# British Pregnancy Advisory Service

## Quality report

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**Dates of inspection visit:**
7 and 8 February 2023

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The British pregnancy Advisory Service provides termination of pregnancy services across England, Scotland and Wales to women and birthing people of childbearing age.

It provides the following services:

- pregnancy testing
- unplanned pregnancy counselling /consultation
- early medical abortion at home (Pills by post) up to 9 weeks 6 days
- early medical abortion in a clinic up to 10 weeks
- surgical abortion up to 23 weeks 6 days of pregnancy
- abortion aftercare
- sexual transmitted infection testing, treatment, and referral
- vasectomy
- contraceptive advice and contraception supply.

The British Pregnancy Advisory Service has a total of 27 registered locations with 22 satellite locations.

The British Pregnancy Advisory Service (BPAS) is an independent healthcare charity which was established in 1968. The charity's stated purpose is advocating and caring for women and couples who decide to end a pregnancy. Most of the patients have their care paid for by the NHS although patients can pay for their own treatment. Patients can self-refer to the service. Vasectomy services are also offered through the service locations. The service is provided to approximately 110,000 women in 2022 in 49 reproductive healthcare clinics nationwide and telemedicine service. With an income of about £40 million and employs more than 1000 staff.

| Core service inspected | CQC Registered Location | CQC Location ID |
|---|---|---|
| Reactive provider Well Led review | BPAS - Basingstoke | 1-584856783 |
| | BPAS - Birmingham Central | 1-129168945 |
| | BPAS - Birmingham South | 1-129168960 |
| | BPAS - Bournemouth | 1-129168465 |
| | BPAS - Chester | 1-805822420 |
| | BPAS - Doncaster | 1-129168540 |

| | | |
|---|---|---|
| | BPAS - Finsbury Park | 1-129168761 |
| | BPAS - Leeds | 1-129168570 |
| | BPAS - London East | 1-129169005 |
| | BPAS - Luton | 1-406574464 |
| | BPAS - Merseyside | 1-129168600 |
| | BPAS - Middlesbrough | 1-363115490 |
| | BPAS - Newcastle | 1-250839154 |
| | BPAS - Norwich | 1-3629670957 |
| | BPAS - Nottingham West | 1-1978824508 |
| | BPAS - Oxford Central | 1-1547117358 |
| | BPAS - Peterborough | 1-129168644 |
| | BPAS - Portsmouth Central | 1-740422701 |
| | BPAS - Richmond | 1-129168659 |
| | BPAS - Sandwell | 1-7934678702 |
| | BPAS - Southampton | 1-377865930 |
| | BPAS - Stratford upon Avon | 1-6892963879 |
| | BPAS Healthcare | 1-13188556955 |
| | BPAS Leicester City | 1-4011066514 |
| | BPAS Northampton Central | 1-2896561882 |
| | BPAS Reading | 1-2100901989 |
| | BPAS Taunton Central | 1-2931928093 |

This report describes our judgement of the quality of care at this Registered Provider. It is based on a combination of what we found when we carried out a reactive provider well-led assessment (RPWL) and from other information from our 'Intelligent Monitoring' system and information given to us from people who use services, the public and other organisations.

# Our findings

## Overall summary

The Care Quality Commission (CQC) carried out a reactive provider well-led assessment of the British Pregnancy Advisory Service on 7 and 8 February 2023.

The British Pregnancy Advisory Service (BPAS) is an independent healthcare charity which was established in 1968. The charity's stated purpose is advocating and caring for women and couples who decide to end a pregnancy. Most of the patients have their care paid for by the NHS although patients can pay for their own treatment. Patients can self-refer to the service. Vasectomy services are also offered through the service locations. The service was provided to approximately 110,000 women in 2022 in 49 reproductive healthcare clinics nationwide and telemedicine service.

The CQC regulates health and social care providers in England, so this assessment did not consider evidence from locations in Wales or Scotland.

CQC has not published a rating as part of this provider well led assessment.

- BPAS has a clear vision and strategy; however, some leaders were unable to provide a clear explanation of the strategy as a provider of health services. There was an ineffective approach to monitoring, reviewing, or providing evidence of progress against delivery of the strategy. The strategy had not been translated into meaningful and measurable plans at all levels of the service. There were teams working in silos and the strategic leadership team did not always work cohesively.

- Not all leaders had the necessary experience, knowledge, capacity, capability to lead effectively. Some leaders were out of touch with what was happening on the front line and could not identify the risks and issues described by Staff. There was little attention to succession planning and development of leaders. Not all leaders were recruited in line with the fit and proper persons requirements. There are some examples of leaders making a demonstrable impact on the quality or sustainability of services.

- Governance arrangements and their purpose were unclear, and there was a lack of clinical oversight and engagement in incident investigation and how individuals were held to account. Arrangements for governance and performance management are not clear and did not always operate effectively. There had been no recent review of governance arrangements. There was a lack of systematic oversight and performance management of treatment units.

- Information that was used to monitor performance or to make decisions was confusing which led inadequate access to and challenge of performance by the strategic leadership team. Finance led decision making and at times impacted on the quality of services. There were significant failings in systems and processes for the management or sharing of performance data.

- There was limited oversight of skills and systems among staff and leaders. Improvements were not identified, and action was not always taken. BPAS did not react sufficiently to risks identified through internal processes, and often relied on external parties to identify key risks before acting. Where changes were made, the impact on the quality and sustainability of care was not fully understood in advance or was not monitored.

- Risks, issues, and poor performance were not always dealt with appropriately or quickly enough. The risk management approach was applied inconsistently or was not linked effectively into planning processes. The approach to service delivery and improvement was reactive and focused on short-term issues. Internal audit processes were inconsistent in their implementation and impact. The sustainable delivery of quality care was put at risk by financial challenges.

However:

- The values supported the BPAS vision and were shared throughout the organisations. Systems were in place to promote transparency following incidents. The need for openness and reporting of incidents was embedded within policy. Operational leaders promoted an open culture in line with the policy. Safeguarding processes, procedures and learning were effective and supported clients to report and seek help when needed.

- BPAS took an active role in research in abortion care and worked collaboratively with stakeholders to add to the evidence base.

Following this inspection, under Section 29 of the Health and Social Care Act 2008, we issued a warning notice to the provider. We took this action as we believed a person would or may be exposed to the risk of harm if we had not done so.

## Our inspection team.

The team included a deputy director of secondary and specialist care, 2 inspection managers, 1 Medicines specialist, 1 safeguarding children's specialist, 1 specialist adviser (experienced in Termination of pregnancy and patient safety) and 3 colleagues from NHS Improvement.

## Background to British Pregnancy Advisory Service.

The British pregnancy Advisory Service provides termination of pregnancy services across England, Scotland and Wales to women and birthing people of childbearing age.

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## Why we carried out this inspection.

