The NICE Guideline Scope will inform a new NICE guideline on Termination of Pregnancy which is expected to be published in Autumn 2019 at the request of the Department of Health in England. According to NICE, the aim of this guideline is to help ensure that termination procedures are carried out based on the best available evidence, and that services provide safe and appropriate access to women who require a termination of pregnancy.

FSRH have responded to the consultation on this draft guideline scope with feedback that aims to ensure that the guidance will be fully encompassing and reflective of FSRH’s Vision. Overall, most of FSRH’s feedback involved broadening the scope of the guidelines, as well as emphasising issues around access, particularly in terms of initial access to abortion services.

**Current Practice**

The NICE guideline scope includes a summary of the current practice for termination of pregnancy. Under this section of the guideline scope, FSRH have emphasised the need to include information about the background change of the increased offer of local anaesthetic and sedation options for surgical procedures and the resulting impact on service delivery.

**Equality Considerations**

The NICE guideline scope provided a list of inequalities which may impact access to terminations. These include people who live in remote areas and people who have complex pre-existing medical conditions, amongst other aspects. FSRH’s response emphasised that obesity should be included as a pre-existing medical condition and that vulnerable women should include those who are limited in accessing services as a result of domestic abuse, or for fear of domestic abuse.

**Key Issues and Questions**

In the guideline scope, NICE identified a number of key issues and drafted questions relating to these. FSRH looked at the key issues and questions that NICE have identified and have highlighted areas where the guideline scope needs to be broadened or clarified.

**Termination of Pregnancy**

FSRH proposed the following amendments to the following questions relating to Termination of Pregnancy:

2.1 *Is it safe and effective to start termination before there is ultrasound evidence of an intrauterine pregnancy (that is, before the appearance of a yolk sac)?*

FSRH agreed that the question around terminations before evidence of an intrauterine pregnancy should also cover cases where there is no gestation sac.

2.5 *Should misoprostol be routinely used for cervical priming before first trimester surgical termination of pregnancy?*
FSRH noted that this question should be broadened to reflect whether cervical priming itself should be routinely used before first trimester surgical termination of pregnancy, rather than just misoprostol.

2.8 For women who are having an early (up to 9 weeks) medical termination of pregnancy, what is the effectiveness, safety and acceptability of mifepristone and misoprostol given simultaneously compared with giving them 24 hours apart?

FSRH highlighted that the guideline scope should cover early medical terminations throughout the first trimester, rather than the first 9 weeks, and should look at the safety and acceptability of mifepristone and misoprostol given simultaneously compared with any other window of time, rather than only 24 hours apart.

2.11 For women who are having medical termination of pregnancy and plan to use the progestogen-only contraceptive implant afterwards, does inserting the implant at first dose of mifepristone influence the efficacy of the termination?

When it comes to care after termination of pregnancy, FSRH highlighted that the question of using progestogen-only contraceptive implants should instead refer to ‘progestogen-only contraceptives’ to reflect the fact that this should also cover injectable forms of the contraception.

Care after termination of pregnancy

3.1 What is the best method of excluding an ongoing pregnancy after early (up to 9 weeks) medical termination of pregnancy, when the expulsion has not been witnessed by healthcare professionals (for example expulsion at home)?

FSRH proposed an amendment to this question in order to cover terminations up to 10 weeks rather than 9 weeks.

3.2 For women who have had medical termination of pregnancy and plan to use the progestogen-only contraceptive implant afterwards, does provision of the implant immediately improve uptake and prevent future unwanted pregnancies compared with offering to insert it later?

FSRH noted that the scope of this question should be broadened in order to cover medical as well as surgical terminations.

Service configuration

4.2 What factors influence women’s access to termination of pregnancy services, and what affects their satisfaction with their services?

FSRH emphasised that there is an issue around access which they hope will be encompassed within this, particularly in relation to initial access to abortion services.