Abortion Access in Rural and Coastal Areas of England: Place-based Barriers to Abortion Care

BPAS
Centre for Reproductive Research & Communication

Lancaster University

Contents

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Executive Summary

This project – a collaboration between Lancaster University and BPAS - was brought together to connect the Renewed Women's Health Strategy 2026's strategic prioritisation of improving access, quality and reducing inequalities in abortion care with the reality of abortion provision in rural and coastal areas. This policy brief provides an overview of the challenges abortion seekers face when they live in these places and spaces. It focuses on two areas to demonstrate the issues: Lancashire and South Cumbria, and Lincolnshire. Synthesising available data, the policy brief compares abortion services in these rural and coastal settings against current quality standards and commissioning guidance. This offers an insight into whether the standards are clearly being met.

Based on the available evidence and Freedom of Information Act (FOI) requests to Integrated Care Boards in both areas, this policy brief indicates that the reality of abortion access in rural and coastal communities is not in line with NICE Quality Standards' or NHSE Abortion Commissioning Guidance and accompanying Commissioning Principles. Patients in these rural and coastal communities do not have a choice of method in their local area and may need to travel out-of-region. This creates additional costs, contravenes the Renewed Women's Health Strategy, the NICE Quality Standards and the NHS Commissioning Principles. It means abortion services are not equitable.

The review makes three core recommendations to ensure that abortion access and abortion care in rural and/or coastal settings in the UK is improved. These are:

1. **Adopting a place-based approach to designing and commissioning abortion services to ensure that the NICE Quality Standards and NHSE Commissioning Guidance are met in rural and coastal areas;**
2. **Integrating the Chief Medical Officer's recommendations on addressing the 'coastal penalty' and evidence of rural health access disadvantage into strategies to improve abortion services; and**
3. **Establishing a national audit of abortion services, addressing the paucity of data on abortion, and connecting data sets to proactively monitor and respond to inequalities.**

Overview of Abortion Services Context

Abortion law has seen significant political and legal interest in recent years, most notably through moves towards decriminalisation and 'buffer zones' around clinics. Clinical practice has also shifted significantly since 2020, with the introduction of telemedicine, a shift away from routine pre-abortion ultrasound scans, and home-use of mifepristone. Access to abortion services is also receiving attention in policy. The Renewed Women's Health Strategy 2026 [1] sets "straightforward access to safe and high-quality [...] abortion care" [2] as a strategic priority. It recognised that "too many women still face barriers shaped by geography, circumstance, culture or fragmented care" [3], the existence of "inequalities in abortion care"[4], and the absence of quality and performance data to measure the standards of abortion services. These statements are welcome and overdue. They also offer a space to prioritise access and foreground geography in the conversation about abortion inequalities, choice of method, and how to ensure we can guarantee abortion services are performing as they should.

Yet, like the 2022 Women's Health Strategy, the refreshed 2026 strategy is a work in progress[5]. It offers a broad direction of travel – towards workforce investment, introducing requirements on Integrated Care Boards to implement the NHS Recommendations on Commissioning, and increasing surgical capacity at a local level. But the next steps are still missing, as is the relationship between the commitments on abortion in the Women's Health Strategy with other Government plans and reviews.

Nowhere is the absence of detail starker than in relation to "barriers shaped by geography"[6] – a phrase mentioned in passing in the Women's Health Strategy 2026 but not discussed. We know that women who must travel further for services and those living in rural areas, carry the burden of abortion access inequalities. However, the 2026 Women's Health Strategy does not mention 'rural' or 'transport' once. Neither does the Renewed Women's Health Strategy mention health in 'coastal' regions – even though the Chief Medical Officer has previously highlighted how health inequalities are most pronounced among communities living at the coast [7].

The Women's Health Strategy's neglect of coastal communities is not unusual; preparatory papers for the 2025 House of Commons' debate on coastal communities [8] noted that even though approximately a fifth of UK residents live in constituencies defined as coastal, their specific needs have been repeatedly overlooked. Part of the challenge is that the evidence base on abortion access and service provision in rural and coastal areas in the UK is limited, and there is a paucity of data available on service quality and accessibility. These data issues are not unusual. The 2021 Chief Medical Officer's report states that health

[1] Department of Health and Social Care. The Renewed Women's Health Strategy for England. April 2026
[2] DHSC. Renewed Women's Health Strategy 2026, pg. 12
[3] DHSC. Renewed Women's Health Strategy 2026, pg. 23
[4] DHSC. Renewed Women's Health Strategy 2026, pg. 24
[5] Royal College of Obstetricians and Gynaecologists (RCOG). A Work in Progress: An evaluation of progress of the Women's Health Strategy for England. Accessed June 2026
[6] Women's Health Strategy 2026, pg 24
[7] Department of Health and Social Care. Chief Medical Officers' Annual Report 2021: Health in Coastal Communities – Summary and Recommendations. April 2021
[8] House of Commons. Coastal Communities Debate Pack. 18 March 2025

inequalities data is rarely made available beyond a local authority and "as a result, deprivation and ill health at the coast is hidden by relative affluence just inland which is lumped together"[9].

Challenges in abortion service access in rural and coastal areas are not due to an absence of policy. There are clear standards for abortion services[10] and commissioning guidelines[11](Box 1). These outline what abortion services should look like and the characteristics of high-quality services. The question is if these standards are being met and commissioning principles followed in rural and coastal spaces and places.

Box 1

NICE Quality Standards

Quality Statement 1: Healthcare commissioners and providers work together to make abortion services easy to access
Quality Statement 2: Women who request an abortion are given a choice between medical and surgical to take place up to and including 23+6 gestation
Quality Statement 3: Women who decide to go ahead with an abortion have the option to have the procedure within 1 week of assessment.
Quality Statement 4: Women having a medical abortion up to and including 9+6 weeks' gestation are given the option to take misoprostol at home.