CQC inspected 12 of the British Pregnancy Advisory Service registered locations in England during a series of inspections between April and December 2022, as part of CQC's planned and risk-based inspection programme. Whilst the inspections identified several positive factors, they also identified some concerns linked to the provider's leadership and governance arrangements. Further details are below.

- Governance arrangements were not sufficiently robust or effective to always identify concerns and risks. Not all notifiable events were reported in line with mandatory legal reporting regulations.
- The correct legal documentation was not always completed before surgical termination of pregnancy.

- Systems to safely prescribe, administer and record medicines were not always in line with national regulations and guidance.
- Women did not always receive care in a timely way to meet their needs.

This led to a reactive provider well-led assessment of the British Pregnancy Advisory Service UK administrative offices in 2 Athena Drive, Tachbook Park, Warwick, CV34 6RG on 07 and 08 February 2023.

## Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

**Action the trust MUST take to improve**:

British Pregnancy Advisory Service **MUST**:

Must ensure that effective governance systems and processes are embedded across all services to support the delivery of sustainable and high-quality care. (Regulation 17: Good Governance)

Must ensure that policies and procedures are consistent across all services to support staff in the delivery of care and treatment and to allow effective audit and assurance. (Regulation 17: Good Governance)

Must ensure that clinical and corporate risks are identified and effectively managed at every level in the organisation including a clear risk escalation process. (Regulation 17: Good Governance)

Must ensure that access to freedom to speak up guardians is equitable across all NHS commissioned services. (Regulation 17: Good Governance)

Must ensure all policies pertaining to fit and proper persons: directors are completed in a timely manner as part of the onboarding employment process. (Regulation 5: Fit and proper persons: directors)

**Action the provider SHOULD take to improve:**

British Pregnancy Advisory Service **SHOULD**:

Should review the arrangements for the independent challenge of the decisions made by the executive team.

Should consider how data is used within the governance of the organisation including trend analysis and exception reporting to support early identification of emerging risks.

Should consider the use of a quality improvement framework to support a culture of continuous improvement across all services.

Should consider how actions from meetings within the governance framework can be more effectively monitored with clear timeframes for completion.

## Is this organisation well-led?

By well-led, we mean that the leadership, management, and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

**Vision and strategy to deliver high-quality care and support, and promote a positive culture that is person-centred, open, inclusive, and empowering, which achieves good outcomes for people.**

The British Pregnancy Advisory Service (BPAS) vision was “A future where every women can exercise reproductive autonomy and is empowered to make her own decisions about pregnancy.”

BPAS describe their work as a combination of service delivery, advocacy, campaigning, and research, so that barriers to exercising reproductive choice and autonomy. In addition, BPAS state they will provide services to the full extent of the law to enable women to both start and end pregnancies and will systematically look for other areas where they can provide reproductive health support and care to those who need it. Where not all services could or should be provided directly by BPAS, where needs were not being met or failed, they will find ways to address them. BPAS campaign for choice across the reproductive spectrum, defending the reproductive rights of women and championing those who provide care and support for them. This should be achieved whilst operating a financially astute and sustainable model that provides not-for-profit services, and will prioritise service delivery, innovation and advocacy activity based on the question: if not BPAS, then who?

BPAS in 2021 had begun to set up a not-for-profit fertility service to provide affordable care for those who would not qualify for NHS funding. BPAS were committed to bringing advocacy around fertility treatment as they had brought to bear on abortion care, campaigning for access to the full 3 cycles of treatment as recommended by the national institute for clinical excellence (NICE), challenging practices that were not evidence based and building coalitions to more effectively champion people’s needs. BPAS determined that this service was not viable and sold this segment of the business in March 2023

Advocacy over recent years had included a strong focus on autonomy across pregnancy-related issues and BPAS stated this gave them the foundation to establish themselves as the UK’s pre-eminent organisation for reproductive choice, taking a comprehensive approach to reproductive autonomy unparalleled anywhere in the world.

The BPAS strategic priorities and business plan 2021-23 identified the need for strong organisational leadership which resulted in an expansion of the strategic leadership team (SLT) to support the growing needs of the business.

BPAS identified strategic priority areas, and short and medium term business objectives have been set accordingly. Progress against the business plan would be assessed regularly by the SLT and new objectives set when resource becomes available as initial goals were met.

There were 6 strategic pillars:

- Service Excellence
  Delivering care directly into women's hands where possible, providing excellent in clinic services for those who need us.
- Research
  Developing a programme that will help us deliver evidence-based care, innovate and advocate.
- Workforce Development & Wellbeing
  Recruiting and supporting staff so they can deliver reproductive choice.
- Innovation & Diversification
  Finding areas of unmet need and offering innovative solutions.
- Social, Legal & Cultural Change
  Securing support for our vision of autonomy and choice.
- Organisational Excellence
  Building outstanding practices in managing our organisation.

Some senior leaders were unable to give a clear explanation of BPAS strategy as a provider of health and social care services and referred to the vision and values of the organisation. There was a lack of assurance that the strategy was provided clearly across the organisation which was consistent with the findings in one of the location inspections.

**Culture**

Not all senior leaders could accurately describe the culture within the organisation. Leaders sought to promote a positive culture, but that we found opinions varied as to whether this was actively achieved. However, senior leaders described the importance of a caring and open culture where staff were respected, valued, and motivated to provide high quality care.

The British pregnancy advisory service (BPAS) had developed values which were consistent with and supported the vision of the organisation.

- Compassionate
  We listen to our clients and deliver services to meet their needs. We build relationships with those we care for based on empathy, dignity, and respect.
- Courageous
  We are the voice of the women we care for and are never afraid to advocate on their behalf, particularly when others are silent. We are at the forefront of innovation in clinical care and campaign tirelessly for the services women need.
- Credible
  We act with integrity. Everything we do is evidence-based and ethical, informed by our knowledge and understanding of the needs of those we serve.
- Committed to women's choice.
  We believe that women are best placed to make their own decisions in pregnancy, with access to evidence-based information to inform those choices, and the services they need to exercise them.

The values had been developed and shared throughout the organisation. This was supported by evidence from our inspection activity in locations and through the corporate documents and communications reviewed. Embedding the values in services was the responsibility of registered managers.

Systems were in place to promote honesty and transparency following incidents. The need for openness and reporting of incidents was embedded within policy. Clinical operational leaders talked about the promotion of an open culture with a focus on quality of care and being able to raise issues without retribution. Evidence from inspections suggested that most staff felt able to be report incidents and raise concerns.

Duty of Candour was part of incident reporting and review processes. Duty of Candour is a regulatory duty that relates to openness and transparency, it requires providers of health and social care services to notify patients (or other relevant persons) of certain incidents. The policy had been updated to ensure written duty of candour was completed and put on file even if the client declined written duty of candour.

