Health and Social Care Committee Inquiry: Delivering Core NHS and Care Services during the Pandemic and Beyond

Marie Stopes UK Written Response

Executive Summary

1. This submission is made on behalf of Marie Stopes UK. Marie Stopes UK is an independent provider of abortion care services throughout England, and a country programme within the global charity, Marie Stopes International. Marie Stopes UK provides quality abortion services to more than 62,000 women every year, with 42 abortion clinic locations in England. We can offer both medical and surgical abortion services, as well as counselling, and post-abortion contraception. We also provide vasectomy services to around 5,000 men every year at 25 sites across England.

2. Marie Stopes UK runs clinics out of 42 sites across England. We describe these sites as Centres (premises that only provide Marie Stopes UK services) which offer both early medical abortion and surgical abortion services, and Early Medical Units (clinics hosted from within a GP surgery or Healthcare Centre) which offer early medical abortion (EMA). We have 7 Centres and 35 Early Medical Units.

3. Abortion is the most common medical or surgical procedure performed in the UK, and one in three women in Britain will have an abortion by the time they are 45.[i] Our clinics across the country support and care for those who choose to access their legal right to an abortion as outlined in the 1967 Abortion Act. Abortion is an essential service for hundreds of thousands of women in the UK every year, and an incredibly time sensitive procedure.

4. During the Coronavirus pandemic, several barriers were identified with the provision and access of abortion care emerging from social-isolation and other measures to prevent and manage COVID-19 infection. We are proud to have been able to overcome many of these barriers to continue to deliver this core NHS service. This submission will address three points of the Committee's inquiry:

   - Meeting the wave of pent-up demand for health and care services that have been delayed due to the coronavirus outbreak.
   - Providing healthcare to vulnerable groups who are shielding.
   - How to ensure that positive changes that have taken place in health and social care as a result of the pandemic are not lost as services normalise.

5. The most impactful positive change to the delivery of our service during the coronavirus crisis has been the implementation of our at-home early medical abortion service via telemedicine. This is following the temporary authorisation of a patient's home being a class of place from where she can use both mifepristone and misoprostol medications to begin a medical abortion. This has been authorised up to 10 weeks gestation.

6. We are delighted we have been able to implement an effective service in response to the crisis. A two month follow up of all telemedicine clients is planned to consult with them on their experience and preferences. We are collecting this data for research to understand the benefits and risks to our clients of the approach, so we can evaluate the impact and make future improvements to the pathway in collaboration with other providers

and with one of the world's leading research units into abortion care pathways based at the University of Texas. We would be happy to share this data with the Health and Social Care Committee at a future date.

Meeting the wave of pent-up demand for health and care services that have been delayed due to the coronavirus outbreak

7. Many GP surgeries across the country have closed and offer telephone appointments only. This has impacted two of our Early Medical Units, with our Southend-on-Sea Clinic and Plymouth Clinic premises closing. The closures of these host premises are out of our control. Our 7 Centres will remain open and during the COVID-19 crisis we have been able to run 90% of all our planned clinics.

8. Delays to care have been experienced by women who felt unsure if leaving their homes to attend their abortion appointment would class as "essential" under the government's guidelines. In the week before the authorisation of the home use of mifepristone we saw the rate of clients who did not attend their booked appointments double to approximately 15%. Now that women have access to our "at-home" service, the rate of clients that do not attend their appointment (now over the phone) has decreased lower than pre-COVID-19 rates.

9. Our appointment waiting times have remained within the National Institute for Health and Care Excellence (NICE) and the Royal College of Obstetricians and Gynaecologists (RCOG) guidelines, ensuring minimal delay to care, and ideally providing the assessment within 1 week of the request and the abortion within 1 week of the assessment. [ii]

10. Providing telemedicine "at-home" services and best-practice in abortion care

11. Prior to the introduction of at-home services, we modelled the 2020 abortion procedures forecast on the latest available Office of National Statistics (ONS) data for England & Wales.[iii] Over three quarters (80%) of NHS funded abortions took place under 10 weeks gestation (160,000 procedures). Of these 160,000 procedures, based on our current modelling, an average of 13,300 service users per month would be eligible for at-home EMA via telemedicine. Every month, this service would therefore negate the need for around 13,300 people to leave their homes to make unnecessary journeys during a period in which we are being advised to stay home where possible. The ability for us to provide an at-home EMA service has already allowed over 2,400 women to access our care without needing to break social distancing or social isolation guidelines.