NHSE Commissioning Guidance Principles:

1. Commissioners ensure a comprehensive offer of abortion services, including choice of procedure type, location, anaesthetic and pain management. Patients are made aware of what treatment and support options are available to them and are empowered to make choices about their treatment.
2. Commissioners consider the range of services a patient might need before, during and after their treatment. They take a holistic view of the pathway and ensure patients have clarity about what services are available and how to access them – including when services are commissioned by other organisations.
3. Services are designed and commissioned with regard to patient experience, and commissioners work proactively with providers to minimise travel and wait times. Aftercare and support is provided, acknowledging that some patients may benefit from support sometime after their procedure.
4. Abortion services are recognised and treated as a vital part of the NHS. Commissioners ensure they are considering stigma in their communications and actively work to de-stigmatise services.

[9] DHSC CMO – Health in Coastal Community, pg 21
[10] NICE Quality Standard QS199: Abortion Care 26 January 2021
[11] NHS England. Abortion Commissioning Guidance 17 March 2025

Abortion access in rural and coastal areas: A case study review of two communities

Case Selection

We have chosen two Integrated Care Board areas as case studies to illustrate the place-based inequalities experienced by those living in rural and coastal areas – Lancashire and South Cumbria and Lincolnshire. These ICBs were selected due to their geographies (both encompass rural and coastal areas) and known issues relating to health service access. They were also selected because they represent two different models of abortion care provision. Lancashire and South Cumbria ICB has contracts with multiple independent providers alongside the NHS; Lincolnshire provides abortion care solely through the NHS.

There are clearly many other areas that are both rural and coastal with similarly different provision arrangements. At the same time, both places offer a robust indication of key challenges relating to abortion access. They also reflect a policy context where the realities of abortion access are masked by data gaps, which experience pronounced health inequalities, and where populations feel 'left behind'.

Here we will provide area profiles of Lancashire and South Cumbria and Lincolnshire ICBs, and outline abortion services and provision. Some of these are specific to each ICB. There are also shared challenges including health inequalities, concentration of deprived areas, transport infrastructures, geographic footprint, rurality and the 'coastal penalty'.

Case study 1: Lancashire and South Cumbria ICB

Area profile

Lancashire and South Cumbria ICB has a geographic footprint of over 5,000 square kilometres across four areas – Blackpool, Blackburn-with-Darwen, Lancashire, and South Cumbria – serving a population of approximately 1.8 million. It is complex including rural, coastal, and urban areas. Lancashire and South Cumbria has areas of high rurality – 20% of the population live in rural communities compared with a national average of 17% - and its footprint includes South Cumbria, one of the most sparsely populated areas in England. Lancashire and South Cumbria's footprint also includes densely populated urban areas in Blackpool, Lancaster, and Preston.

Lancashire and South Cumbria ICB has a concentration of high deprivation in urban areas, particularly Blackpool and Blackburn with Darwen. Coastal deprivation, in South Cumbria (e.g. Barrow in Furness) and Morecambe, is less marked. At the same time, there are issues with data representations of these

rural-coastal areas. As observed in the CMO's report, areas of high deprivation in coastal areas are masked by their proximity to more affluent areas. Population needs assessments of Lancashire and South Cumbria indicate that neighbourhoods in the index of multiple deprivation deciles 1-4 in Barrow-in-Furness, Central Lancaster, and Morecambe Bay (representing high deprivation) border neighbourhoods in Lakeland and West Lancashire of low deprivation [12].

Transport infrastructures are a priority investment area in the ICB footprint. The fragmentation of public transport networks has been recognised as a particular issue in the South Cumbria and West Lancaster areas. Rural and coastal populations reliant on public transport face barriers due to limited and irregular provision. The recently formed Combined County Authority (CCA) is consulting on a transport plan that would enhance connectivity across the region.

Abortion services

Abortion services in the Lancashire and South Cumbria ICB footprint are delivered by a combination of independent and NHS providers. The incumbent suppliers, as of 2026, are: BPAS, NUPAS, MSI Reproductive Choices, Blackpool Teaching Hospitals NHS Foundation Trust, East Lancashire Hospitals NHS Trust, and University Hospitals of Morecambe Bay NHS Foundation Trust.

Care pathway

Self-referral for NHS abortion services is permitted; patients requesting abortion through NHS providers have to attend a hospital for a pre-abortion ultrasound scan (not including Westmorland Hospital in Kendal) to confirm gestational age. NHS providers in the ICB footprint can perform abortions up to 10 weeks' GA via medical abortion. Patients must attend a clinic for mifepristone. If they are under 12 weeks', and the NHS provider consents, they may take misoprostol at home.

Surgical abortions are available for complex cases in Blackpool Victoria Hospital and Morecambe Bay NHS FT (Royal Lancashire Infirmary and Furness Hospital) over 10 weeks' but under 18 weeks' gestation. Royal Preston Hospital offers surgical abortion up to 12 weeks under general anaesthetic but currently advises a two-week wait time for non-emergency treatment under this pathway. Patients cannot self-refer to NHS providers for mid-to-late gestation surgical services. Abortions for non-complex cases between 10 and 18 weeks, without a referral for hospital-based services in the ICB footprint are referred to specialist centres out-of-region (normally Merseyside or Greater Manchester).

Independent providers in the ICB footprint can provide medical abortions up to 10 weeks' gestational age, supported by telemedicine. Abortions after 10 weeks' or surgical abortions through the independent provider pathway will be referred to one of the independent, out-of-region centres in Merseyside or Greater Manchester.

