British Pregnancy Advisory Service

Quality report

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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 24 registered locations with 26 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. Between April 2022 and March 2023 98.6% of patients had 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 111,000 women in 2022/23 in 50 reproductive healthcare clinics nationwide and telemedicine service. With an income of about £40 million and employs more than 800 contracted staff.

Core service inspected	CQC Registered Location	CQC Location ID
Provider Well Led review	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 - Peterborough	1-129168644
	BPAS - Portsmouth Central	1-740422701
	BPAS - Richmond	1-129168659
	BPAS - Sandwell	1-7934678702
	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 an inspection to reassess services following the imposition of a Section 29 Warning Notice and from other 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 focused reinspection of the British Pregnancy Advisory Service on 16 April 2024 following the imposition of a section 29 warning notice on 25 May 2023. Following this inspection BPAS entered a programme of intensive support and oversight provided by NHS England to drive the required improvements.

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 111,000 women in 2022 in 50 reproductive healthcare clinics nationwide and telemedicine services.

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 focused follow up assessment.

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

We conducted a focused inspection to assess actions taken by BPAS following the 29A Warning Notice we served after our last inspection. Following the inspection and a review of the evidence provided CQC were satisfied that BPAS had met the requirements of the S29 warning notice and it has been removed.

Our inspection team.

The team included a senior specialist and governance specialist from NHS England.

Background to British Pregnancy Advisory Service.

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Why we carried out this inspection.

In February 2023 we carried out a responsive provider well led inspection of the British pregnancy advisory service, following the inspection 12 of the British Pregnancy Advisory Service registered locations in England. Whilst these inspections identified several positive factors, they also identified some concerns linked to the provider's leadership and governance arrangements.

On 25 May 2023 CQC served the British Pregnancy Advisory Service with a Warning notice served under Section 29 of the Health and Social Care Act (2008) with a compliance date of 31 January 2024. We found significant improvement needed to be made in the following areas:

- The board oversight of operational risks, issues, and performance.

- Incident investigation processes, ensuring timely and appropriate clinical oversight to identify themes and trends.
- Adherence to the fit and proper and persons requirements.

The purpose of this inspection was to check whether the British Pregnancy Advisory Service has complied with the requirements of the Section 29 Warning Notice.

Areas for improvement

Action the provider MUST take is necessary to comply with its legal obligations. Action a provider 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 provider SHOULD take to improve:

The British Pregnancy Advisory Service:

Should continue to ensure effective governance systems and processes are embedded across all services to support the delivery of sustainable and high-quality care.

Should continue to ensure 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.

Should continue to ensure that clinical and corporate risks are identified and effectively managed at every level in the organisation including a clear risk escalation process.

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.

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

At our previous inspection we found the strategic leadership team did not have the necessary experience knowledge, capacity, and capability to lead effectively. This meant the organisation was not clinically led at a provider level. There was also a disconnect between the operational and clinical elements, specifically nursing & midwifery as evidenced within the organisational structure.

At this inspection we found a new executive leadership structure in place. BPAS had a board of trustees as directed by the charity commission since our last inspection an executive chair had been appointed to drive improvement. The executive leadership team were accountable to the board of trustees who themselves did not actively work in the organisation or were involved in the organisation's daily operations. BPAS had also appointed 3 new trustees which helped to fill skills gaps identified in the board following our inspection. (Charity trustees are the people who are legally responsible for the control, management, and administration of a charity).

Our assessment identified that the executive leadership of BPAS consisted of an executive chair, newly appointed chief executive who started 3 weeks prior to our assessment, director of finance and corporate services, director of research and innovation, interim medical director, chief of staff, director of operations, director of nursing, midwifery and quality, company secretary and head of corporate governance, director of human resources and organisational development, director of business development

We found a cohesive executive leadership team who all had an equal understanding of the challenges BPAS faced and took collective responsibility to drive the required improvements.

Since we previously inspected, the executive leadership team had been supported to develop their leadership roles. We found a strong triumvirate had been formed with the director of operations, interim medical director, director of nursing, midwifery, and quality to jointly lead clinical operations leadership and management at BPAS. This triumvirate had been formed in the 7 weeks prior to our inspection, however, were able to identify and articulate single vision for what they collectively wanted to achieve with a strong narrative on quality governance and assurance across all levels of the organisation.

The interim medical director worked clinically within BPAS which meant they were credible with their peers and aware of the challenges colleagues experienced on a daily basis.

At the time of our inspection the director of research and innovation was the responsible officer and also the Caldicott Guardian. The responsible officer is a senior doctor who is responsible for the revalidation of doctors within an organisation. The 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 our previous inspection we found disjointed working relationships within the strategic leadership team. However, during this inspection we found a collective voice of improvement, with all those we spoke with identifying the importance of the quality of care patients receive and oversight of operational activity.

We reviewed board of trustee meeting minutes and found in improvement of the flow of information with evidence of discussions and data of operational issues and performance. We also saw improved recording of check and challenge in both board of trustees and board sub-committee minutes.

We heard and saw examples of succession planning for key roles within the charity and providing opportunities to support aspiring leaders to develop their skills, knowledge, and experience within the organisation.