12. Medical team member absences impacted on our services and caused some delays to care before the authorisation of the home use of mifepristone on 30th March 2020. Our Early Medical Abortion Physicians are now able to carry out their crucial roles while in social isolation as their home is authorised as a class of place from which to certify abortions and prescribe EMA medication. This is especially important as our Early Medical Abortion Physicians are predominantly younger doctors, often with young children, and so have a higher chance of having to care for dependents at home due to school closures.

13. To further ensure continuity of services and minimise delay to care before 10 weeks gestation, we strongly recommend task-sharing considerations, to authorise nurses and midwives to certify abortions and prescribe the EMA medication in line with NICE abortion care guidelines.[iv] With increased volumes of clients being transferred to us from NHS Trust abortion services, it is essential to remove the avoidable delays to timely care.

14. Our EMA telemedicine service was launched on Monday 6th of April and saw a 10% increase of daily calls in this week. We believe that clients were delaying booking an appointment until it was possible to take both EMA medication at home. Many clients also called to change existing appointments to the new service in order to suit their need to isolate.

15. Clients who meet our telemedicine eligibility criteria will be able to have their medical abortion consultation with a Marie Stopes nurse or midwife conducted remotely over the phone. They then have the option to collect a specially designed medical abortion pack from a Centre or Early Medical Unit or have it posted to their registered address in England. The new pathway follows best practice set out in NICE and RCOG/RCM/FSRH/BSACP joint guidelines to improve access for women, and particularly for vulnerable groups.[v]

16. Clients who do not fulfil the eligibility criteria, will be booked into a face-to-face appointment for a gestation scan and EMA care if eligible. Clients who have specific safeguarding concerns around home-use abortion are booked into a face-to-face appointment or for a surgical abortion. Fitting of Long Acting Reversable Contraception as post-abortion contraception is available for face-to-face clients. We are able to post other methods, such as the contraceptive pill, to telemedicine clients if this is their preference.

17. Informed consent for at-home EMA consists of a dialogue between clinician and client and is evidenced and recorded within the medical records system. Clients receive a link to detailed written information and the consent form in advance of their consultation and discuss it during the consultation. We have found that this improves the quality of the consultation as the client has had a chance to consider her treatment options prior to the consultation appointment.

18. All aspects of good practice can be achieved via remote consultations. NICE guidance recommends this approach, as there is good evidence telemedicine improves access to abortion care, is acceptable to women and is safe.[vi] Counselling, safeguarding, providing information, discussing options and taking informed consent can be done effectively by phone or video call. Of course, some clients will need or benefit from face-to-face assessment, but for most this isn't necessary.

19. Working with NHS Trusts

20. Many NHS Trusts are showing consideration for the urgency of abortion care throughout the crisis period, but they recognise the need for support from the independent sector. Our nurses, midwives, doctors and call centre teams have been asked to take on additional patients from some NHS Trusts, which are having to suspend surgical termination of pregnancy services whilst they re-direct resources. As things stand, we have been approached by 15 NHS Trusts & Clinical Commissioning Groups (CCGs) to ask if we can support them to deliver abortion services for patients in their area.

21. Prior to government introduced measures to prevent the spread of the virus, 72% of all abortions in England and Wales were provided in the independent sector at specialist clinics such as Marie Stopes UK. During this crisis and given the pressure on acute hospitals to focus on COVID-19, this share is rising.