Waiting Times

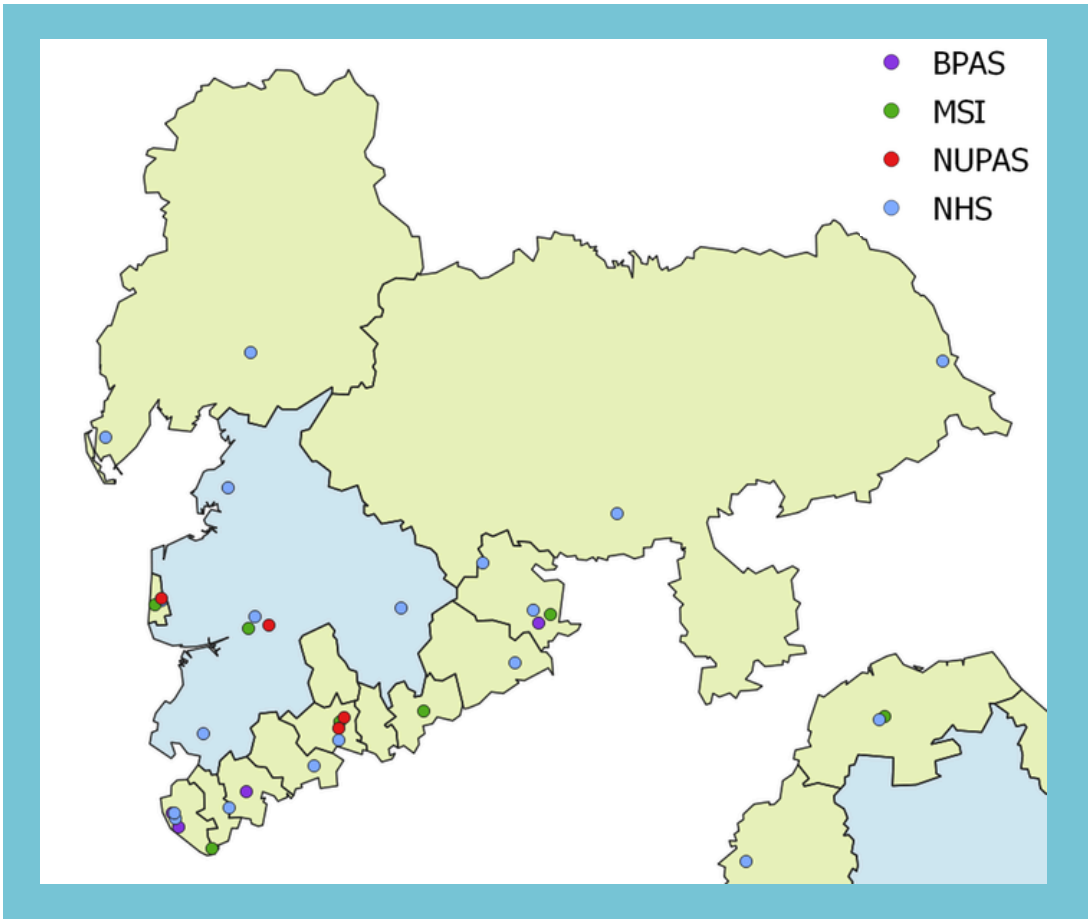
Records of waiting times are not available. The Lancashire and South Cumbria ICB stated, in response to a 2026 FOI request, that it does not hold this information.

[12] Niebieski, C et al., Lancashire & South Cumbria Integrated Care Board Population Needs Assessment, Accessed June 2026

