BPAS has achieved an extraordinary amount in 2016/2017 in terms of growth of service provision, clinical excellence, and political progress advocating for women’s reproductive rights – so it was wonderful to be recognised for these achievements.

Chief Executive, Ann Furedi, said:

“This is fabulous recognition of the work done by a marvellous team of staff, who do everything in their power to help women with problem pregnancies. But most importantly, it marks that abortion is no longer seen as something shameful to apologise for. The provision of good abortion care is honourable, just as the provision of good maternity care is honourable. And BPAS is proud to provide it. We trust women to make decisions about their lives, and they can trust us to provide their care and to fight for legal and policy changes to improve it.”

In October 2017 BPAS was awarded Charity of the Year (income over £10m category) at the ‘charity Oscars’. At the London ceremony hosted by the Charity Times, BPAS was commended for its advocacy and campaigning, and its work to take on additional clients and maintain the quality of services, when demand suddenly increased due to problems experienced by another large provider.
Fifty years on

2018 marks our 50th Anniversary. We have come a long way since gaining our charitable status and opening our first premises in Birmingham in 1968. The forthcoming anniversary has made us reflect how much BPAS has evolved in half a century.

I recently discovered a dog-eared, yellowing newspaper supplement from the Coventry Evening Telegraph dated March 1975. It contained an article by Janet Buckton, entitled ‘Behind the open doors of Blackdown’ reporting her visit to our former Leamington Spa clinic. It was fascinating to read about one of our clinics in those early years. Here are some excerpts from the article:

“I rang the bell and stepped into an ordinary nursing home atmosphere – nurses bustling about, patients resting and the nursing superintendent coping with telephone calls and paperwork. But their work is different. For here frightened girls, their faces full of apprehension as they are wheeled to the operating theatre, have their fears allayed.” Janet writes that sympathetic nurses tend patients following surgical abortion with General Anaesthetic (GA) and that patients stay overnight in ‘cosy rooms’ to be discharged the next day. Today, most treatments conclude in a single day and an overnight stay following abortion is rare. In accordance with best practice, GA is now reserved for surgical abortion from 15 weeks upwards - surgical abortion under 14 weeks is with Local Anaesthetic and optional conscious sedation. The most radical development is the introduction of Early Medical Abortion (EMA) in 1993. EMA allowed us to treat women in a less formal clinical environment (no scary operating theatre necessary) facilitating quicker, local treatment.

Today 62% of abortions are medical procedures and 92% of abortion treatments take place before 13 weeks’ gestation. ‘Here the postbag doesn’t bulge with just documents and official letters. There is a continued flow of thankful letters. Glancing through them you can see how they describe their feelings before they were eventually allocated a place in the home. Words like “traumatic”, “wits end” and “terrible ordeal” balanced by words like “courtesy”, “kindness”, “patience”, and “understanding” – qualities the letter writers found in the home.” Although abortion is still stressful for women today, they rarely voice feelings of such intense desperation and distress prior to treatment. This could be because abortion is less of an ordeal; waiting times have improved, treatment is usually local, and established referral pathways are in place. We continue to receive frequent cards, letters and emails from grateful patients, their partners and loved ones – these communications invariably mention the acute relief experienced after treatment and the kindness and care they were shown by BPAS staff.
Today 98% of UK women benefit from NHS funding. In 1968, 65% of women had a funded abortion in an NHS hospital and the remaining 35% paid for their own treatment at private or charitable abortion clinics. In 1974 BPAS obtained its very first NHS agreement but most of the women attending our clinics still needed to pay. Janet details the cost “an initial £10 at the branch for pregnancy counselling and doctor’s fee and £56 operating fee”. The Retail Price Index inflation guide indicates that this would now equate to approximately £635.

I feel sure that the next 50 years will see radical changes to the way we help women. However I am willing to wager that BPAS will still be doing do the best it possibly can for women and that the postbag continues to bulge with letters from grateful patients.

Mandy Hamilton-Smith
Marketing Officer

Today 62% of abortions are medical procedures and 92% of abortion treatments take place before 13 weeks’ gestation.
Too many abortions?
In fact, some women are not getting the abortions they need.

You may find it shocking, but 50 years on from the 1967 Abortion Act, UK women are still forced to continue pregnancies that risk their health. In March we released a report entitled ‘Medically complex women and abortion care’ which explains why this occurs.

BPAS runs a Specialist Placements Service (SPS) to find hospital appointments for women with complex medical needs. This service is not commissioned or paid for but is offered on a charitable basis. On 46 occasions in 2016 and 2017 (twice a month) our dedicated team could not secure suitable NHS hospital treatments before the 24 weeks’ gestation limit was reached.