22. Unfortunately, there has been indication that some Trusts are not considering the urgency of abortion care in the midst of this crisis. In the West Midlands, a CCG has blocked us from treating two women who approached us directly as they were unable to access care from providers in their area before passing the gestation threshold for at-home EMA. It is our understanding that choice of NHS provider is guaranteed for non-urgent care when waiting times are being breached, in accordance with the NHS constitution and NHS Choice Framework. With an urgent, time sensitive and essential service such as abortion care, the same should be true, particularly during a time of increased strain on NHS services.

23. Due to these instances we have had concerns over CCGs who have exclusive or 'sole provider' contracts with single abortion care providers. This is a high-risk approach in areas of high population, as there is no

resilience should that provider run into workforce difficulties during this crisis. This may mean patients facing delays to their treatment (meaning they may fall into a higher gestation band) or they may have to travel long distances to receive care.

Providing healthcare to vulnerable groups

24. In March 2020, the UK Government announced measures to slow the spread of COVID-19, including working from home recommendations and school closures. Many parents are now juggling work at home with full-time childcare responsibilities. Women who are single parents would find it near impossible to arrange childcare should they need to attend a face-to-face abortion care appointment during this time, due to this and social distancing guidelines. There are also instances where there is no option to leave the home; those with symptoms of the virus in their household, self-isolating and those who are shielding.
25. Our ability to offer at-home EMA via telemedicine has worked to remove the barrier to medical abortion care that self-isolation or shielding for health reasons created.

26. Accessible services for domestic abuse survivors

27. We know that some of our most vulnerable clients will be impacted by social-isolation and an inability to leave their homes to visit our clinics. Women's Aid have suggested that COVID-19 is becoming a way in which abusers will further control victims every move.[vii] Controlling pregnancy and / or contraception is a method of control widely used by perpetrators of domestic abuse, over a third of domestic abuse begins or worsens in pregnancy.

28. Given our role on the frontline of supporting women in communities across the country, we care for many who are facing domestic abuse. Domestic abuse is one of the issues most commonly disclosed to teams in our clinics. In our supportive and non-judgemental environment, people often feel more able to reach out to us about issues of protection. year we identified hundreds of cases of domestic abuse, both current and historic, and made many Social Care referrals due to domestic abuse concerns. When we identify protection issues, we work collaboratively with women and girls to support them in taking whatever next steps they are comfortable with.

29. Safeguarding can be conducted effectively over the phone. Our teams are trained to develop a rapport with clients and have considerable skills and experience in face-to-face consultation. The initial feedback from our teams is confidence that safeguarding is equally effective, if not more effective, through remote consultation.

30. At the time of writing, we have surveyed 108 clients who have completed treatment through the telemedicine service and all of them reported that they had the opportunity to ask any questions or raise any concerns. All reported that they could talk privately during the consultation.

31. We perform our initial safeguarding checks during the first telephone contact with a client as standard. In the past few months this safeguarding protocol initiated multi-agency action in major safeguarding cases, demonstrating that telephone assessment can be a powerful tool when used by experienced, trained teams. One involved the identification of a human trafficking ring, in which two clients were successfully treated and the police were able to rescue a number of women.

32. We have noted an increase in flagged safeguarding concerns since the social distancing measures with a 21% increase in all safeguarding concerns (Table 2) and a 15% increase in safeguarding concerns specifically linked to domestic violence (Table 1). All types of safeguarding concerns can include domestic violence, honour based violence, homelessness, child sexual exploitation, mental health issues, rape or

sexual assault, modern slavery and reproductive coercion. Our robust safeguarding protocols continue to identify these issues over the phone as well as we would have in the face-to-face clinic environment.

Domestic Violence	**Safeguarding Concerns raised**	**%**
Before Lockdown 8th - 22nd March	90	15% increase
During Lockdown 23rd - 8th April	105	

Table 1: Domestic violence safeguarding concerns raised pre-social distancing and during social distancing.

All Types of safeguarding	**Concerns raised**	**%**
Before Lockdown 8th - 22nd March	629	21% increase
During Lockdown 23rd - 8th April	779	

Table 2: All safeguarding concerns raised pre-social distancing and during social distancing

How to ensure that positive changes that have taken place in health and social care as a result of the pandemic are not lost as services normalise

33. The authorisation of at-home EMA and telemedicine has ushered in the ability for us to provide a modern abortion service in line with best practice. The approaches that we have been able to implement were already recommended in the 2019 NICE guidelines and we are able to show that they improve access, allows for an effective and caring service, and that this model of care is welcomed by NHS patients.

