All Provider sites shall be easily accessible by public transport and must provide information about parking. Provision shall be made under the Disability Discrimination Act, to ensure that disabled women are able to access the Service.
- All Provider sites shall include adequate security arrangements to ensure the protection of women attending the premises.
- Acceptance of referrals from a wide range of sources, including but not limited to: health professionals, community contraceptive services, GUM clinics and from services run by third sector organisations, the Local Authority, including schools and colleges, young people's services, Sexual Assault Referral Centres (SARCs) and social services.
- Where the referring doctor has not provided a signed form HSA 1, or in the case of self-referral it has not been possible to complete the Form, the Provider shall make the necessary arrangements and bear overall responsibility for completion of the forms required under the Abortion Act. This process shall comply with the legal requirement for two separate signatures from two separate doctors.
- All women accessing the Service are offered an assessment appointment within 5 calendar days of referral or self-referral.
- Once the decision to proceed has been taken, all women accessing the Service are able to have the TOP procedure undertaken within 7 calendar days. The minimum standard is that the TOP shall take place within 2 weeks (14 calendar days) of the decision being taken to proceed. However Providers shall aim to enable all women to be able to have the TOP within 7 calendar days.
- No woman shall wait more than 3 weeks (21 calendar days) from initial referral to time of TOP (above two points RCOG recommendation 7).
- Local referral forms may be developed to ensure consistency and minimise delays. Self-referrals are supported, but services should signpost clients to local abortion providers without needing to use time and resource completing unnecessary referral

forms.

Service Delivery

Acceptability:

The Provider shall ensure that:

- The assessment appointment is within clinic time dedicated to women requesting TOP (RCOG recommendation 8).
- Women accessing the Service are seen within half an hour of their appointment time and flow through the clinic shall be without undue delay.
- Appointments are not cancelled by the Provider. Where this cannot be avoided, the woman must be offered another appointment within 5 calendar days. The Commissioning organisation must be informed of all such cancellations as part of quarterly monitoring returns.
- All women accessing the Service are offered a chaperone for any examination. If a chaperone is present a record shall be made of the identity of the chaperone. A chaperone policy shall also be visible and available to women.
- Waiting areas have sufficient seating to accommodate the number of women accessing the Service and their partners. Such areas shall take into account the comfort of those waiting for others as they may experience an extended wait during a consultation or procedure. Support and advice shall also be available for the partners of women accessing the Service if required.
- Women accessing the Service are cared for by staff who are trained and competent in caring for women undergoing TOP, evidenced by records of training and regular appraisal and supervision.
- At no time during the assessment or procedure shall women accessing the Service 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 TOP is managed on a day care basis (RCOG recommendation 9).
- Women accessing the Service having second trimester TOPs by medical means are cared for by an appropriately trained and competent experienced midwife or nurse. Ideally they shall have the privacy of a single room (RCOG recommendation 12).
- Where possible, women accessing the Service, who have not yet had a TOP, shall be kept separate from those who have already undergone their procedure. Women in the initial stages of recovery from anaesthesia shall be given privacy as they pass through this stage.
- Women sometimes return years later to ask what happened to the foetus. It is important that the Provider can demonstrate that appropriate arrangements were made and maintain records of the arrangements.
- If there is a need to ensure that the products of conception are retained for criminal paternity testing, then the Provider shall work with the woman, the police and any of the Patient's other support workers or advocates determining the most appropriate method of TOP. The method shall be what is best for the woman and linked to gestation.
- Women accessing the Service are able to consult the service without the presence of a partner or guardian and are always seen alone at some point in the consultation. In some cases with children who are not Gillick competent, they may need to be seen with the responsible adult as defined by Statute.

- Sustaining an unintended pregnancy is stressful. Needing to use TOP services may produce a variety of feelings, including anxiety, guilt and fear. It is important that health professionals are sensitive to the woman's needs and feelings. Information, both written and verbal, shall be provided in an objective and non-judgemental way, which allows the woman to make her own choices. Staff shall respect the woman's decision. Respect and sensitivity shall be offered to women accessing this service irrespective of their circumstances, including age or repeat TOP. Women should be signposted and encouraged to discuss their feelings with appropriate support including liaison with IAPT/GP.