Women with uncontrolled epilepsy, blood disorders, and heart conditions were particularly affected. Abortion is nearly always clinically safer than carrying a pregnancy to full term. However, UK women with medical conditions can struggle to obtain abortion care, even though continuing the pregnancy poses a significant threat to their health.

The briefing was based on 2,900 women with medical complexities, who we helped to find abortion care during 2016 and 2017. It highlights that women are being compelled to continue pregnancies due to a lack of appropriate services, or endure stressful, long waits for care while also coping with a health condition that may be exacerbated by pregnancy. These are women who cannot be seen in stand-alone clinics such as BPAS, but must be cared for in NHS hospital settings where there is swift access to specialist medical care if their condition deteriorates.

Behind the stark figures lie the personal stories of the women for whom we could not secure an appointment. These include:

- Teenager (22 weeks) recently left foster care. Lives alone and feels unprepared to become a parent. She has a thyroid condition (at risk of potentially fatal thyroid storm).
- Client (22 weeks) has a heart condition and is currently attempting to get a non-molestation order against ex-partner due to domestic violence. Has a child with a serious illness.
- Client’s pregnancy (22 weeks) was planned, but her health has sharply deteriorated. She has pulmonary fibrosis and other medical problems. Decided to end the pregnancy so she can care for her existing child.
The 3 NHS hospitals which can provide suitable care are all in London - travelling long distances and time away from home can prove to be an insurmountable obstacle.

- Client (15 weeks) recently had a heart attack. Unable to travel far as she cares for her existing children and disabled partner.

In other cases women must sometimes wait many weeks before an abortion appointment is identified:

- Mother with cancer whose treatment could not start until the abortion was performed waited 45 days for an appointment.
- Mother with epilepsy and learning difficulties who presented at the end of first trimester was treated nearly 7 weeks later.

Work is underway to commission a specialist pathway for women who cannot be cared for in stand-alone clinics. The Royal College of Obstetricians and Gynaecologists (RCOG) has also established an Abortion Taskforce to improve women’s access to high quality abortion care. BPAS will do all it can to support these initiatives.

The 1967 Abortion Act did not decriminalise abortion. Instead it made it legal if two doctors authorise the procedure on specific grounds - an abortion performed outside of the Act carries the threat of life in prison. We believe that abortion should be removed from criminal law and the unique threat of prosecution of abortion healthcare workers lifted. The criminal law deters doctors from training in this area, and many young medics are not exposed to abortion care, hence have no opportunity to train.

Those opposed to abortion sometimes claim there are ‘too many’ abortions, or casually declare that the time limit needs to be reduced. The fact is that in 21st Century Britain, there are women who are not getting the abortions they need, despite fully meeting the grounds of the 1967 Abortion Act.

These are women for whom the continuation of the pregnancy threatens their health. These are women with existing children to care for. These are women who are often in complex social circumstances at the same time as struggling to deal with a health condition and an unwanted pregnancy.

There is no single solution to problems with service provision – but one thing is certain. While abortion remains in the criminal law, separated and stigmatised, we will struggle to provide women with the reproductive healthcare services they need and deserve. Abortion is part and parcel of women’s healthcare. It should be regulated and delivered as such.

Clare Murphy
BPAS Director of External Affairs
British Journal of Midwives (BJM) Award

BPAS was awarded third place in the ‘Charity of the Year’ category at the British Journal of Midwifery Practice Awards. This was in recognition of our contribution to the midwife profession and the passion and commitment of all our staff.

The winners were announced at a gala dinner in Liverpool in February, which was attended by some of our wonderful clinical staff. We are so pleased that BPAS’ contribution to midwifery has been recognised in this way.

Michael Nevill
Director of Nursing

Merseyside clinic facelift

BPAS’ Merseyside clinic has just concluded an extensive refurbishment.

The team endured the inevitable upheaval really well – even though they knew they were never going to get that hot tub they had playfully requested! Makeshift offices sprung up in the most unlikely places, including under the stairs and in the kitchen. After a long, hard six months of making do, we are all so pleased with how the clinic looks now. It is clean, bright, welcoming and feels like a fresh start.

The clinic has a new disability access to the front of the building (rather than past the bins) and a dropped reception counter for wheelchair users. There is an additional scan room so we can see more clients for consultation and EMA. The client pre-op changing room is updated with modern hard flooring too. Waiting areas are also improved and updated. Air conditioning is a welcome addition for those clients waiting for treatment in the hot summer months.

Several of the improvements benefit BPAS staff. The staff dining area was improved and extended. Nurses now have a PC each - including in recovery to keep a track of the list. There are better staff-changing facilities with separate cubicles for males and females.