**Whistleblowing / Freedom to Speak up.**

BPAS had a public interest disclosure (whistle-blower) policy and procedure, with a review date of August 2025. BPAS had identified 3 freedom to speak up guardians (FTSUG), however, these were the Chair of the board of trustees, the risk and governance director and a human resources business partner. The FTSUG acts as an independent and impartial source of advice to staff at any stage of raising a concern, with access to anyone in the organisation, including the chief executive, or if necessary, outside the organisation. The NHS standard contract requires that providers appoint one or more FTSUG. However, there was no FTSUG provision in each of the registered locations, for example ambassadors or champions. We found there were 2 issues raised with the FTSUG in the 12 months prior to our inspection. Due to the seniority of the FTSUG we were not assured BPAS had sufficient processes in place to ensure staff in all registered and satellite locations could raise concerns without fear of reprisal.

**Safeguarding**

The safeguarding and management of clients aged under 18 (2020) in use at the time of our inspection was generic and confusing, however, it was in the process of being updated to include sections pertaining to, for example, child criminal exploitation (CCE), County Lines, modern slavery, and Child Sexual Exploitation (CSE). The operations and quality services director was the executive lead for safeguarding and was supported by the lead professional for safeguarding (who had been in post since August 2022), who had significant experience working within the field of safeguarding. The safeguarding lead managed the safeguarding team who in turn provided support to registered managers and front-line staff.

We heard there had been overreliance on the central safeguarding team by front-line practitioners, who should have been supported to make autonomous decisions in consultation with local leaders. The recent changes in the national safeguarding team were beginning to change practitioner perception regarding their own responsibilities in terms of safeguarding. The national safeguarding team only accept cases with an assessment and plan in place. This supported front-line staffs' professional curiosity in their discussions with vulnerable children and young people. This system has resulted in better information sharing between national hubs so that local and national themes could be understood, for example, local training resources put in place.

The safeguarding supervision policy had been rewritten and launched in January 2023 however, this was not yet embedded within the organisation. The updated safeguarding supervision policy mandated 2 supervision sessions per year with additional sessions as and when required and was led by the national safeguarding team. Supervision followed a reflective model which included assessment of case files, and there was a stronger emphasis on compliance with supervision which was previously lacking.

Safeguarding training was included in mandatory training across locations and the required level of training was clearly indicated by staff role in the safeguarding policies. Safeguarding mandatory training completion across the organisation was 96% to quarter 2 2022/23.

**Notifications**

BPAS are required to notify the CQC about certain changes, events and incidents that affect a service or the people who use them. BPAS had a notification policy and procedure with a review date of October 2023, this policy also contained uniform recourse locator (URL) links which were not in use.

The notification policy and procedure did not include the entirety of the legal requirement to notify CQC in line with Sections 16 and 18 of Care Quality Commission (Registration) Regulations 2009. Including, death of a service user (16-2a, b); injury to a service user (18-2a, b); abuse or allegations of abuse (18-2e); incidents reported to the police (18-2f); events which prevent a provider's ability to carry out the regulated activity (18-2g). Separate to the notifications policy there was an operating procedure with a review date of May 2023 in place for clinical operations. The numbers of notifications were likely to be higher in areas where there are more services, and it should be noted that notifications may be made prior to full investigation and outcomes being agreed.

During the period January and December 2022 BPAS submitted 746 notifications of these notifications the largest number was for injury to a service user (18-2a, b) at 595 notifications and there were 47 incidents reported to the police (18-2g) were also included in the overall notifications.

During our inspection of BPAS Birmingham South we found not all serious incidents were investigated in a timely way or reported to the Care Quality Commission in line with the statutory requirements of the CQC registration regulations for notifiable incidents. For example, not all incidents where women required transfer to an acute hospital were reviewed to identify themes and trends.

CQC could not be assured there were effective systems and processes in place to ensure all registered managers were aware of the legal duty to submit statutory notifications to CQC. Failure to notify the commission is a criminal offence.

**Staffing levels and sickness absence rates**

Staffing levels and sickness absence were managed at location level by registered managers with oversight by the director of human resources. Evidence provided showed sickness absence rates were calculated in hours, we saw between July and December 2022 where between 3,685 and 6,186 hours lost. It was unclear where this information was discussed as we did not see evidence staffing levels and sickness absence rates discussed at board nor sub-committees. Therefore, we could not determine the level of oversight or actions that were being taken to increase staff resilience and address any potential contributing factors.

BPAS uses employed staff on permanent, fixed term/temporary, or casual contracts, as well as agency staff where required. Recruitment was co-ordinated by the human resources team. It was unclear where and how this was reported to board through its governance structures. Turnover data for 2022 showed high numbers in both voluntary and non-voluntary leavers, primarily due to savings identified in the business transformation plan. Evidence provided identified, 54% of all leavers in 2022 had less than 1 year service with BPAS. Themes for people leaving were identified as a lack of career progression and instability/financial insecurity.

## Leadership capacity and capability to deliver high-quality, sustainable care.

A leadership structure was in place; however, the strategic leadership team did not have the necessary experience knowledge, capacity, and capability to lead effectively. We found most were in their first strategic lead role. This meant we were not assured that the organisation was clinically led at a provider level. There was a disconnect between the operational and clinical elements, specifically nursing & midwifery as evidenced within the organisational structure.

We found that whilst the medical director had a strong voice throughout the organisation, this was in stark contrast to the chief nurse and midwife who, although was a member of the strategic leadership structure and discussions was line managed by the director of operations and quality and not the chief executive in line with their peers. There was a lack of governance and healthy check and challenge at board. Where we found strong clinical voice during location inspections this was due to individual leadership at a local level rather than being driven from the top.

Some leaders were out of touch with what was happening across the operational elements of the organisation and did not demonstrate an understanding of the risks and issues raised by colleagues. There was little attention to succession planning and the development of leaders. However, there were examples of recently appointed operational and clinical leaders making a demonstrable impact on the quality and sustainability of services.

The strategic leadership of BPAS consisted of the chief executive; finance director, medical director and director for reproductive research and communication; innovation and marketing director; chief of staff; operations and quality services director; chief nurse and midwife; risk and governance director; human resources director and national business development director.

BPAS has a board of trustees as directed by the charity commission. The strategic leadership team are accountable to the board of trustees who themselves do not actively work in the organisation or involve themselves in the organisation's daily operations. Charity trustees are the people who are legally responsible for the control, management, and administration of a charity.

The chief executive joined the charity in 2010 as director of external affairs and was based in the advocacy arm of the organisation and was appointed in 2020 as chief executive. Prior to their tenure at BPAS they had been a health reporter for a national news organisation.

Many of the strategic leadership team lacked experience in senior leadership roles. The most experienced was the medical director and director of reproductive research and communication who had been in post for more than 15 years.

The operations and quality services director were solely responsible for the clinical operations leadership and management at BPAS. In addition, they were the CQC nominated individual for the organisation which meant they were responsible for the management of all activities regulated under the Health and Social Care Act 2008 across the whole organisation.