Safety, Confidentiality and Safeguarding

Confidentiality and safety are of paramount importance to women seeking to discuss their pregnancy options and undergo TOP. The Provider of the Service shall ensure that confidentiality is maintained while also recognising the need, on relevant occasions to share information in the interests of Patients and the wider public and to ensure guidelines relating to young people under 18 years are observed.

The Provider of the Service shall ensure that women who seek a TOP following rape receive services and care which acknowledge and respond sensitively to their situation.

The Provider shall ensure that a written confidentiality policy is prominently displayed and made available to women accessing the Service. The policy needs to clearly state the circumstances in which other agencies may need to be informed. Staff delivering the Service shall be able to demonstrate an understanding of the policy and process and be able to communicate this to women.

All Providers of the Service shall have arrangement and provision for Safeguarding Leads to be in place.

The Provider of the Service shall ensure staff understand and implement processes to enable Patient Informed consent. This shall include the woman's ability to understand the choice available and the consequences of the choice, including the nature, purpose and possible risk of any treatment (or non-treatment). In assessing Patient understanding the Provider shall comply with the Department of Health reference Guide to Consent for Examination or Treatment (2001)

The Provider shall ensure that:

- Information to Patients shall either be provided in relevant community languages or women whose first language is not English, shall be offered access to a trained advocate or to a local interpretation scheme e.g. Language Line, for which the cost shall be payable by the commissioning organisation. Local arrangements shall be in place for access to advocacy services (if commissioned) through the commissioning organisation. The use of family members for translation purposes shall never take place.

- Confidentiality is maintained throughout the visit, including the minimal use of names in public areas, such as the reception or waiting areas.
- Information is not sent to the Patient's home address, unless the Patient expressly wishes this, in order to maintain confidentiality.
- Information is not shared with anyone else, including the Patient's General Practitioner, without her consent. However, this does not apply to information which

must be sent to other agencies to comply with the Abortion Act 1967 and the Care Standards Act 2000. For under 18's, this must be made with consideration with the Children's Act of 1989.

- Information for women accessing the Service and professionals shall emphasise the duty of confidentiality by which all health care professionals are bound. This applies to all women, regardless of their age, providing that they are assessed as competent under the Fraser Guidelines (RCOG recommendation 15).

Consent

The Provider shall ensure that:

- A policy is in place and implemented for obtaining consent that complies in all respects with the requirements of National Minimum Standards and the Private and Voluntary Healthcare (England) Regulations 2001 and any other relevant guidelines.
- Competent consent is understood in terms of the woman's ability to understand the choices available to her and their consequences including the nature, purpose and possible risk of any treatment (or non-treatment). In assessing competence, the Provider needs to refer to the Department of Health Reference Guide to Consent for Examination or Treatment (2001)
- Any competent young person, regardless of age, may independently seek medical advice and give valid consent to medical treatment. Young women under 18 years of age are able to access TOP services and treatment. Under 18s shall be strongly encouraged to talk to their parent or carer about the fact that they have an unwanted pregnancy, but parental consent is not required. Support and the presence of a third party at all stages of the procedure shall be available if required
- In the case of young women under 16, the Provider shall follow the advice set out in the guidance issued by the Department of Health (July 2004: Gateway Reference 3382.)

Additional provisions for young people:

The Provider shall ensure that the Service achieves the "You're Welcome" accreditation within 12 months of its launch.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216350/dh_127632.pdf
http://www.youngpeopleshealth.org.uk/yourewelcome/

Under 18s:

- The Provider shall ensure, for Patients under 18 years accessing the Service, are aware that they can consult the Service in confidence.
- Competency is understood in terms of the young person's ability to understand the choices and their consequences, including the nature, purpose and possible risk of any treatment (or non- treatment).
- Parental consent to that treatment is not necessary if the young person is deemed Gillick competent.
- The Provider shall ensure that there is awareness and understanding by staff delivering the Service that, although the majority of <18 year olds are in consenting relationships, occasionally young people may be in abusive relationships and may need additional support. The Provider shall consult with local safeguarding teams and

comply with local safeguarding procedures.