We’ve had lots of compliments from our clients, and we feel that the fresh environment has made the client journey a much nicer experience.

Lauren Dodd
BPAS Merseyside Clinic Manager
Let’s talk about contraception

All BPAS clients have the opportunity to discuss contraception prior to treatment so we can provide their chosen method upon discharge from our care. Most women have face-to-face contraception counselling during their abortion consultation, but some CCGs also fund a dedicated, pre-treatment telephone contraceptive counselling session for their patients.

In February, we published a retrospective evaluation of the telephone-based counselling service in a paper entitled ‘Telephone or integrated contraception counselling before abortion: impact on method choice and receipt’. We collaborated with researchers at Princeton University and received ethical approval from the Institutional Review Board there, and from the BPAS Research and Ethics Committee.

For the study, we identified all cases of women who were eligible for both telephone-based and face-to-face contraception counselling between 2011 and 2014.

We examined the contraceptive methods chosen and received by women who had an abortion at BPAS.

We also explored whether there were any factors that were associated with the choice and receipt of the most effective reversible contraceptive methods, an intrauterine contraceptive (IUC) or implant.

The sample included over 18,000 women - of these 31% chose telephone counselling and 69% chose face-to-face counselling. Our key findings were that:

1. Women choosing telephone counselling were more likely to report difficulty obtaining contraception in the past than women choosing integrated counselling (40% vs. 3%) and more likely to report not using a method of contraception at conception (37% vs. 34%).

2. Most women (93%) seen at BPAS who have contraceptive counselling and an abortion choose and receive a contraceptive method.

3. Contraception counselling over the phone prior to an abortion consultation was significantly associated with both choosing and receiving an IUC or implant.

Our findings suggest that women want options in terms of when and how they access contraception counselling before abortion. For some, a dedicated, remote session was preferred, perhaps because it allowed for a more in-depth discussion or was more private. For others, an integrated visit was preferred perhaps because it was more efficient. Offering a remote option also appears to broaden the contraceptive method mix, supporting women in choosing a receiving the right method for them from the range of available methods.

The research project was undertaken by Patricia A. Lohr, Abigail R.A. Aiken, Tracey Forsyth, and James Trussell.

Visit http://srh.bmj.com/ for the full text of the publication.

Patricia Lohr
BPAS Medical Director
Getting to Know Maria Ellery…
our new, full-time Safeguarding Lead Nurse

Maria has provided all BPAS’ safeguarding training on a freelance basis for 12 years. Over this time, the volume of safeguarding cases has grown hugely, so we are really pleased that she has now joined BPAS as our full time safeguarding lead.

Maria will work closely with the Director of Nursing responding to safeguarding queries from clinical teams. In addition, she will audit safeguarding cases, produce a SII and annual report and continue to deliver BPAS’ established safeguarding training programme.

BPAS staff members undertake the full day, level 3 safeguarding training within four months of joining the organisation and repeat it every two years. The course has evolved to meet the diverse needs of both sexually active young people, and vulnerable adults.

It provides an overview of children’s legislation and the Sexual Offences Act, explaining what happens following a referral into statutory services. It explores the issues of grooming, child sexual exploitation, social media, and gang culture.

The adult module teaches staff about working with victims of domestic abuse, the issue of capacity to consent for patients with learning difficulties or mental health issues. It also recognises how safeguarding may impact parenting if children live with those clients.

Maria has specialised in Safeguarding for 25 years, working as a Named Nurse in acute hospitals and Community Health, and as a Designated Nurse in four CCGs. She has also provided training and consultancy for many prominent charities, various LSCBs and an NHS Trust.

She has helped devise joint policies with Local Authority Children’s Social Care Departments, designed and delivered training needs analyses, strategies and packages, contributed to Serious Incidents, Individual Management Reviews and Serious Case Reviews, chairing and contributing to a number of working groups.

It is our intention to set up regional Safeguarding Supervision groups to support our Clinic Managers who make most safeguarding referrals.

We are confident that BPAS has extremely robust risk assessment processes which enable us to identify both young people and vulnerable adults. This has been reflected in recent CQC inspection comments.

“We staff knew their own role and remit for safeguarding children and vulnerable adults, and had a heightened awareness of the needs and vulnerabilities of children and young people using their service.”

Extract from recent CQC report

We are thrilled to welcome Maria to BPAS and are grateful that we can share in her knowledge and experience to benefit our vulnerable patients.

“Staff could demonstrate their understanding of safeguarding adults and children and knew what actions they needed to take in cases of suspected abuse.”

Extract from recent CQC report

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