The chief nurse and midwife joined BPAS in 2021 and was promoted to their current post in 2022. They were a member of the strategic leadership team, however, was line managed by the operations and quality services director. The chief executive described there was a “dotted line” to them as and when required. However, evidence provided as part of the inspection did not provide assurance that key metrics such as nursing and midwifery staffing was discussed in strategic leadership team meetings, board subcommittees or board of trustees.

The medical director and director for reproductive research and communication was the responsible officer. The responsible officer is a senior doctor who is responsible for the revalidation of doctors within an organisation. We found much of the role of the responsible officer had been delegated to the 3 clinical leads, 1 anaesthetic lead and lead appraiser; however, the medical director and director for reproductive research maintained the statutory responsibility of the responsible officer in line with national guidance. In addition, the medical director and director for reproductive research and communication had recently increased their portfolio and taken over as the Caldicott guardian. A Caldicott Guardian is a senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly.

During the inspection, interviews and reviewing of evidence it was clear there were disjointed working relationships within the strategic leadership team. There was a clear disconnect between the operational (client facing treatment and caring) activity and the advocacy and research activities. However, it was also evident there was also a fragmented relationship within the clinical operations workforce itself, namely a separation of the medical and nursing/midwifery teams. Although during the location inspections carried out prior to the reactive provider well led inspection, there was evidence of multidisciplinary teams working well together.

We reviewed board of trustee meeting minutes and found there was minimal evidence of discussion around operational issues and performance amongst senior leaders and trustees. There was minimal check and challenge in board sub-committee minutes. For example, following the report of a never event and a near miss along the same theme there was no additional discussion nor assurances offered in the minutes of the Clinical Governance Committee. Therefore, although it was reported there was no evidence that there were actions being taken or monitoring & oversight to ensure improvement and mitigation of risk to others.

BPAS did not have a leadership strategy. However, strategic leaders recognised the importance of developing leadership in the organisation. Opportunities were available to support leaders to develop their skills, knowledge, and experience within the organisation. Training was available for managers at all levels within the organisation; many people in leadership roles had a history of working for BPAS. There was system of support for strategic leaders who were new in post and in their first strategic leadership role to have access to buddying or coaching. This was expressed as a gap by leaders and something which would support development of a strong strategic leadership team.

There was no appreciation of the importance of succession planning for those trustees coming to the end of their tenure and within the strategic leadership team. This was of particular concern in the finance team, which was led by the interim finance director, was not supported by a ‘deputy’ or ‘head of’ which would allow for succession planning or acting up at short notice. In addition, the interim financial director had committed to providing support for 1 year, however, the recruitment of a substantive finance director had not commenced and there was only 6 months remaining of the interim contract. BPAS had also not defined the future role of a finance director to the extent to

which the role will be strategic vs operational. Consequently, there was uncertainty around arrangements for a substantive appointment to the position.

The strategic leadership team understood their portfolios and had a knowledge of the current priorities and challenges to the organisation. However, as a collective we saw there were competing priorities for example, the unstable financial position of BPAS and the ability to provide a quality service to women and pregnant people. The pace of change and improvement was slow and inspection and monitoring activity by the CQC found repeated issues across locations resulting in requirement notices being issued and a reduction in location rating.

**Fit and proper person review**

Systems and processes were not undertaken to ensure appropriate appointments at director level.

BPAS had a fit and proper person policy and procedure in place which was issued in January 2023. It outlined the procedure to ensure that directors of the company were fit and proper persons.

The required checks for directors or equivalent roles had not been fully completed. We reviewed the human resources records for trustees and a sample of the strategic leadership team held at the head office during the onsite inspection activity.

For trustees, the shortlisting process was completed by a third-party company with the interviews and selection being made by the chair of the board and 2 others. There were no financial checks nor employment history checks. We were unable to see if all trustees had reference checks held on file, however, it was not clear if these were in place or human resources did not have access to them. Once new trustees were offered a post, they were invited to the next board of trustees meeting even if the 3rd part had not been received, however none had access to BPAS systems or email address and none received any papers until after their first meeting.

We saw that BPAS did not always follow their own fit and proper persons policy in procedure during the recruitment of the interim finance director. The incumbent had previously held this role and retired in 2019, the chief executive had directly approached them to return to support the delivery of the financial recovery plan. Their consultancy agreement was signed in September 2022; however, we saw the confidentiality agreement and third-party checks (including disclosure and barring service checks) were applied for on 2 February 2023, this was 6 months after they had commenced their contact.

## Responsibilities, roles, and systems of accountability to support good governance and management.

Governance structures and processes were not effective in supporting good quality and sustainable services. Governance arrangements and their purpose were not clearly understood across the organisation. There was a lack of clarity about accountability structure and therefore how individuals were held to account for their roles and functions. From the evidence received prior to our inspection and through the interview process did not identify a process to review key items for example organisational values, a strategy, objectives, plans or formalised governance framework.

A matrix approach to governance was being adopted with several lines of reporting across the organisation giving opportunities for issues to be identified or raised. However, a clear line of accountability from the “floor to board” could not be established across all BPAS and there was no

formal governance framework or strategy that was fully embedded across all operational parts of BPAS.

Governance systems and processes were ineffective and had failed to prevent or identify significant issues within locations to allow effective intervention by the strategic leadership team.

In August 2021 we found significant concerns in we found that safe care was not being provided; ineffective safeguarding processes; incomplete risk assessments were not fully completed; observations were not monitored or recorded; records were not fully completed, clear or up to date; ineffective systems to safely prescribe, administer and store medicines; staff did not always recognise and report incidents; managers did not consistently check staff followed national and local guidance; staff did not always support clients to make informed decisions about their care and treatment. This resulted in the imposition urgent conditions on the registration of each location under section 31 of the Health and Social Care Act 2008, to drive improvement. Following an application made by BPAS the Section 31 conditions were removed from the registration of each of the BPAS locations where they were imposed in January 2023.

Whilst actions were taken at these locations there was limited evidence that learning was shared, and mitigations put in place. There was inconsistent governance, oversight, and monitoring to ensure patient safety. Subsequent inspections between March and October 2022 found similar concerns. Policies and procedures were in place, but these were not consistently followed. Access to treatment and recognition of the deteriorating patient was inconsistent.