- Staff delivering the Service understand that, although it is preferable for young people to have their parents' support for important and potentially life changing decisions, young women may chose not to be accompanied by their parents and may request for their parents not to be informed of a medical consultation or its outcome. The doctor shall not override the young Patient's views.
- In line with Fraser guidelines, young women under-18 years shall be allowed to consult the Service without the presence of a parent/carer or guardian. However, they should be encouraged to have support and presence of a 'trusted adult' chosen by them at all stages of the procedure

Young people under 13 years:

Young people under 13 years of age are not considered capable of consenting to sexual activity (Sexual Offences Act 2003) and Providers who see a young person of this age shall ensure they follow their local safeguarding procedures.

Face to Face Consultations for Under 18's:

During the initial call into the Service, all clients must be given the option on how they would like their assessment consultation as per RCOG guidelines, however young people under 18 shall be encouraged to have a face to face consultation. If a telephone consultation is chosen and during the consultation the Health Professional has concerns around the 'Gillick' competency for a client under 18 years old, then a mandatory face to face consultation will be needed to ascertain whether safeguarding procedures need to be implemented. If a mandatory face to face consultation is declined by the client in this case, then local safeguarding policies should be followed.

Health professionals should adhere to BMA guidance which states Health professionals who assess competence need to be skilled and experienced in interviewing young patients and eliciting their views without distortion.

Support, Advice and Assessment Appointment

The Provider shall ensure that:

- The content of the assessment, the standards to which the assessment is carried out and confidentiality women can expect to receive, shall be the same regardless of which setting or settings are used to carry out the assessment.
- Clinical staff undertaking assessment are appropriately trained and experienced and the assessment is undertaken in accordance with the RCOG Guideline and any other appropriate current and emerging clinical evidence or guidance.
- A dedicated clinic for the support, advice and assessment of women requesting a TOP is provided.
- A mechanism to minimise the number of empty appointments and ensure timely access to the Service is implemented.
- Those not wishing to proceed with a TOP, by whatever method, are referred back to the original referrer and the referrer shall be notified of the reason for this, in writing, providing the Patient consents to this action.
- Informed consent to examination and/or treatment is obtained and standard procedure followed as per the Provider's protocol regarding consent.

- The method of TOP, the risk of complications and the arrangements for TOP, is discussed with the woman and supported with accessible written information.
- If the Patient's pregnancy is of more advanced gestation than the Service can cater for, or the Patient has a significant medical condition requiring specialist care, then the Patient shall be referred into the appropriate care pathway.
- If miscarriage is diagnosed, the Staff delivering the Service shall obtain the Patient's consent for a medical or surgical evacuation as appropriate, or shall refer the Patient to other services for evacuation, if she prefers.
- Patients have the opportunity to discuss their contraception needs, and receive an appropriate method of contraception, which may be supplied before or following the procedure (see Contraception below).

Assessment

The Provider shall ensure:

- On site availability of screening, treatment and partner notification (where required) for Chlamydia, Gonorrhoea and Syphilis infection. Clear mechanisms for notifying the woman of results shall be in place.
- Onsite near patient testing for HIV. Clear mechanisms for notifying the woman of results should be in place. In the case of a reactive result, referral into appropriate HIV clinical service for confirmatory testing and care.