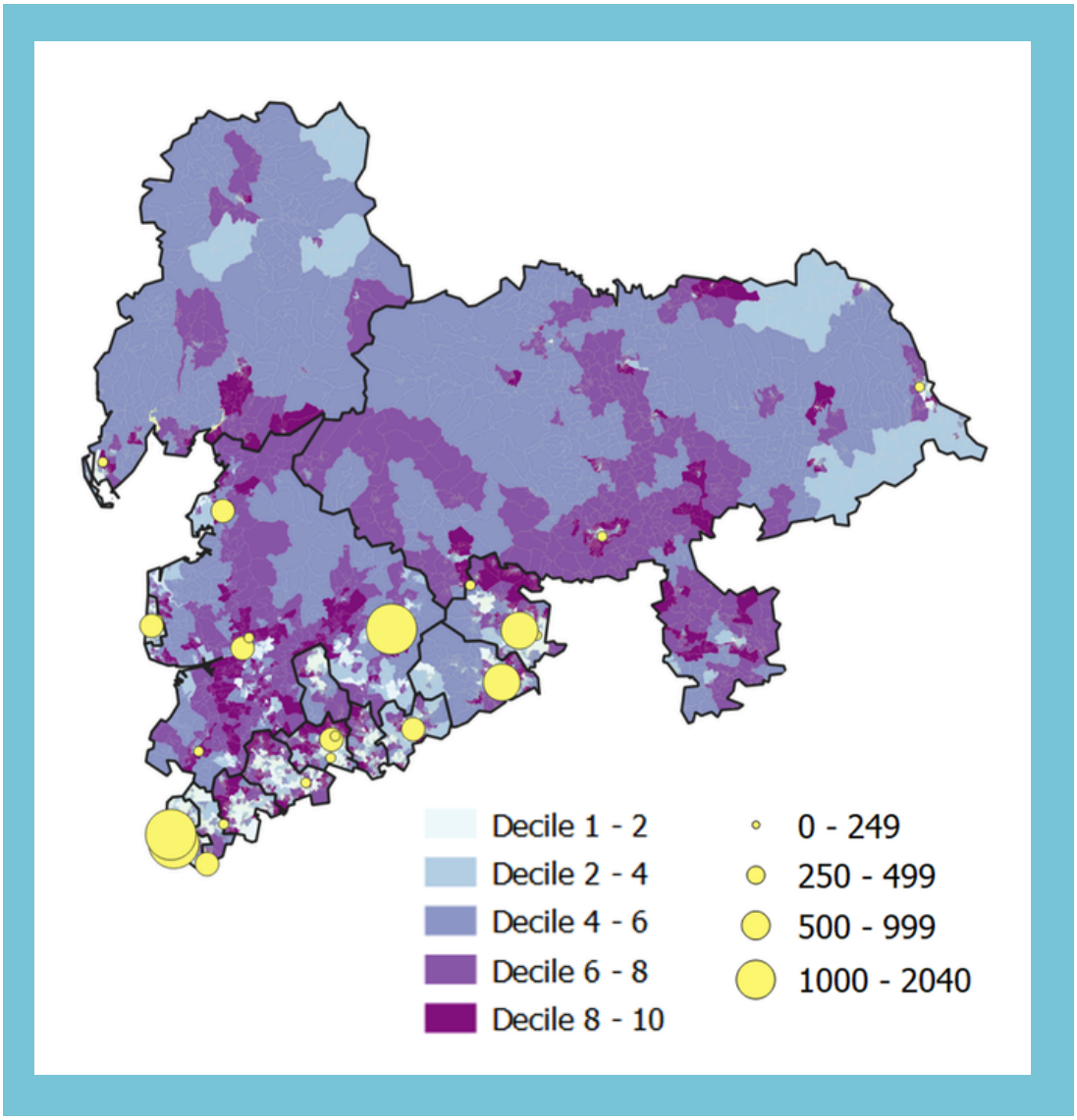
Location of services

Abortion providers' physical clinics/hospitals are clustered to the south and east of the ICB footprint, in Blackpool and Preston and surrounding areas in Greater Manchester and Merseyside, as illustrated in Map 1 with limited services in coastal and rural areas of Cumbria including areas of rural deprivation (Map 2, overleaf).

Map 1: Abortion Clinics in Lancashire and Surrounding Area



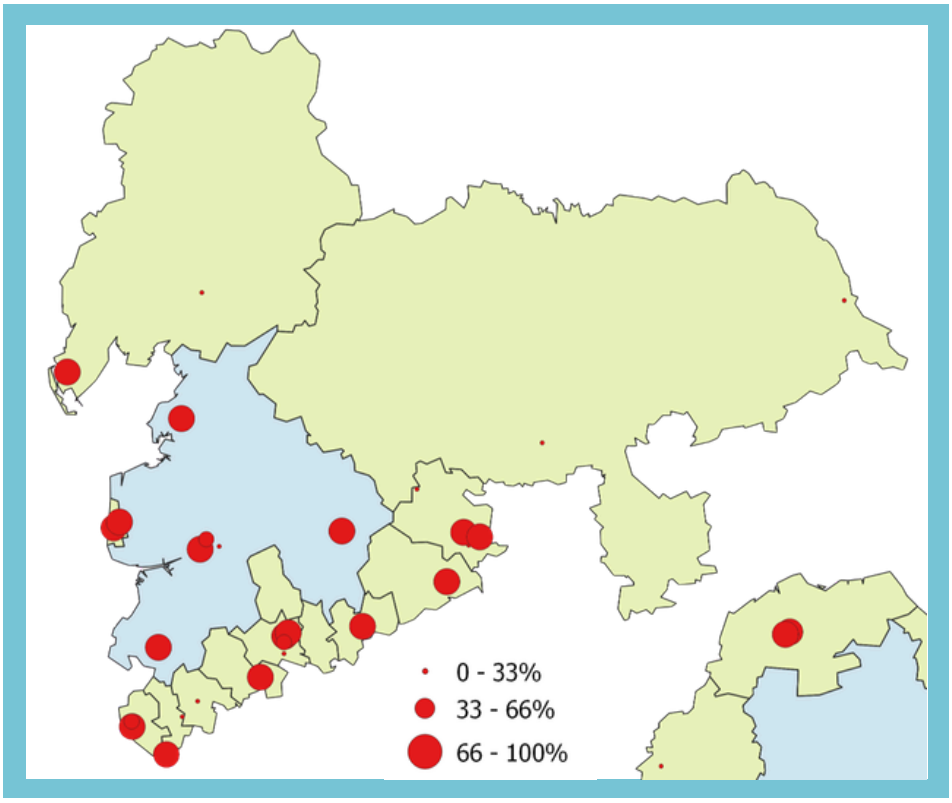
Map 2: Number of abortions by clinic and IMD decile, 2023



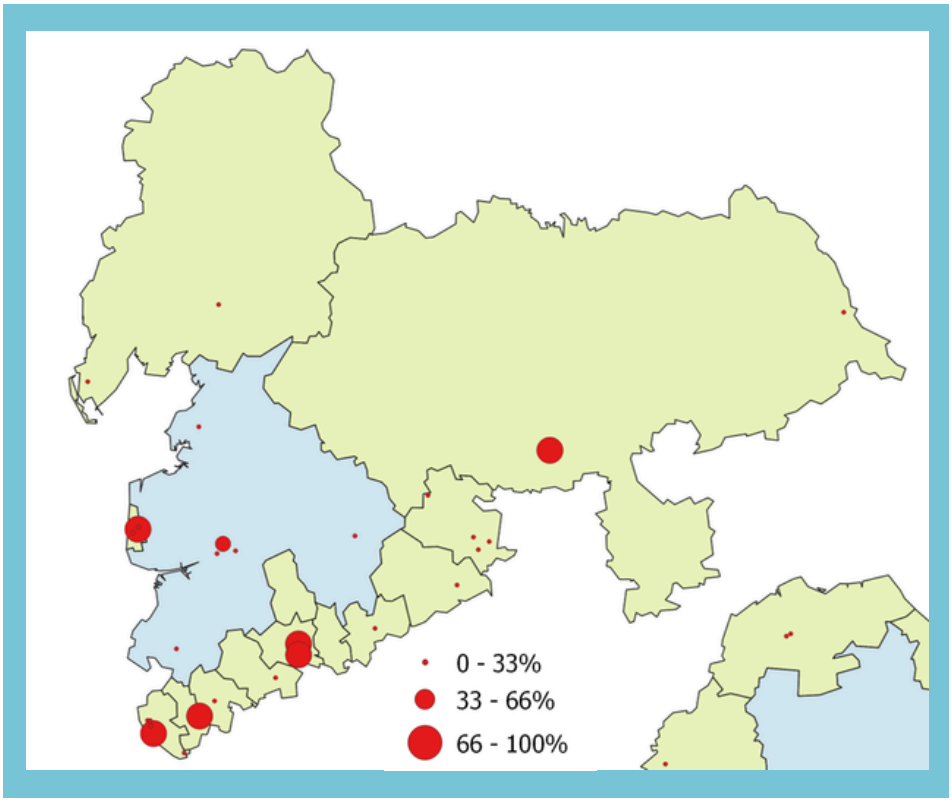
Number of abortions and access challenges

The challenges in accessing abortion services are reflected in abortion statistics for residents of the ICB footprint (Maps 3 and 4). These demonstrate that while the number of abortions under 10 weeks gestation is relatively evenly distributed across the ICB (Map 3), the number over 10 weeks is clustered in urban areas to the south of the ICB area (Map 4).