For example:

- BPAS – Taunton Central, in March 2022 we found women did not always receive timely care and treatment in line with national targets. The service did not have effective processes to identify or escalate a deterioration in the condition of children.
- BPAS – Sandwell, in May 2022 we found women did not always receive timely care and treatment in line with national targets. Pregnancy remains were not always stored following the provider's own policy. The service did not have effective processes for identifying or escalating a deterioration in the condition of children. Venous Thromboembolism risk assessments were not always completed in line with the BPAS policy.
- BPAS – Doncaster, in June 2022 we found services had improved, however, the service did not have effective processes for identify or escalated a deterioration in the condition of children nor were there supplies of emergency equipment suitable for intubation of children. Storage of medicines was not always in line with best practice. Women did not always receive timely care and treatment in line with national targets. There had been improvements to governance processes, however, these had not been embedded.
- BPAS – Middlesbrough, in June 2022 we found services had improved, however, the service did not have effective processes for identify or escalated a deterioration in the condition of children. Labelling of medicines was not in line with legal requirements. The service did not have enough staff to offer cover arrangements in the event of staff absence. Women did not always receive timely care and treatment in line with national targets. There had been improvements to governance processes, however, these had not been embedded.
- BPAS – Stratford upon Avon, in June 2022 we found women did not always receive timely care and treatment in line with national targets. The requirements of duty of candour where

not fully med. Medicines were not always stored appropriately. The service did not always submit timely statutory notifications to the CQC.

- BPAS – Basingstoke, in July 2022 we found that the service did not manage emergency equipment safely. The service did not have effective processes for checking emergency drug boxes. Intermediate life support training was low. Women waited for longer periods to access interpretation services. Women did not always receive timely care and treatment in line with national targets.
- BPAS – Merseyside, in July 2022 we found services had improved however, the service did not have effective processes for identifying or escalate a deterioration in the condition of children. There was no process of effective handover. Women did not always receive timely care and treatment in line with national targets. Staff did not feel respected of valued. There had been improvements to governance processes, however, these had not been embedded.
- BPAS – Norwich, in July 2022 we found women did not always receive timely care and treatment in line with national targets. Pregnancy remains were not always stored following the provider's own policy. The service did not have effective processes to identify or escalate a deterioration in the condition of children.
- BPAS – Birmingham South, in September 2022 we found not all notifiable events were reported in line with mandatory legal report regulations. The service did not have effective processes to identify no escalate a deterioration in the condition of children. Governance arrangements were not sufficient or robust. Pregnancy remains were not always stored following the provider's own policy. Not all staff had completed their mandatory training. emergency equipment and intravenous medicines were not stored securely.
- BPAS Bournemouth, in October 2022 we found the service did not always ensure the correct legal documentation was completed before surgical terminations. The service did not always provide care and treatment following current national guidance to ensure pregnancy remains were treated with respect. The service did not have effective processes to identify or escalate a deterioration in the condition of children. The service did not operate effective systems to safely prescribe, administer medicines. Not all staff have completed mandatory training. Staff did not always recognise, and report incidents Women did not always receive timely care and treatment. Leaders did not always operate effective governance processes. Although leaders had the skills and abilities to run the service, they did not always have capacity to provide leadership as they had dual roles. Not all staff understood the organisation's vision and strategy, and they were not all aware of the freedom to speak up guardian and how to contact them.

BPAS was taking action to make improvements at the locations identified and had submitted all post inspection action plans as required by the health and social care act 2008. We were not assured during the provider inspection that the gaps within the leadership, management and overall, across the organisation were recognised.

We asked for all external developmental reviews of leadership and governance; however, these were not available. Therefore, we were not assured BPAS had sought any external or independent scrutiny of the strategic leadership team and governance processes.

There was a governance structure in place, this was split into corporate which was aligned to the charity governance code set out by the charity commission and clinical governance. The structure showed how governance meetings related to each other. Below the board of trustees, there was a structure of 4 committee meetings including:

- Strategic Leadership team
- Governance, renumeration and nominations committee
- Finance, audit ad risk committee
- Clinical governance committee.

The chief executive chaired the strategic leadership meeting, trustees chaired the remaining 3 committees.

There were 10 sub-committees at provider level. Area compliance boards were co-chaired by operational quality managers unit level oversight meetings were co-chaired by the treatment unit manager or lead nurse (or equivalent role). At location level there were unit level overview meetings and area compliance boards. The area compliance boards, and unit level meetings were aligned to the Quality and Risk Committee and Clinical Governance Committee, however, we did not see where the outputs of these meetings were noted or discussed.

The board of trustees and subcommittees met 4 times a year, there were plans to bring together the subcommittee chairs to gather between meetings to improve communication across the organisation, but this was not yet in place. Unit level meetings took place weekly and area compliance boards met monthly.

Board of trustee meetings and committees were supported by a data pack which included papers produced by the strategic leadership team for discussion. Meeting minutes were pulled together following each meeting; however, these minutes were brief and there was minimal reference to any challenge articulated by trustees.

Meeting papers showed a lack of analysis or interpretation of the data pack for the board of trustees. There were detailed statistical charts, however, there was limited, or no explanation of what the charts meant or showed. For example, the summary report for clinical incidents, Quarter 1 2022 presented to the clinical governance committee in November 2022, included a table where incident categories/ experiences had notable change which included headings such as missed opportunities to safeguard and appointment not cancelled; each heading had a description, however it was a statistical commentary on the findings.

> “Missed opportunities to safeguard a client The number of incidents reported in quarter 1 is significantly greater than the number of incidents recorded in the preceding quarters, suggesting the start of an upward trend. Over the year, the number of missed opportunities to safeguard has increased but the growth is not statistically significant (2020/21, N=84, 0.09% Vs 2021/22, N=126, 0.11%, P=0.27)”

BPAS were not using charts as a visual tool which would enable the board of trustees and leaders to study changes in performance over time. In addition, data was not presented at location level to enable leaders to identify themes or trends at a location level. We were not assured that data was presented in a format that could be understood in a meaningful way to enable comparative analysis across locations.

In January 2022 BPAS implemented the local clinical audit compliance board (LCACB) which was a programme of audits undertaken by each treatment unit (dependant on the service provided) and telemedicine hub. We found there was limited evidence of a summary to the board of trustees regarding location and area level audit and no evidence of discussion at the board of trustees in the minutes and no actions identified.

At the time of our reactive provider well led inspection BPAS was in the process of launching an operational dashboard. This was described as an organisation wide dashboard to maintain clear and documented timelines of change. This had been tested in a small number of locations and was in the process of being rolled out across the organisation.

Actions from meetings were not effectively managed. We saw an example of an action from the Clinical Governance Committee in April 2022 regarding a review of the available resources to conduct investigations in a timely manner to ensure actions had been effectively delivered. There was no reference to this action in the following meeting in July nor November 2022. There was no evidence of an action log to show which actions had named and responsible individuals, which meant there was no oversight of actions generated from committee and board of trustee meetings, this demonstrates a failure to manage risk.

There was evidence that the board of trustees had received minutes from committees within the governance structure. In the papers from November 2022 the minutes were submitted from the Clinical Governance Committee also in November 2022. We saw the papers for the Clinical Governance Committee included reference to 2 serious incidents which were reported as never events. There is no evidence of check and challenge within the minutes of the Clinical Governance Committee which then meant it was not included within the information pack for the board of trustees. Given the lack of documented discussion, audit, check and challenge we were not assured that the board were fully sighted of serious incidents reported within the organisation.

