Welsh Government consultation: Termination of Pregnancy arrangements in Wales

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Our response is based on the information available in the consultation. While we welcome in principle the change in routine practice outlined in the consultation, we ask that in order to protect patient safety that the service is regularly audited and reviewed, and that any safety incidents or any quality improvement needs are shared across Wales as part of a national approach.

1. **Do you consider that the temporary approval has had a positive impact on the provision of abortion services for women accessing these services with particular regard to safety, accessibility and convenience of services? Please provide your reasons**

We support the evidence showing that the temporary approval has had a positive impact on the provision of abortion services, providing effective, safe, and improved access to care. We are encouraged by:

- How the use of new technologies, including telemedicine, has resulted in a drop in average gestation and abortions being performed earlier than ever before. We are aware from recent DHSC data, that since the introduction of telemedicine, 30% of abortions now happen before 6 weeks' gestation, compared to only 13.5% in the same period in 2019.

- The results of a recent analysis of medical abortions which have showed shorter waiting times, earlier access and improved effectiveness for abortions conducted using a telemedicine-hybrid service than for those conducted in-person (footnote Lancet ref?).

- How telemedicine services have helped people to be seen on average 4.3 days earlier by virtual consultation. Increased flexibility and new access opportunities to services to support early termination of pregnancy would appear increase effectiveness by offering patients better control over the timing at which they took the medication.

- Evidence that shows significant adverse events are rare for women accessing the pills via a telemedicine service and clinical outcomes with telemedicine are equivalent to in-person care.

- The overall acceptability in the analysis of traditional vs telemedicine services which showed 96% approval, with 80% reporting a future preference for telemedicine.

- The reduction in the risk of women being confronted by anti-abortion protesters when attending a bricks and mortar clinic. These women often report being watched, observed, and being made the feel guilty. There have been multiple reports of women knowing a protester outside the clinic, compromising their privacy. Telemedicine therefore reduces the number of women exposed to this damaging activity.

- The added flexibility of the temporary approval for women and removal of barriers such as travelling long distances to a licenced clinic, taking time off work, and covering or paying for childcare.

While we support the positive impact of the temporary removal and the added flexibility for accessing services, we are cognisant that not all women and girls will have access to an electronic device in order to be able to undertake a remote consultation and there may be other barriers. We believe it is essential that people are given a choice of service provision to help overcome such barriers.

2. **Do you consider that the temporary measure has had a positive impact on the provision of abortion services for those involved with service delivery? This might include greater workforce flexibility, efficiency of service delivery, value for money etc. Please provide your reasons.**

Anecdotally, we have heard that staff involved in triaging patients consider that the service is continuing to be delivered to a high standard

Remote consulting enables greater workforce flexibility, for example, in cases of staff shielding and access to a wider pool of staff across a larger geographical area. It must however be considered that time, resources, and training are required to undertake video or telephone consultations, and this should continue to be available to those providing the service. The time spent in consultations with patients, whether provided in person or remotely, is likely to be similar.

3. **What risks do you consider are associated with the temporary measure? If you consider that there are risks, can these risks be mitigated?**

We would be concerned of the risk that people may access the service, under the temporary measure, when their pregnancy may potentially be over 10 weeks gestation. We appreciate this risk is very low but should be considered i.e. according to a large-scale analysis of abortion provision before and after the change in regulation, 0.04% of abortions appeared to have been provided at over 10 weeks' gestation. More recent assessments indicate that the risk within the BPAS service is lower, at around 1 in 3285. This is roughly 14 times lower than the risk of a pregnancy ending in stillbirth.

Mitigating this risk will require providers to have discussions with people in the same way as other kinds of risks and complications of abortion treatment. Healthcare professionals are the best people to determine what they need to discuss with their patients and will ensure all individuals have the relevant information to make an informed choice.

To mitigate the risks associated with medicine supply, the safe and effective use of medicines should underpin these arrangements. This includes mifepristone, misoprostol and analgesia, as well as anti-emetics, prophylactic antibiotics and ongoing contraception where used. Therefore, it is essential that all services have clear arrangements in place for confirming each medicine, including analgesia, is appropriate and safe for an individual patient. Where services are being provided remotely, remote access to clinical information and a discussion with the patient will be key components of confirming the safe use of medicines.

There are potential safeguarding and women's safety risks detailed in question 5.

4. **In your experience, have other NHS Wales services been affected by the temporary approval? If so, which?**

We are supportive of the data that suggests that the temporary approval has had a positive effect on other NHS Wales services. For instance, BPAS data from April – July 2020[1] shows that complications for Early Medical Abortions declined compared to the same period in 2019. The risk of continuing pregnancy after treatment fell by three-quarters to 0.28%, down from 1.12%, potentially as the result of women being able to choose the best time for them to start the procedure, rather than having to fit it around their commitments in addition to the in-clinic appointment for the first medication. The same data shows that the risk of major complication (usually the only kind of complication that need hospital care) fell by 2/3rds from 0.09% to 0.03% thereby reducing pressures on NHS Trusts.