Map 3: Percentage of abortions under 10 weeks' by clinic, 2023



Map 4: Percentage of abortions over 10 weeks' by clinic, 2023



Case Study 2: Lincolnshire ICB

Area profile

The Lincolnshire ICB has a geographic footprint of over 5,000 square kilometres. It covers Lincolnshire, encompassing seven District and Borough Councils – City of Lincoln, East Lindsey, Boston, North Kesteven, South Holland, South Kesteven, and West Lindsey – and serves over 800,000 patients. 72% of the ICB footprint is rural – it is classified as predominantly rural by the UK government - and includes 80km of coastline[13].

Over 15% of Lincolnshire ICB's patient population live in the 20% most deprived areas in England[14]. There is a concentration of deprivation in coastal areas, including East Lindsey, Boston and South Holland. The coastal resort towns of Skegness and Mablethorpe contain neighbourhoods in the 10% most deprived areas nationally. There are also pockets of high deprivation across the county masked by proximity to more affluent areas, e.g. Lincoln and Gainsborough [15].

Transport is a pronounced issue for those living in Lincolnshire ICB. The geographic footprint is unique in the total absence of motorways. Like other rural and coastal areas, public transport is fragmented and irregular. Addressing transport barriers has been identified as an area of need by the Greater Lincolnshire Combined Authority and in NHS Lincolnshire's Joint Forward Plan [16]

Abortion services

Abortion services in the Lincolnshire ICB footprint are delivered by the NHS, and are referred to on the NHS website as the LINC Support Service. Services are provided through a hub and spoke model, with various activities taking place across Lincoln, Boston and Louth hospitals. An April 2026 FOI response lists the main incumbent supplier as United Lincolnshire Teaching Hospitals NHS Trust (ULTH). The ICB also holds contracts with Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) and North West Anglia NHS Foundation Trust (NWAFT).

Care pathway

Self-referral is available, and sexual health clinics and GPs can also make referrals on behalf of the patient. However, signposting to the "LINC Support" service is not clear and some information on the Trust website is out-dated and/or inaccurate. [17] Patients must attend a hospital appointment, either in Lincoln or Boston, for a pre-abortion ultrasound scan and in-person consultation. Home-use of mifepristone and telemedicine are not currently available. Home-use of misoprostol is available up to 9 weeks and 6 days' gestation. NHS patients may be offered mifepristone at the first consultation if there is staff capacity to dispense. If there is no capacity at the clinic, they will have to return for administration of mifepristone and to receive misoprostol for at-home use. The latter may also be dispensed at an additional in-person appointment. The early medical abortion pathway may therefore potentially involve up to three or four in-person visits to the hospital. In-patient medical abortion services are also available up to 12 weeks' gestation.

[13] Rural Services Network. Rural Funding: The facts for Lincolnshire Accessed June 2026
[14] Lincolnshire Health Intelligence Hub. Our Place Accessed June 2026
[15] Lincolnshire County Council. Adult Social Care Strategy 2026 – 2028 Accessed June 2026
[16] Lincolnshire Integrated Care Board. Joint Forward Plan Accessed June 2026
[17] LINC Support. LINC Support - United Lincolnshire Hospitals, Accessed June 2026

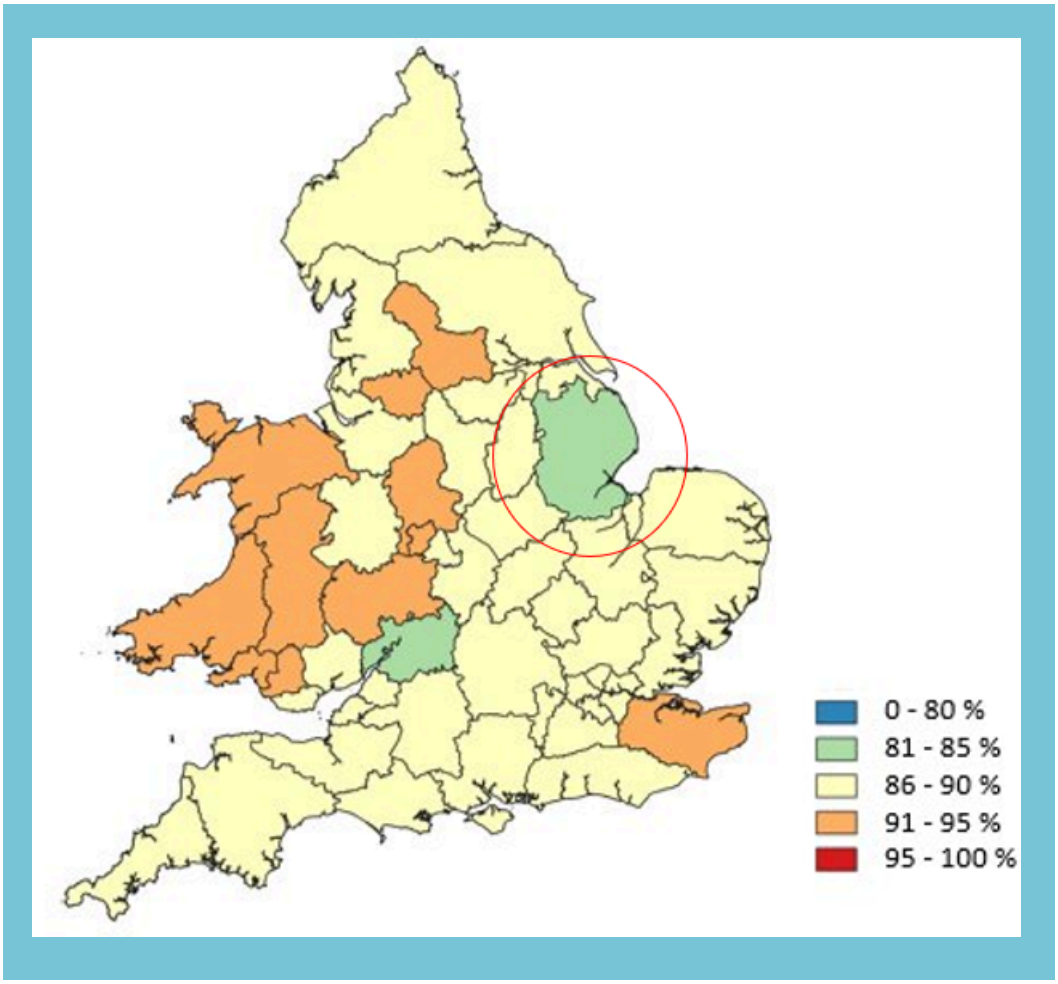
Surgical abortion (manual vacuum aspiration) under general or local anaesthesia is available up to 12 weeks' gestational age, but is currently only provided at Louth Hospital. Abortions over 12 weeks' gestation will be referred to an out-of-region specialist centre by the NHS. Patients are also advised to contact independent providers themselves to arrange out-of-region services. There are no abortion services available after 12 weeks, unless this is for a medical indication.