The Provider shall ensure that Patient assessment includes:

- Confirmation of pregnancy and assessment of gestational age by physical examination/ ultrasound examination/medical history according to patient choice and/or clinical need.
- General medical examination to determine Patient fitness for procedure, as per RCOG Guidance.
- Any woman whose test result for Chlamydia is not available prior to the procedure shall be treated prophylactically. Women with a positive Chlamydia result prior to procedure shall receive treatment. Treatment shall be given in accordance with BASHH guidelines.
- Referral to GUM services for further STI screening if required and in all cases where a positive result is given.
- Appropriate pre-procedure blood-testing including HIV/STIs, as per RCOG Guidance.
- Information about post procedure support.
- Advice provided on pregnancy options shall cover the benefits and risks of continuing with the pregnancy or opting for TOP and shall be provided by staff who are competent to advise on these benefits and risks and supported with written information.
- If the Provider determines that the woman might benefit from additional support, the Provider shall ensure every opportunity is offered to the woman to access this support and a referral shall be made to the appropriate service.
- All women, including those who are not found to be pregnant, shall be offered advice on contraception together with the supply of an appropriate contraceptive method (see Contraception below) either at the time of procedure, at a follow up appointment, or

through referral to a local community contraceptive service.

- Those not wishing to proceed with TOP shall be referred back to the original referrer (if any) and the referrer shall be notified of the reason for this, in writing, providing the user consents to this action, and advised of the need for prompt access to antenatal care. The Provider shall also direct women to self-refer to appropriate services.
- Condoms shall be offered to all women at the assessment appointment as a method of preventing STIs, and the Provider shall ensure that the women know how to use them correctly. Information shall be given to women about the availability of condoms in their local area.
- All assessments will include screening for vulnerable adults, child protection, domestic violence, gender based violence as per RCOG Guidance.

TOP procedure

The Provider shall ensure that:

- Clinical staff undertaking the procedure are appropriately trained and experienced and the procedure shall be undertaken in accordance with the RCOG Guideline 2011 and any other appropriate clinical evidence or guidance.
- Clinical appraisal / revalidation procedures are in place to ensure that clinicians keep up-to-date with the continuing professional development requirements set down by their professional body.
- Access to specialist care in the case of complications and/or in the case of an unexpected ectopic pregnancy diagnosis.
- Foetal tissue is treated with dignity and respect in accordance with local policies, which reflect the Human Tissue Authority's Code of Practice 5, *Disposal of human tissue.* Attitudes towards disposal may vary widely among cultures and religions. Full account shall be taken of any personal wishes that have been expressed about disposal.
- If there is a need to retain the products of conception, then these shall be recovered and stored according to instructions from the police, ensuring there is no risk of contamination.
- Compliance with RCOG 2011 Guidelines, and any subsequent update on these guidelines.
- Appropriate pain relief is offered to all women and all aspects of care shall be in line with RCOG guidance.
- Women who are RhD-negative are offered anti-D immunoglobulin. The woman's GP shall be informed immediately in the case of refusals (subject to consent).
- Most women shall only require day care involving one or two visits. The Provider shall have access to inpatient care if complications occur. Additionally all Women will be able to access the NHS in the event of an emergency. Written procedures covering arrangements for dealing with any post-operative complications including bleeding, infection or continuing pregnancy are in place.

Aftercare/Post TOP Support and follow-up arrangements

Aftercare and follow-up are crucial to ensuring that women experience the best possible outcomes. The Provider shall ensure that women receive suitable aftercare and follow-up, delivered in an environment which meets their needs:

The Provider shall ensure that:

- Women accessing the Service receive verbal and written information on discharge, which explains the likely course of recovery, including pain and bleeding. Symptoms indicating deviations from the normal course of recovery and/or symptoms of a continuing pregnancy must be explained and the women must be advised how and when to seek medical help. Providers shall ensure that women understand the information they have been given.
- Telephone support is offered for the next 24 hours following the procedure for Patients who choose an early medical TOP and opt to go home once they have their medication. This shall be encouraged for women who live locally. Should Patients wish to remain at the facility, a quiet space is made available for them.
- As well any verbal and written advice given before discharge, women accessing the Service shall also have access to 24 hour telephone advice.
- Women accessing the Service receive follow-up care as required post TOP. This follow-up care can be provided either by the Provider, the woman's GP, or by the community contraceptive services, depending on the woman's preference (RCOG recommendations 5.2 and 5.3) or if the woman prefers, by telephone.
- Clinical staff undertaking follow-up care are appropriately trained and experienced and that care is provided in accordance with the RCOG Guideline and any other appropriate clinical evidence or guidance.
- Clinical appraisal / revalidation procedures are in place to ensure that clinicians keep up-to-date with the continuing professional development requirements set down by their professional body.
- Follow-up appointments, including appointments for post TOP support and contraceptive advice are confirmed by written material provided to Patients when they attend for the initial assessment appointment but may also be booked at the time of treatment.
- Women accessing the Service are given a written account of the symptoms they may experience and those that would make an urgent medical consultation necessary (RCOG recommendation 5.2).
- Other services which provide follow-up care are informed in writing of the date of a TOP, method used, any complications, any physical, psychological or social problems, antibiotic treatment, screening results, contraception provided (including none), any referrals made to other services.
- Where Patients need post-TOP support in addition to clinical follow-up care, Providers shall ensure that vulnerable women, particularly young women who have sought a TOP without their parent's knowledge, or Patients who are victims of rape, are referred post-abortion into an appropriate care pathway commissioned by the relevant Commissioner.
- Women accessing the Service are provided with contraception advice and information. Women who are undecided on their preferred contraception method, or unable to have their preferred method installed due to the type of TOP procedure carried out i.e. LARC during a Medical TOP, shall be provided with contraception leaflets, as well as leaflets to local GUM and contraceptive clinics.
- Women accessing the Service who have been identified with safeguarding concerns, should be provided with support information, including social services, police, psychological support etc. The Provider shall ensure that Safeguarding Alert

procedures are complied with.

- Women accessing the Service are sign-posted to relevant local support services in their area, which may include but are not limited to: online forums, contraceptive services, sexual health services, drug and alcohol services, mental health services such as IAPT, secondary care services such as HIV clinics, etc.

Contraception

Use of effective contraception will help to promote better sexual health among women and reduce unintended pregnancies and the need for repeat TOPs. The Provider shall facilitate contraception with the aim to ensure that women accessing the Service receive an effective method of contraception of their choice which suits their health and other needs. All methods of contraception shall be discussed in line with FSRH Guidance, this is the standard by which all contraception should be prescribed:

The Provider shall ensure:-

- Contraceptive information and advice is provided to all women accessing the Service.
- All methods of contraception including Long Acting Reversible Contraception (LARC) are offered by the Service. The methods shall be discussed and offered in line with NICE Guidance.
- Staff providing contraceptive advice must have a sufficient level of training and competency to discuss all methods of contraception, their mode of action, their efficacy in a range of circumstances, their benefits and risks, to enable the woman to make an informed decision about an appropriate method for them, depending on their health and personal circumstances. All staff who provide contraceptives shall have the correct training, skills and experience to enable them to supply/fit safely and effectively.
- Women who wish to continue with their pregnancy shall be signposted towards their general practitioner for access into ante-natal care and supplied with details of local contraceptive services and advised to contact these services after the birth of their child.
- Women who are not pregnant or who have a miscarriage shall be supplied with their chosen method at the assessment appointment, where possible. Consent must be sought and contraception provided by appropriately trained and competent staff.
- Women who wish to proceed with TOP shall be supplied with their chosen non-LARC method (including contraceptive pills) at the assessment appointment or procedure, or any chosen method immediately following the procedure. Consent must be gained for any treatment (where necessary) and it shall be provided by appropriately trained and competent staff.
- Women who choose a non-LARC method of contraception shall receive condoms from the Provider and supplied with details of their local sexual health and GP services. If it is not possible or appropriate to supply the woman's chosen method an interim method shall be supplied and the chosen method shall be supplied at the follow-up appointment. If the appointment shall be conducted by the woman's GP or another service, then the Provider shall provide details of the woman's chosen method in the discharge letter.
- Women shall be advised to practice safe sex including condom use to be discussed by the Provider with all women. Condoms to be offered to all women including a condom demonstration if appropriate

- The Provider shall ensure that the woman is aware of where they can access emergency contraception in their local area.