All minutes we reviewed showed limited evidence of discussion or challenge regarding the data presented. There was no escalation of reports from location and area governance meetings to the sub-committees and committees of the board of trustees.

**Incident investigation**

We found there was limited clinical involvement in incident investigation within BPAS. Presentation of incidents did not lead to openness and transparency. We were not assured that the board were fully sighted or that where incidents were presented these were understood to enable appropriate oversight.

There was an electronic incident reporting system, all reports were reviewed and signed off by treatment unit managers; in addition, the risk team reviewed all incidents.

Evidence provided as part of the inspection showed between January and December 2022 there were 10158 incidents reported by staff; of these 72% (n7361) were categorised as no harm; 24% (n2419) were categorised as low (minimal) harm; 3% were categorised as moderate (short term) harm; 0.3% were categorised as major (long term) harm. We found 50% of the incident reported were made by the booking and information centre, and the 5 telemedicine hubs in Birmingham, Bournemouth, Coventry, Doncaster, and Richmond. During interview we were told most incidents reported were not clinical, however, we found 97% (n9906) of the incidents reported were done so by the clinical operations teams and related to care provided. Of the 9906 operational incidents 30% (n3020) pertained to either potential ectopic pregnancy or a confirmed ectopic pregnancy, therefore, information provided in interview was incorrect.

We found none of the treatment unit managers were from a clinical, background, and this meant we were not assured they had the training and competence to identify and escalate incidents consistently. During the inspection we were provided with an example of a significant incident which resulted in a client being transferred to the local NHS hospital. The clinical operations leadership team were not aware of the incident, in addition the area quality matron had not had oversight of the 24-hour report prior to being sent to the integrated care board (formally clinical commission group / CCG).

The January 2023 strategic leadership team meeting papers recognised the challenges with the incident reporting process. The papers stated a CQC inspection team had identified a never event which had been reported in such a way that it did not trigger the risk team to review, or the first line assurance function identified as the Quality team. To reduce the likelihood of an incident being mismanaged, the 'datix' and risk data manager (DRDM) had been redeployed to review all incidents the day after they have been initially reported. The DRDM would then flag any case that represented potential significant learning or risk to the Clinical Risk Team (none of whom were from a clinical background) for further review and management. These cases were classed as 'Risk team Review' cases. First line assurance functions, such as the Quality team, Safeguarding team and regional clinical directors were identified as support for this process with subject matter expert reviews. However, this was dependant on the clinical risk team identifying subject matter expert review was required. In addition, we saw due to the number of incidents requiring a risk team review, and the available resource, there was approximately 400 cases awaiting review, this meant there was a delay in identifying any causality or learning.

**Audit**

During the simultaneous inspections of Doncaster, Merseyside, and Middlesbrough in 2021 it was identified there was a lack of audit activity to assure leaders systems and processes were effective. We found all audit activity has been suspended apart from medicines management, clinical supervision, and infection prevention. Following on from this the clinical operations leadership team had developed and trialled a new system of local clinical audit compliance board (LCACB). Following a successful trial, the LCACB was in the process of being rolled out across the organisation from January 2023.

Whilst there had been an improvement in audit within BPAS it was not clear where the outputs of the LCACB audits would be presented. We saw in the April 2022 Quality and Risk Committee minutes there was a request for the LCACB audits to be included within the reporting requirements for the quality and risk committee; we saw the papers were included, however there was no discussion recorded with in the minutes of the meeting. We saw LCACB audits for March, April, May, July, and August 2022; audits included surgical case notes, safeguarding adults, safeguarding under 18, client well-being checks, consultation, early medical abortion (EMA), infection control, essential steps, crash trolley, and medicines management. We saw there was a gradual improvement in compliance over the 5 months reviewed. We did not see evidence the LCACB audits were discussed at strategic leadership team meetings, however, they were presented to the clinical governance committee, however, we saw no evidence of discussion or challenge within the minutes provided.

The LCACB audits were co-ordinated by the clinical operations leadership team including the chief nurse and midwife, and not the quality and risk director.

**Medical Governance**
BPAS employed 37 doctors across its locations (including clinical leads), which totalled 530 contracted hours.

Most doctors were substantively employed by BPAS, however, there were some who were engaged to provide services to women through practising privileges. There was a process in place to recruit and review practising privileges to ensure doctors share their annual appraisal documented from their substantive employment in the NHS.

BPAS had a responsible officer advisory group (ROAG), which met quarterly. The purpose of this group was to act as a mechanism of formal assurance to internal and external stakeholders that BPAS had effective systems for the identification, investigation, and management of concerns about medical professionals. This meeting was chaired by the medical director and director for reproductive research and communication, however, one of the documents provided titled “BPAS Governance” stated the meeting was chaired by a regional clinical director, and the membership included the medical director. The terms of reference included within the member chief nurse (as required) there was a standing agenda item titled “Concerns raised – Individual doctors/nurse/midwife. However, we reviewed meeting minutes from April, August and October 2022 and saw there was no representation of the chief nurse and midwife by them or their deputy, apologies were given in April 2022.

The quoracy requirement of ROAG stated “If the matter concerns a nurse/midwife, the chief nurse must also be present.” This did not align to the requirement of the standing agenda item, but also did not promote an inclusive and multidisciplinary culture within the organisation across both medical and nursing/midwifery staff.

## How appropriate and accurate information is processed, challenged, and acted on?

The board of trustees received a range of information on service quality and performance which were reported in data packs produced for use in meetings. There was inadequate access and challenge of performance by leaders and staff. There were significant failings in systems and processes for the management or sharing of performance data.

There were clear targets for the timeliness of abortion care (NICE), of all the inspections completed in 2022 we found in 8 of the 10 locations inspected women did not always receive timely care and treatment in line with national targets. We reviewed the Clinical Governance Committee minutes for April, July, and November 2022; we saw although there was an acknowledgement of the issues, however, there was limited check and challenge from the committee. Waiting times were discussed in the Quality and Risk Committee, however, there was inconsistent reporting of discussion in the meeting minutes and the concerns were not always escalated to the Clinical Governance Committee. There was evidence in papers that the concerns with waiting times was presented to the board of trustees, however, minutes did not provide any assurance that the concerns were acknowledge nor what actions were being taken to reduce them.

A lead was identified for the General data protection regulation (GDPR). There was a Caldicott guardian and senior information risk owner in place at executive level.

The BPAS information systems for recording training were not fit for purpose, there was a disparity between what was happening in treatment units and what was recorded centrally. This meant the

strategic leadership team did not have accurate oversight of the training requirements of staff. We were also told centralised systems did not accurately record professional registrations and when they were due to be renewed/revalidated, this responsibility was devolved to the treatment unit managers. This meant leaders could not assured all registered staff had current professional registration. During the factual accuracy review process BPAS provided evidence that a process had been put in place to monitor and record professional registration of nursing and midwifery staff.