Waiting times

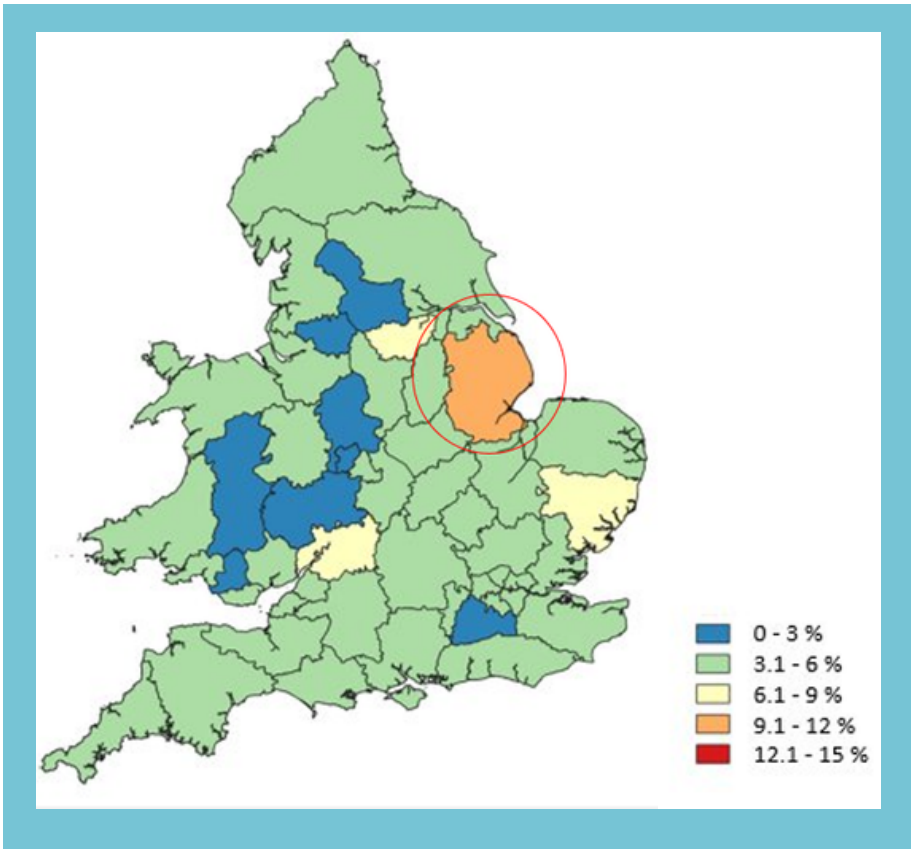
Waiting times for abortion care are unclear. A 2026 response to an FOI request to Lincolnshire ICB provided waiting times between "Decide to Admit" and "Admission" for each NHS provider as follows:
ULTH: 3.9 days
NWAFT: 6.5 days
NLAG: 1.9 days

The FOI response noted this was based on incomplete data. It also did not provide information on waiting times in line with the NICE standards. A further FOI request was submitted to clarify waiting times according to this definition. Unpublished data from one co-author's research suggests some patients have waited up to 8 weeks for treatment. Delays in access to abortion care or longer waiting times are also indicated by abortion statistics which indicate that Lincolnshire ICB has a higher percentage of abortions completed after 9 weeks gestation than neighbouring inland areas (Maps 5-7).