Sharing of information between professionals

- The GP, referring doctor/nurse and doctor providing follow-up care shall be informed in writing of the date of TOP, method used, antibiotic treatment and other medical problems, any complications or referral to other services and arrangements for contraception and follow-up (subject to consent.)
- Notification of major complications must be provided to both the referrer and the commissioner and the woman informed of the GP's notification due to aftercare requirements.

Monitoring staff quality

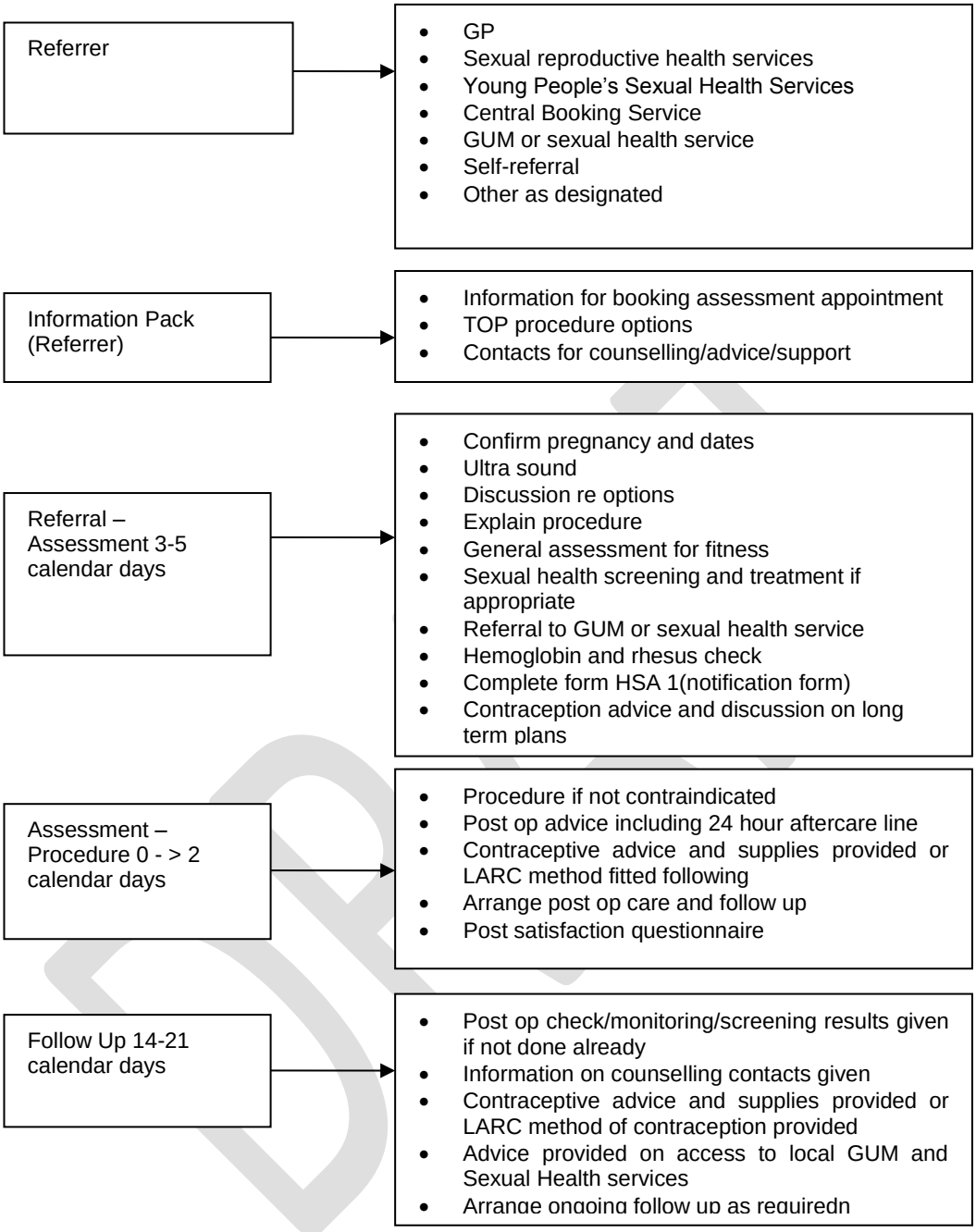
- Clinical audits shall be undertaken regularly. Professional and support staff shall be involved in the audit of organisation care. Professional staff shall undertake interdisciplinary clinical audit and receive clinical supervision.
- Clinical staff undertaking either TOP procedures or the fitting of contraceptive methods must be appropriately trained, experienced and supervised ensuring that all clinical competencies are met and maintained. For example, letters of competence and or supervision on fitting 12 devices a year, etc.