Existing DHSC provisions ensure that independent abortion care providers provide follow-up care for women who access care with them. They have 24-hour aftercare phone line staffed by trained clinical staff, they provide in-clinic appointments for women with suspected incomplete abortions or retained products of conception, and they provide post-abortion counselling where a woman requires it. Telemedicine has not changed this. Uptake of pre and post counselling is low and has been provided via a telephone service prior to the telemedicine service being initiated.

We welcome the reduction in gestation which means more women can access early medical abortion, reducing the need for surgical services and releasing capacity for other medical procedures.

5. **Outside of the Covid-19 pandemic, do you consider there are benefits in relation to safeguarding and women's safety in requiring them to make at least one visit to a service to be assessed by a clinician? Please outline those benefits.**

We would advocate for patient- centred approach to the provision of abortion services where clients can choose their preferred method of service delivery. There must however be assurances that abortion services will continue to provide in-person care where people would prefer it or when telephone consultations raise potential safeguarding concerns such as safety or privacy at home, ability to consent, or wider safety concerns surrounding existing children or statutory concerns such as Female Genital Mutilation.

While we appreciate that safeguarding issues or coercion may be more difficult to detect via a remote, non-face to face, consultation, we are encouraged by anecdotal reports that providing care remotely for abortion has led to increases in the number of women disclosing problems at home. We are aware that BPAS has reported that in the first three months of their Pills by Post service, the number of clients completing enhanced safeguarding risk assessments increased.

Additionally, some women seeking access to services are in relationships or home environments where their behaviour and travel are monitored which means travelling to an abortion clinic is

difficult or dangerous. Telemedicine enables these women to access abortion care without risking their personal safety.

We believe considerations must be given to the method of virtual consultations. We note that the preferred option for women in one survey is for telephone consultation rather than video consultations yet some other services specifically recommend use of video consultations to reduce the risk of coercion (e.g., moving the camera to check who else is in the room with the patient). Where there are safeguarding issues that cannot be resolved remotely, women should be seen in person. The preference for use of telephone vs video consultations may need further research to mitigate against any safeguarding and coercion risks.

In addition, some women may find remote consultations impossible to access (e.g., lack of privacy at home for a remote consultation) and therefore alternative options should be available and we would advocate patient choice.

To ensure confidentiality is maintained the postal or courier delivery service needs to be robust.

6. **To what extent do you consider making permanent home use of both pills could have a differential impact on groups of people or communities? For example, what is the impact on people with a disability or on people from different ethnic or religious backgrounds?**

Based on the information available it is difficult to determine the impact on age (for example, younger women may have less privacy at home) and it is unclear if there is any impact on ethnicity or disability. Any changes made must be responsive to individual patient needs

Being able to remotely access services from the privacy of home may be especially significant for women in remote parts of Wales, since having to travel away from home to access care may be difficult to keep private in a small community. However, the ability to access urgent care should any adverse outcomes occur may be even more challenging in remote locations and therefore arrangements must be put in place for this before women in remote locations are supplied with medical abortion treatments as part of contingency plans.

Also essential to the safe use of medicines is women receiving clear information about how to take their medicine and when to seek further help. Information may need to be provided in multiple formats, recognising an individual woman's level of literacy, health literacy and languages spoken. Work should be undertaken with patient representative groups and health literacy experts to ensure information resources are fully accessible. In addition, consultations should be structured to confirm a patient's understanding of the information, especially as this may be more challenging in a remote consultation.

7. **To what extent do you consider that making permanent home use of both pills for EMA would increase or reduce the difference in access to abortion for people from more economically disadvantaged areas or between geographical areas with different levels of disadvantage?**

By giving women more choice about how to access care this could have a positive impact on socio-economic equality. There is also a financial benefit by reducing the costs of travel to clinics and a reduced need to be absent from work.

However, some women may find remote consultations impossible to access and therefore alternative options must be available.

8. **Should the temporary measure enabling home use of both pills for EMA:**
   1. Become a permanent measure?
   2. Remain unaffected (i.e. be time limited for two years and end two years after the Coronavirus Act came into force (25 March 2022), or end on the day on which the temporary provision of the Coronavirus Act 2020 expire, whichever is earlier).
   3. Other [please provide details]?

Based on information available, it appears that women are well supported by the clinical specialists providing this service. The service appears to run well, and it provides quicker access and more choice for women. We believe, based on experience to date, it would be clinically appropriate to continue with the arrangements.

However, more evidence of the impact of the change to this service needs to be collated and shared before a permanent change is made. Any national guidelines that are in place should be regularly reviewed and changed as appropriate based on good practice or in response to a safety incident.

Abortion care should be evidence-based and reflect the best possible care available to women. Telemedicine is potentially able to provide up to date, high quality care going forward. Further research, particularly on acceptability, will be necessary post pandemic.