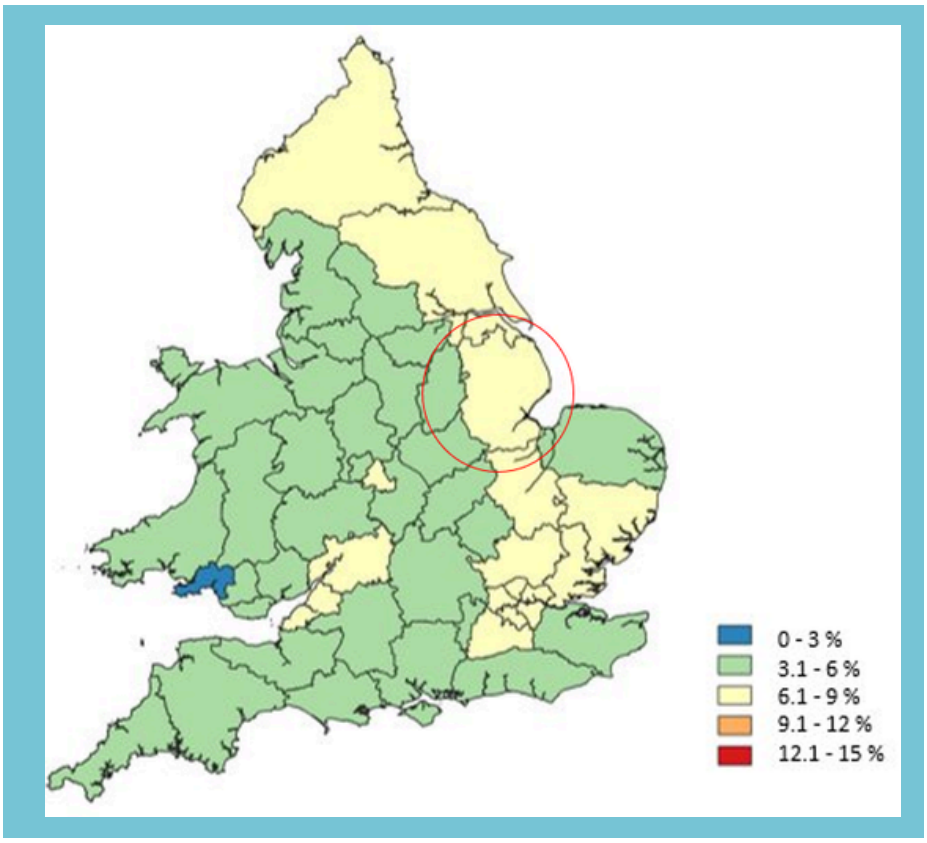
Map 5: Percentage of abortions between 2 to 9 weeks by ICB/Health Board, 2023 (patient-level data)



Map 6: Percentage of abortions between 10 to 12 weeks' by ICB/Health Board, 2023 (patient-level data)



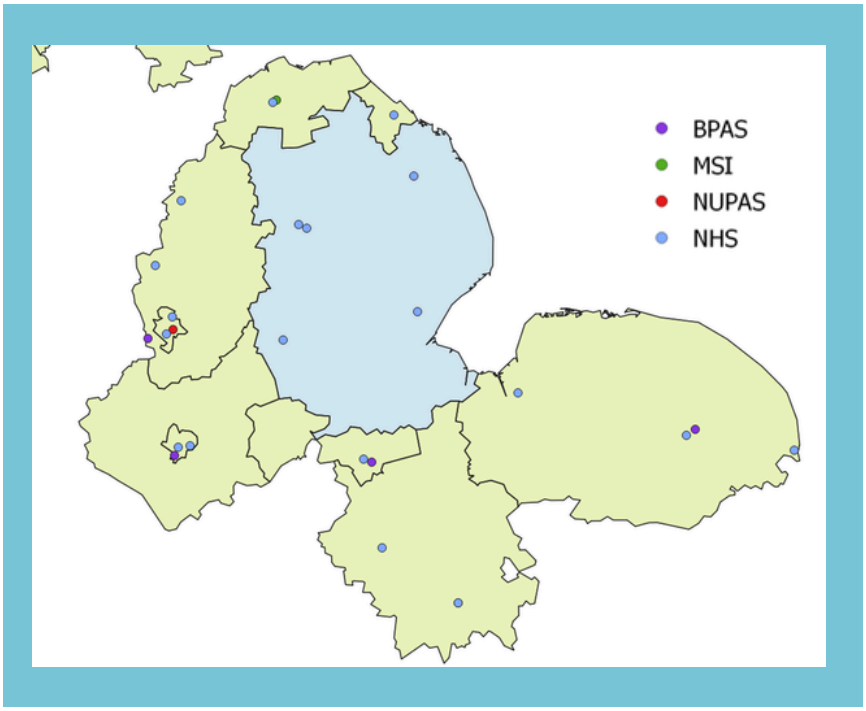
Map 7: Percentage of abortions at 13 weeks' and above by ICB/Health Board , 2023 (patient-level data)



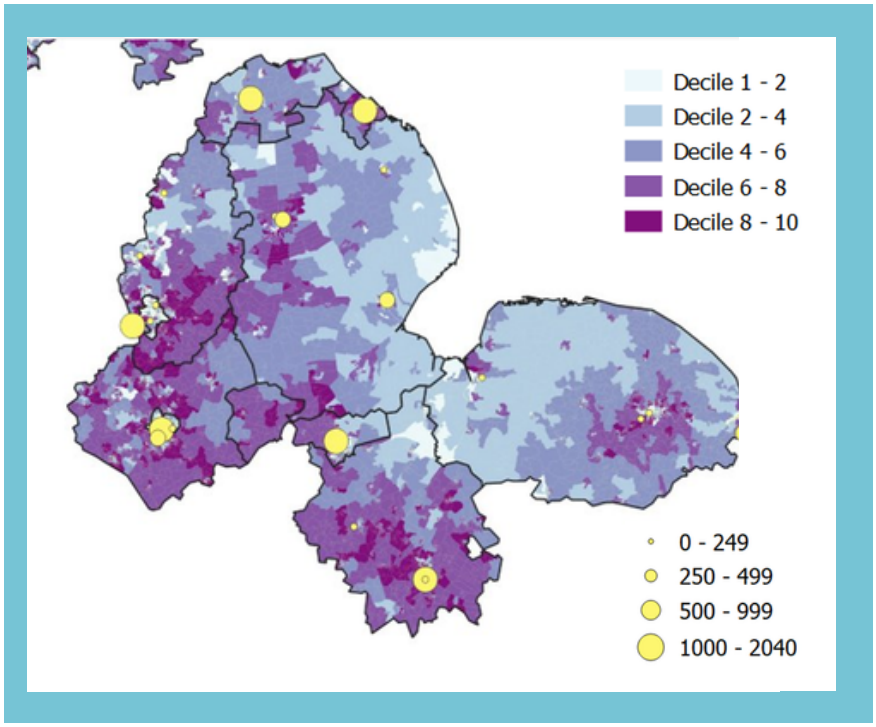
Location of services

Services are clustered in Lincoln, and the smaller market towns of Boston and Louth, as illustrated in Map 8. However, not all services within the care pathway are provided at all locations (e.g. surgical services are only based at Louth, consultations are only available in Lincoln and Boston). There are no services in the most deprived, coastal parts of the county (Map 9).