Women's experience

Feedback from women and other stakeholders beyond direct service users' is essential to developing quality TOP services. The Provider shall ensure that such feedback together with other relevant information is used to assist performance management and improve service delivery. Mechanisms to gather feedback shall include, but not be limited to:

- All women having a TOP shall be asked to complete an anonymous post treatment satisfaction survey within a timescale agreed between the Commissioner and the Provider. The survey results shall be forwarded to the Commissioner on a quarterly basis so that they can be used for performance management and service planning in line with CQC standards. The information gathered by the patient satisfaction survey shall be taken into account when reviewing standards as part of clinical audit and when reviewing commissioning arrangements.
- The Provider shall put in place and maintain throughout the episode of care an effective representation and complaints procedure and have systems in place, which monitor the incident and outcome of all complaints and investigations regarding the service.
- Serious incidents shall be reported to the individual commissioning organisation as soon as possible.
- Complaints shall be reported to the individual commissioning organisation quarterly.
- Safeguarding incidents shall be reported to the individual commissioning organisations as soon as possible.

Care pathway



In implementing this care pathway, the Provider will work collaboratively and integrate with local health services to deliver all the essential criteria and standards of the TOP services set out in the entirety of section 3 of this specification.

3.3 Population covered

- Women registered with a GP in the geographical area covered by the North Central London Clinical Commissioning Groups.
- Women resident within the Boroughs of North Central London Clinical Commissioning Groups.

The Services are being commissioned over 5 CCG areas whose population are as follows

Geographical Areas	Services Being Procured	Population
NHS Barnet CCG	TOP Service with Central Booking Service	TBC
NHS Camden CCG	TOP Service with Central Booking Service	TBC
NHS Enfield CCG	TOP Service with Central Booking Service	TBC
NHS Haringey CCG	TOP Service with Central Booking Service	TBC
NHS Islington CCG	TOP Service with Central Booking Service	TBC
TOTAL		TBC

Source: https://www.england.nhs.uk/?s=CCG+population 2017 Registrations

3.4 Any acceptance and exclusion criteria and thresholds

Exclusions:

- Prisoner health.
- Women ineligible for NHS treatment.
- Women not registered with a GP or resident in the areas of the commissioning organisations.
- Women post 24 weeks gestation.
- Complex medical cases may be excluded in some settings as per the pre-existing conditions policy – see medical exclusions list under section 3.2.
- Women requiring an overnight stay, including miscarriages.
- Women referred for a termination of pregnancy due to foetal abnormality (TOPFA) – this is NHS England commissioned activity.

3.5 Interdependence with other services/providers

- The service shall receive referrals from sexual health and reproductive healthcare services and general practice for the majority of the women accessing the service.
- The Provider shall work with the police and courts and other services such as crisis centres, offering support to women who are victims of rape or domestic violence
- Chlamydia Screening Programme – women are screened on an opt out basis and Chlamydia coordinators shall ensure all test results are sent to Providers for the woman care and audit purposes and reported by the relevant date
- All other STi screening will be done as indicated and provided on an opt put basis.

The service provider should have clear documented criteria for referral to NHS, which are freely available to clinical staff. If a patient requires referral to an alternative provider such as the NHS for a TOP of pregnancy due to complicating conditions or co-morbidities, these cases should be retained and intensively managed by the Provider to ensure the patient receives a clinical assessment and an appointment with the Provider. The clinical outcome shall be obtained by the Provider. Where the individual Patient is further referred, they shall continue to be supported by the Provider until the individual receives their chosen outcome. Where consent is given, the patient's GP shall be advised of the Patient's pathway and outcome.