Due to the significant financial challenges faced by BPAS, all non-essential spending was frozen which meant there was limited ability to address the performance problems identified in information systems. For those investments which had previously been made there was limited assurance BPAS had maximised the full benefits of the information technology infrastructure investments, or that learning from these projects had been consolidated to inform future decision making. There was a single electronic patient record system, however, there was limited functionality at times to extract data and this caused delays when reviewing records or requesting information.

We saw that the presentation of monthly profit and loss results was visually dense. Non-financial readers would find it difficult to identify areas of significance, and what they should be interpreting from the numbers. In addition, the narrative accompanying monthly financial results was historically focussed. The forecast outturn and its significance were not highlighted or explained. The narrative was also profit and loss focussed, this meant other aspects that may give rise to financial risk such as working capital movements, aged debtors, cash, fixed assets, and reserves were not highlighted or explained.

## How the service continuously learns, improves, and innovates to ensure sustainability?

There was weak and inconsistent investment in improvement skills and systems among staff and leaders. Improvements were not always identified, or action was not always taken. BPAS did not look to identify systematic risk and respond effectively, but often relied on external parties to identify key risks before they started to be addressed. Due to the limited number of improvement initiatives which had been implemented prior to our inspection it was not possible to determine if these changes had an impact on the quality and sustainability of care.

We found following an audit by an external organisation BPAS did not have the appropriate, legal and governance processes in place to use patient group direction (PGDs). PGDs allow healthcare professionals specified within the legislation to supply and/or administer a medicine directly to a patient with an identified clinical condition without the need for a prescription or an instruction from a prescriber. Organisations should have policies and processes in place to consider all aspects of medicines management for patients within the service or pathway. PGDs must be authorised by the authorising body in line with the Human Medicines Regulations 2012. Once identified it was discovered BPAS had not implemented the recommendations of the NICE 2017 patient group directions (MPG2), there was no transparent process with an authorising body, there was no PGD policy in place, there was no template to ensure consistency across all the commissioning organisations. Where the authorising bodies had been asked to authorise the PGD there was no process to ensure BPAS supplying medicines using PGDs in line with the Human Medicines Regulations 2012.

There were systems in place to identify complaints, serious incidents, and unexpected deaths in the organisation. However, these were not always investigated nor learning identified. Systems were not in place to allow the sharing of learning across the organisation; however, a system was being tested in one region.

Staff interviewed did not always articulate the importance of transparency when things went wrong. We found registered managers often had created local standard operating procedures when things went wrong to address any gaps identified in individual policies. This gave way to local variations in standards of care, but also meant the strategic leadership could not have oversight of the effectiveness of policies and standardisation across the organisation.

BPAS did not have a formalised quality improvement strategy, however, we saw evidence of discrete quality improvement projects, including “you said we did” scorecards and quality improvement and performance boards and situation-based education. All quality improvement projects used the Plan-Do-Study-Act (PDSA) cycle which was an iterative 4 stage problem solving model used for improving a process or carrying out change.

From September 2022 BPAS had begun to implement the roles of professional midwifery advocate (PMA) and professional nursing advocate (PNA). The training for the PMA and PNA roles provided participants with the skills to facilitate restorative supervision with colleagues and equips them to and lead, support and deliver quality improvement projects. Whilst this was a positive step these roles were in their infancy and would need time to begin to embed and drive change.

BPAS actively took part and led research into abortion care. The medical director was also the director for the centre for reproductive research and communication (CRRC). The CRRC developed and implemented internal research and evaluation, facilitated research by external investigators and participated in collaborative projects. BPAS also had its own research and ethics committee (REC) committee which met quarterly to discuss ongoing studies and review new applications and amendments. The BPAS 2021/2022 clinical governance report dated July 2022 showed they were facilitating 7 external research projects which involved clients and staff. By the close of March 2022 11 projects had been carried over from 2020/2021 and 11 new projects were approved and 7 had been closed.

**Mortality and Unexpected deaths**

If BPAS were notified of the death of a client these incidents were reported both internally alongside a statutory notification submitted to CQC. In 2022 we saw all deaths were reported in line with their own policy and the regulations set out by the health and social care act 2008. Following review of all the client death’s the primary cause of death was not attributed to any treatment received from BPAS.

**Complaints**

BPAS had a current complaints and client feedback policy in place which included information about their complaints management process and timeframes. The policy identified complaints could be managed in 3 ways, local, informal, and formal. A local complaint was defined as being raised at the time, which enabled prompt action to resolve concerns and prevent escalation. It was expected clients would receive a response at most within 2 working days. An informal complaint was defined as being raised at the time, but could not be resolved within 2 working days, but should be resolved within 5 working days. Formal complaints were usually submitted in writing

and acknowledged within 3 working days and a full response should be provided within 20 working days.

Complaints were reported to the clinical governance group, these were documented in the minutes, however there was no discussion pertaining to complaints in the board of trustee minutes we reviewed.

We saw between April and June 2022 BPAS received 94 complaints, none of these were formal complaints, and 75 were local complaint, however 19 required a formal written response. In addition, BPAS received 811 concerns, the main theme in terms of complaints were waiting times and a need for more information and support needed. This meant a very slight increase however largely the complaints remained the same and therefore if actions had been taken to try and address the themes had not been effective.

We saw evidence which showed between July and September 2022 BPAS received 86 complaints, none of these were formal complaints, and 77 were local complaint, however 9 required a formal written response. In addition, BPAS received 605 concerns, the main theme in terms of complaint was waiting times and a need for more information and support needed.

## Processes for managing risks, issues, and performance.

Risks, issues, and poor performance were not always dealt with appropriately or quickly enough. The risk management approach is applied inconsistently or is not linked effectively into planning processes. The approach to service delivery and improvement was reactive and focused on short-term issues. Clinical and internal audit processes were inconsistent in their implementation and impact. The sustainable delivery of quality care was put at risk by financial challenges.

There was a lack of pace when incidents were identified, during our inspection of BPAS Bournemouth we found reported incidents of when terminations had been carried out in 2021 without the required legal documentation being present or fully completed. Despite these incidents had not been investigated as thoroughly as they should have been. A system to prevent a repeat occurrence was not put in place until December 2021,

**Risk management**

There was a structure and process in place to oversee performance, quality, and risk. However, the structure did not support the board of trustees to effectively identify emerging performance, quality, or risk issues with operational concerns. The structure focused on the corporate and advocacy side of the business.

There was no clear escalation process of risks from location level to the executive team. The process did not evidence that where risks were identified, an appropriate level of risk agreed mitigations put in place across the suitable levels within the organisation. However, we heard examples where the clinical operations team had recognised and tried to escalate some of the risks which formed part of the CQC enforcement action in BPAS Doncaster, Merseyside and Middlesbrough in 2021. We were constantly told during the reactive provider well led inspection by trustees and senior leaders that BPAS were grateful for the urgent Section 31 Conditions imposed following the 2021 inspections as this opened their eyes to some of the challenges BPAS faced.