Map 8: Abortion Clinics in Lincolnshire and Surrounding Area



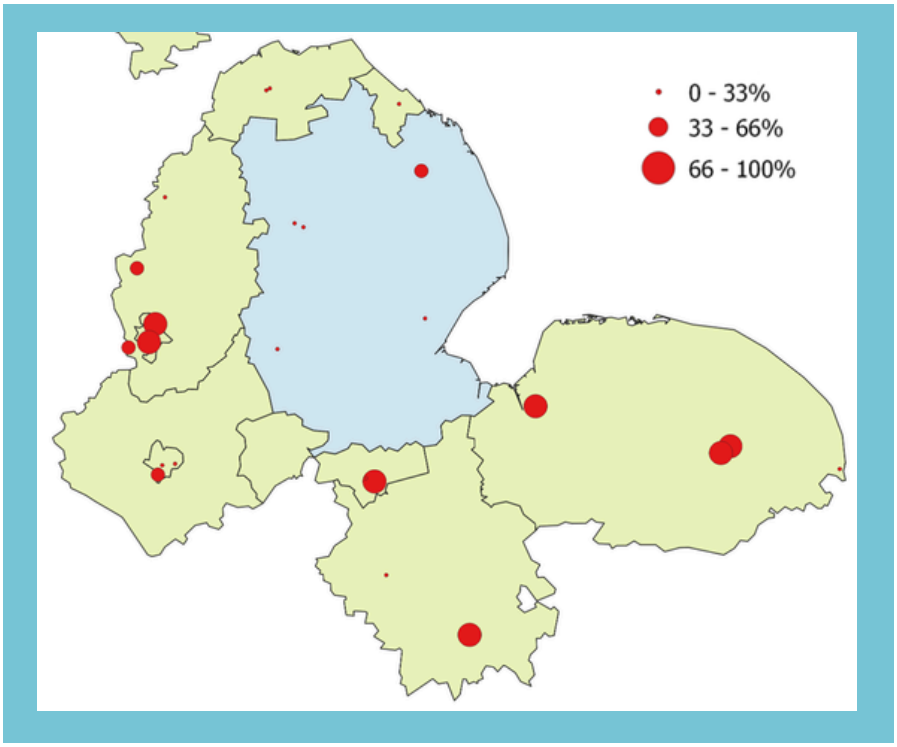
Map 9: Number of abortions by clinic and IMD decile, 2023



Abortion statistics and access

Abortion statistics demonstrate serious challenges in access to abortions over 10 weeks gestations across the ICB footprint (Map 10). There are almost no abortions over 10 weeks gestation within Lincolnshire ICB area reported in the most recent published data.

Map 10: Percentage of abortions over 10 weeks' by clinic, 2023



Summary and Recommendations

Abortion services in rural and coastal areas should adhere to the same NICE Quality Standards and NHS Commissioning Principles as inland and urban areas. Combined, these policy frameworks should be applied in ways that ensure abortion services are "easy to access" (NICE Quality Standard) and demonstrate that Commissioners have "taken a holistic view of the pathway" (NHS Commissioning Principles).

This policy brief raises a question mark over whether the NICE Quality Standards and NHS Commissioning Principles are being met in rural and coastal areas. For example, it shows that abortion services in the case study sites are not easy to access at every stage of pregnancy. The review also shows that choice of method is limited and mid-to-late gestation abortion in both ICB footprints involves out-of-region travel. Travel is also required for hospital/clinic based appointments for consultations, scans, and dispensing of medication. This presents an economic burden, compounding pre-existing inequalities experienced by those living in some of the most deprived areas nationally.

An absence of data or data linking between different, relevant data sources hampered this review. For example, it is not possible, without additional research, to assess if commissioners are "proactively working to minimise travel" (NHSE Commissioning Principles). Data confirming that NICE Quality Standards on waiting times are being met is not readily available from ICBs, and unpublished research suggests that some patient waiting times far exceed them. As a result, it is not possible to confirm if women are being offered procedures within one week (QS 3). While NICE Quality Standards exist, there is no way to audit if these standards are being met.

While this policy review is not a comprehensive study, the case studies indicate that there are clear issues relating to abortion care in the countryside and the coast. Based on the evidence collated, we make the following recommendations to improve abortion services and improve care:

1. **Adopt a place-based approach to designing and commissioning abortion services to ensure that the NICE Quality Standards and NHS Commissioning Guidelines are met;**
2. **Integrate the Chief Medical Officer's recommendations on addressing the 'coastal penalty' and evidence of rural health access disadvantage into strategies to improve abortion services; and**
3. **Establish a national audit of abortion services, address gaps in data and connecting data sets.**

Appendix

Data Notes

Maps have been produced using clinic data tables published from the Department of Health and Social Care's Abortion Statistics for England and Wales, 2023 and information provided from the following sources:

- BPAS Unit Structure list (provided on request, March 2026)
- NUPAS Centre list (provided on request, March 2026)
- Freedom of Information Act Request - Lancashire and South Cumbria Integrated Care Board (April 2026)
- Freedom of Information Act Request - NHS Lincolnshire Integrated Care Board (April 2026)

Data on population was sourced from mid-year estimates of usual resident population by broad age groups and sex and is available here.

Data on IMD was sourced from the 2025 Index of Multiple Deprivation and is available here.

Data on housing tenure and number of households was sourced from the Census 2021 estimates and is available here and here.

Above data is shown at the Lower Super Output Area (LSOAs) level.

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