Where referral out of the services is required the turnaround time for referral shall not be longer than 24 hours.

The key stakeholders and relationships to this service include:

- Drug and alcohol services
- Sexual and Reproductive Healthcare services
- Young People's Sexual Health Services

- NHS gynaecological services
- GUM services
- Chlamydia Screening Office
- Social Services
- Public Health
- Children's centres
- A&E services
- Safeguarding Teams

Information Management and Technology (IM&T)
The Provider shall ensure IM&T systems are effective for referrals and bookings, including appointment booking, scheduling, tracking, clinical capture and coding and any onward referral of patients for further specialised care provided by the NHS, independent sector or social care and must be compliant with choose and book requirements. The IM&T system should allow for safeguarding and/or vulnerable person alerts.

The Provider shall be responsible for all software licences for those applications.

4.1 Applicable national standards (e.g. NICE)

The Medical Foundation for AIDS and Sexual Health (MedFASH) produced standards on sexual health services (Recommended Standards for Sexual Health Services, MedFASH, March 2005), setting out best practice across the whole field of sexual health for both providers and commissioners. A copy can be accessed using the link below:-
http://www.medfash.org.uk/publications/current.html

The National Institute for Health and Clinical Excellence (NICE) has produced a clinical guideline on long acting reversible contraception (The effective and appropriate use of long-acting reversible contraception, NICE, October 2005) which discussed the efficacy of contraceptive methods and the efficacy in particular of long acting reversible contraception. A copy can be accessed using the link below:-
http://www.nice.org.uk/CG030

The British Association for Sexual Health and HIV (BASHH) produce a number of guidelines on best practice and evidence-based treatment of a number of Sexually Transmitted Infections. The most up to date BASHH guidelines can be accessed using the link below:-
http://www.bashh.org/guidelines

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

The Royal Colleges of Obstetricians and Gynaecologists produced guidance on TOP services (The Care of Women Requesting Induced Abortion, RCOG, 2011) and this sets out best practice in delivering TOP services. A copy can be accessed using the link below:-
http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion

4.3 Applicable local standards

- Standards set out in the 'Service description' of section 3.2 of this specification

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4 Parts [A-D])

5.2 Applicable CQUIN goals (See Schedule 4 Part [E])

6. Location of Provider Premises

The Provider's Premises are located at:
For early medical abortions, a facility in each CCG's locality, otherwise within 2 hours travelling distance of the woman's borough of residence, based on use of public transport.

7. Individual Service User Placement

Not applicable

Tariff
This tariff is based on an active payment system applied across circa 21 of the 32 CCGs in London with the net inflator, deflator and growth for 2017/18 applied as set by NHS England in the Financial Planning Guidance.

Abortions	Price		Contraception	Price
Consultation	£63.00		IUCD	£40.40
Early Medical (to 9 weeks +6 days)	£301.00		IUS	£106.00
Medical 10 - 18+6 days	£507.02		Implant	£112.11
Medical 19+0 – 24+0	£959.50		Depo	£10.10
LA to 12+0	**N/A**		Nuvaring	£25.25
LA to 14+0	£297.00		Patch	£18.18
CS to 14+0	£300.00		Fitting only	£20.20
CS 14+1 -19+0	£407.03		Vasectomy	**N/A**
GA to 14+0	£304.00		**Screening***	**Price**
GA 15 -18+0	**N/A**		Gonorrhoea	£4.04
GA 14+1 -19+0	£570.65		Syphillis	£20.20
GA 19+	**N/A**		HIV	£27.27
GA 19+1 -24+0	£959.50		***Chlamydia included in service * Contraceptive pill and condoms included in the cost of the procedure**	
Post Abortion counselling (when procedure delivered by another provider)	£66.00			

The tariff will incur annual net inflator, deflator and growth as set by NHS England.