The strategic leadership team did not have oversight of significant risks identified by regional teams. BPAS did not use a live system to notify and manage risks across the organisation. Inspection activity of registered locations showed risks were discussed at a location level. The risk

appetite for the organisation was unclear, records of recent strategic leadership team meetings showed no evidence of risks being escalated, nor that these had been but not being entered onto the corporate risk register.

During inspection activity in locations, we saw evidence of clinical, environmental, and operational risks being identified and managed appropriately in most locations.

Again, risk appetite was not set clearly enough at leadership level therefore, the corporate risk register only had 1 clinical risk and 1 operational risk identified. The clinical risk pertained to information technology development teams and competing priorities, system updates and processes not being completed in a timely manner which may result in regulatory action. The operational risk related to resilience and business continuity events which may create a financial impact on the organisation. We saw in the November 2022 board of trustees' information pack that the strategic risk register contained 6 risks out of 38 which has a date added following the review date, there was no evidence of challenge or discussion noted of this error in the meeting minutes. However, we saw this had been corrected in the strategic risk register that was supplied as part of our inspection.

**Finance**

BPAS has been through a period of revenue growth in recent years and during this time had reported operating losses. At the time of publishing the report an interim Director of Finance was in post.

BPAS's most recent set of published statutory accounts for the year ending March 2022 showed revenues of £39.5m and an operating loss of £2.9m before unrealised gains on evaluations. The net assets of the organisation were £12.0m.

In the year ending March 2022 the charity raised £3.6m from the disposal of property, plant and equipment and reported spending £2.8m on new property plant and equipment including £2.1m on setting up the fertility business. The charity has since (post March 2022) taken the decision to divest of the fertility business for a net fee of £0.3m to improve its financial resilience.

**Performance**

There were processes in place to manage performance however this was led within the clinical operations team and not owned by the whole of the strategic leadership team. The clinical operations team had implemented local clinical audit compliance boards (LCACB), local themes for non-compliance were managed locally by the lead nurse/midwife and treatment unit manager with support from the quality matron and operational quality manager. The board of trustees had limited oversight of performance across the organisation, key issues and concerns were not always discussed at the fortnightly strategic leadership team meetings.

There was a significant referral to the CQC inspection and rating methodology as part of performance and governance processes within the organisation. The minutes of meetings did not evidence variations in performance at location or regional level being identified or the actions required being discussed.

Key performance indicators were reported to the strategic leadership team fortnightly and were presented in the form of activity charts, with no additional context provided, the minutes of these meetings did not provide any evidence of check and challenge. The board of trustees did not receive detailed information pertaining to performance, we saw there was reference in the chief

executive's overview. Therefore, we could not be assured trustees were fully appraised of performance challenges that BPAS faced.

BPAS was able to demonstrate that where the CQC had raised concerns or found a breach of regulation, it was discussed with the Clinical Governance Committee and the Quality and Risk Committee, however, due the financial challenges which faced the organisation action in the form of additional resource and support was not an option available.

Following location inspections when a requirement notice had been served the location must show how they will comply with their legal obligations and must explain the action the location is taking or proposes to take to do so. Issuing a Requirement Notice notifies a provider that we consider they are in breach of legal requirements and should take steps to improve care standards. There was no evidence in any of the papers we reviewed that the strategic leadership team had oversight of progress towards each of the individual location action plans.

## Engagement with the people who use services, the public, staff, and external partners to support high-quality sustainable care.

The full range of people's views and concerns was encouraged; however, it was difficult to identify if it was heard and acted on to shape services and culture. The service proactively engaged and involves all staff and ensured that the voices of staff were heard and acted on to shape services and culture.

There were systems in place to obtain feedback from staff and people who used services.

**Engagement with people who use services.**
BPAS had a feedback and complaints policy freely available on their website dated January 2023. There were 4 ways in which clients could provide feedback, these included:

- Speak to a member of staff, or as to speak to the unit manager.
- Complete an online satisfaction survey if the client had agreed BPAS may do so.
- Contact the BPAS's client experience manager at the head office address.
- "Rate your experience" via NHS choices.

Evidence showed 13,522 completed 2012/2022 which equated as a response rate of 15%. The overall satisfaction score was 9.29 out of 10. Ninety-eight percent of surveyed clients would recommend BPAS to someone they know who needed similar care. However, key areas of dissatisfaction were, the percentage of clients informed of long waiting times which had remained consistently high; the wait times between initial contact and treatment, escort involvement, and clinic location had increased.

All client feedback was reported to the clinical governance committee, however, in the minutes of these meetings from April, July and November there was only 1 mention of client experience. However, the minutes did not reflect a summary of client experience, but, focused on the engagement manager workload due to the increasing client numbers and was developing a business case for extra resource. This was in response particularly to CQC and CCGs require demonstration of increased reporting and learning from client feedback and complaints. This meant there was no information presented as part of the minutes for the board of trustees.

We saw papers for the board of trustees made no reference to client experience nor were client stories presented. This meant we could not be assured the board of trustees were aware of the client experience.

**Staff engagement**
BPAS carried out an annual staff survey. The most recent staff survey results (2022) showed participation in the survey was 55% of staff, 50% had worked for BPAS between 1 to 5 years.

The 2021 staff survey 51% of staff disagreed in response to the question of whether senior managers had a good understanding of how this really were and 18% neither agreed nor disagreed. Following this strategic leadership team carried out a programme of site visits, this saw an improvement in the 2022 staff survey where 37% of staff disagreed senior managers had a good understanding of how thing really were and 23% neither agreed nor disagreed.

We saw evidence of examples of senior leaders visiting services and speaking to staff teams regarding any concerns they may have, and initiatives put in place following including “you said we did.”

The 2022 staff survey showed improvements in the key engagement indicators from 61% in 2021 to 73% in 2022, the key findings were:

- 71% don’t have plans to leave BPAS compared to 58% in 2021.
- 88% understand how their job contributes to BPAS’ objectives compared to 87% in 2021.
- 61% look forward to going to work compared to 53% in 2021.
- 70% would recommend BPAS as a place to work compared to 61% in 2021.

Whilst BPAS recognised there was improvements the strategic leadership team visits were to continue into 2023 with a repeat staff survey taking place in December 2023. Due to the timing of reactive provider well led inspection the 2022 staff survey action plan had not been completed.

**Engagement with external partners.**
BPAS engaged with external partners, however, the service was not always transparent and open with all relevant stakeholders about performance. We saw 2 quality monitoring reports which covered July to September 2022. The quality performance dashboard was service specific the in terms of the number of clients who accessed treatment. However, we found the information in both reports which focused on client feedback was the same. There was no information in either report to state this was BPAS wide data therefore misleading for the commissioning integrated care board.