There was system of support for executive leaders and a programme of board development had begun to ensure those leading the organisation were aware of their responsibilities.

The executive leadership team understood their portfolios and had a knowledge of the current priorities and challenges to the organisation. We saw priorities were patient focused including experience, key performance indicators and offering choice. The pace of change and improvement have improved significantly, we found much of the improvements and change had occurred in the preceding 6months to our follow up inspection.

Fit and proper person review

There were effective systems and processes to ensure the appointment of and recruitment checks for executives and trustees.

BPAS had a fit and proper person policy and procedure in place which was issued in April 2024. It outlined the procedure to ensure that directors and trustees of the company were fit and proper persons.

The policy had been updated following our previous inspection to amalgamate the levels of checks appropriate to each of the roles and to comply the NHS England Framework and recommendation

following the Kark review (2019). The updates included clarity on the scope of the policy and additional recruitment processes.

We found BPAS had enhanced their recruitment checks which now included a social media review. We also saw where there were gaps in checks there was a risk assessment in place which had been escalated to the executive chairperson for a decision for example if the person needed to be suspended from activities until their checks were completed.

All outcomes for individuals were recorded on the BPAS FPPR annual summary for which was reviewed quarterly at the governance, nomination and renumeration committee. Assurance was then provided annually to the board.

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

Governance structures and processes had been redefined following our previous inspection. Governance arrangements and their purpose were also clearly understood across the organisation. We found a greater clarity in the accountability structure which showed how individuals were held to account for their roles and functions. Evidence provided as part of the inspection and also during the interview process demonstrated a process had been put in place to review key items for including organisational values, strategy, objectives, plans, or formalised governance framework. Whilst still in their infancy all those we spoke with were able to articulate the process.

We found a simplified “floor to board” governance structure which enabled a flow of information; however, these processes were in their infancy and the effectiveness could not be fully identified.

Below the board of trustees, there was a structure of 4 Board led Sub-Committee with scrutiny and assurance by trustees with specialist knowledge:

- Clinical Governance Committee (quarterly)
- Better BPAS Board (monthly)
- Governance, renumeration and nominations committee (quarterly)
- Finance, audit and risk committee (quarterly)

Below the board led sub committees there were executive leadership team led groups whose remit was oversight and assurance from reporting sub committees, these made key decisions regarding challenges and risks, escalate key assurances and exceptions to the board led sub committees:

- Quality and Risk Group (monthly)
- Executive Leadership Team (weekly)
- Policy ratification and oversight group (monthly)
- Finance and Organisational Risk group (monthly)

Below the executive leadership led groups there was a structure of executive leadership team led sub committees which were used to seek assurance and provide advice and guidance and escalate specific risks to executive leaders. There were 6 committees reported directly to the Quality and risk group, and 7 committees which reported directly to the finance and organisational

risk group. There were 2 groups/meetings which were accountable to both groups and these were the:

- Event response group (semi-weekly)
- National integrated performance meetings (monthly)

The final level of governance groups were based within the treatment units, and led by a senior manager this provided a mechanism for communication, measuring performance at a local level.

BPAS had worked to standardise and improve the meeting papers for both the board of trustees and sub committees and groups. Meeting minutes were pulled together following each meeting; we found an improvement in the records of meetings, which were more detailed and also identified challenge from trustees and executive leaders.

Additionally, BPAS had begun to use statistical process control (SPC) charts. This made data easier to understand and demonstrated trends. Data was presented network directorate level, (regional) which enabled the board and sub committees to identify themes and trends. We were assured that data was now presented in a format which could be understood in a meaningful way to enable comparative analysis across directorates.

BPAS continued to monitor effectiveness through 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 a full discussion and analysis of the results within the clinical governance committee and a summary provided to the board of trustees.

Incident investigation

During our previous inspection we found there was limited clinical involvement in incident investigation within BPAS. Presentation of incidents did not lead to openness and transparency. Therefore, the board was not fully sighted or that where incidents were presented these were understood to enable appropriate oversight. This formed part of the section 29 warning notice.

During our follow up inspection, we found each directorate had implemented incident review groups which met bi-weekly or as required. The incident review groups were chaired by the quality matron, with the regional clinical director, operational manager, lead nurse or midwife and treatment unit manager.

A process of peer review was being rolled out at the time of our inspection with an overall aim that 7 peer reviews would be completed monthly across all of the treatment units and directorates.

Evidence provided as part of the inspection showed between June and December 2023 (Quarter's 2 and 3) there were 3780 incidents reported by BPAS staff. It was difficult to compare the data provided due to the pace of change within the organisation and the reporting timeframes of committees and groups. However, we found between November 2023 and April 2024 the number of incidents graded moderate or above which required a duty of candour response was 32; of these 4 had been approved, 19 were being reviewed and 10 were awaiting final approval, these were monitored by the directorate triumvirate via the live dashboards and weekly risk reporting governance email.

Whilst we saw some delays in the sign off of those incidents graded moderate and above we were assured that BPAS had a process in place to review and sign these off.