From: (NHS ENGLAND & NHS IMPROVEMENT - X24)
[mailto: @nhs.net]
Sent: 21 May 2020 09:34
Subject: FW: URGENT Information and Action re: Pills in the Post ToP service
Importance: High

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To: GM CYP Clinical Director's and Heads of Nursing

Dear All,

Below is some feedback from the CMO in about an issues which is building linked to the Pills in the Post ToP service.

the CMO for met with the CQC on behalf of all Regional CMO's yesterday and has since shared that the CQC have been aware of an escalating risk around the 'Pills by Post' process for TOP during Covid, especially the process linked to 3 independent providers, BPAS, Marie Stopes and NPAS, since the 1st May 2020. This led to an abortion task force meeting last week and a review by the RCOG also last Friday. There was an indication that there had been a judicial review that Ministers are also being kept updated.

shared that the CQC indicated that they are aware of 13 incidents related to this process, which when compared to the number of TOPs using Pills by Post (circa 16,000 since March) is a very small number, though recognising that the impact of poor outcomes for women is tragic.

herself had been made aware of 10 incidents across 6 organisations on her DOMs calls and forwarded the list of those incidents to the CQC so that they can x-ref with their list if they are already known. In we are aware that there have been 2 maternal deaths linked to this issue also. One case where a woman was found at home the morning after starting the process and the second where a woman presented with sepsis and died very quickly in the A&E dept. Neither of these women were known to our maternity or gynae services as far as we are aware.

The incidents in range between women attending ED with significant pain and bleeding related to the process through to ruptured ectopics, major resuscitation for major haemorrhage and the delivery of infants who are up to 30 weeks gestation. There was also a near miss where a woman had received the pills by post and then wished for a scan so attended a trust and was found to be 32 weeks. There are 3 police investigations in linked to these incidents and one of those is currently a murder investigation as there is a concern that the baby was live born. The PM is being undertaken by a home office pathologist.

reports that it was clear on the call that the only reporting of incidents, to the CQC, from this sector are those that are significant i.e. babies that are found to be a late TOP, as all the other outcomes are seen to be a complication of the process which could occur in any setting. There is therefore no data to compare current outcomes to.

Given the perceived small numbers of incidents there is concern that there is a risk of changing the process and that having a greater impact on women and girls choices. There is therefore a real need for us to better understand the outcomes for the women who are presenting to NHS services. The balance of risk both physically , mentally and for safeguarding is challenging especially without data.

The CQC will present the issue to Nigel Acheson as Deputy Chief Inspector of Hospitals and the link to the RCOG to consider a joint letter being sent to all NHS Trusts about this concern and will be setting up a reporting process. As this may take some time to set up, therefore an interim process is needed.

I have therefore been asked as the Regional Chief Midwife to:

1. Request that the D/HoMs alert the ED, EPAU, Obstetric team and paediatric services within the trust to be aware of any presentations of girls and women to their services with complications of this process

2. Ask if the D/HOMs would capture any reports from their organisation

3. Request that all the incidents collected by the D/HoMs is passed to the Regional Chief Midwife who can pass the incident to me for onward dissemination to the team who are working on this

I would be grateful for your support with this request.

Finally I would like to ask any of you who may be aware of any such similar cases already, that I am not aware of to please contact me asap so we can keep a record of the issues in pertaining to this issue and if necessary inform the CQC.

BW

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Links to online resources COVID-19

	RCOG – Landing Page for all Infection and Pregnancy guidance	Link
	RCM - Landing Page for all covid-19 guidance	Link
	Refer patients for help from NHS Volunteer Responders	Link
	SBLCBv2: Covid-19 information	Link
	Revised Guidance PPE – from PHE Infographic PPE	Link Link
	HEE - Landing Page for Covid-19 training programme for health and care workforce	Link
	NHS Specialty guidance during the pandemic - landing page for all specialties	Link