34. The feedback and service data we are monitoring shows that at-home EMA telemedicine is a viable service during the pandemic and beyond. We will be happy to share our research on this abortion pathway when collated and will use this to make our evidence-based recommendations to continue the availability of this service as services normalise.

35. Further changes that can be made to reduce delays and to improve access to NHS care

36. As seen above, one practical and effective solution to the problem of decreased access to abortion services during the pandemic has been the introduction of the at-home EMA telemedicine service.

37. However, the approval order that permits the use of mifepristone and misoprostol at home in England is restricted to pregnancies under 10 weeks gestation. There is no medical rationale for this arbitrary limit, and the effect is restricted access. The Scottish government has not imposed a gestation limit on their at-home EMA authorisation and leave it to clinical judgement in line with published guidelines.[viii]

38. We recommend amending the home use of mifepristone and misoprostol approval order to be in line with that of Scotland so that the arbitrary gestation limit for access to EMA is removed. The decision for what treatment is most appropriate should be one based on an informed choice of the client following the evidence-based advice of her clinical team.

39. The current law on abortion in Britain requires that two doctors provide signatures to certify that the abortion is in line with the grounds outlined in the Abortion Act 1967. This requirement is not clinically necessary. Due to innovations in care since the Abortion Act 1967, independent clinics that provide abortions are increasingly led by Registered Nurses and Registered Midwives. In Britain, NHS nurses and midwives are authorised to manage miscarriage by providing the same procedures and medication that is involved in abortion care, and yet are not permitted to perform that same care for abortion services users. There is no clinical reason why this should be the case and we strongly support task-sharing in abortion care provision for nurses and midwives to be authorised to perform procedures they are appropriately trained for in line with their professional body's requirements and guidelines. Delays could be made worse during this pandemic due to not being able to utilise our nurses and midwives fully.

40. We recommend the authorisation of nurses and midwives to prescribe abortion medications and certify the legal grounds for an abortion to strengthen the essential abortion care health systems against doctor absence and to avoid delays to care.

41. We also recommend removing the need for two doctors to certify the grounds for an abortion, permitting one registered medical professional (doctor, nurse or midwife) to certify the legal grounds for a requested abortion in good faith, to strengthen the essential abortion care health systems against doctor absence and to avoid delays to care.

End Notes

[i] Royal College of Obstetricians and Gynaecologists, (2017) "Abortion Care: Our Responsibility". Available at: https://www.rcog.org.uk/globalassets/documents/members/membership-news/og-magazine/spring-2017/abortion-care-services.pdf

[ii] NICE, (2019), "Abortion care NICE guideline [NG140]". Available at: https://www.nice.org.uk/guidance/NG140

[iii] Department of Health and Social Care, (2019), "Abortion Statistics for England and Wales: 2018". Available at: https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2018

[iv] Ibid.

[v] FSRH (2020) "FSRH, RCOG, RCM and BSACP launch joint guidance on COVID-19 and abortion care". Available at: https://www.fsrh.org/news/fsrh-rcog-and-bsacp-guidance-on-covid-19-abortion/

[vi] NICE, (2019), "Abortion care NICE guideline [NG140]". Available at: https://www.nice.org.uk/guidance/NG140

[vii] Womens Aid, (2020), " Survivors say domestic abuse is escalating under lockdown". [Press Release] 28th April 2020. Available at: https://www.womensaid.org.uk/survivors-say-domestic-abuse-is-escalating-under-lockdown/

[viii] Scottish Government, Chief Medical Officer Directorate (2020), "Abortion – Covid-19 – Approval For Mifepristone To Be Taken At Home And Other Contingency Measures", [Letter]. Available at: https://www.sehd.scot.nhs.uk/cmo/CMO(2020)09.pdf