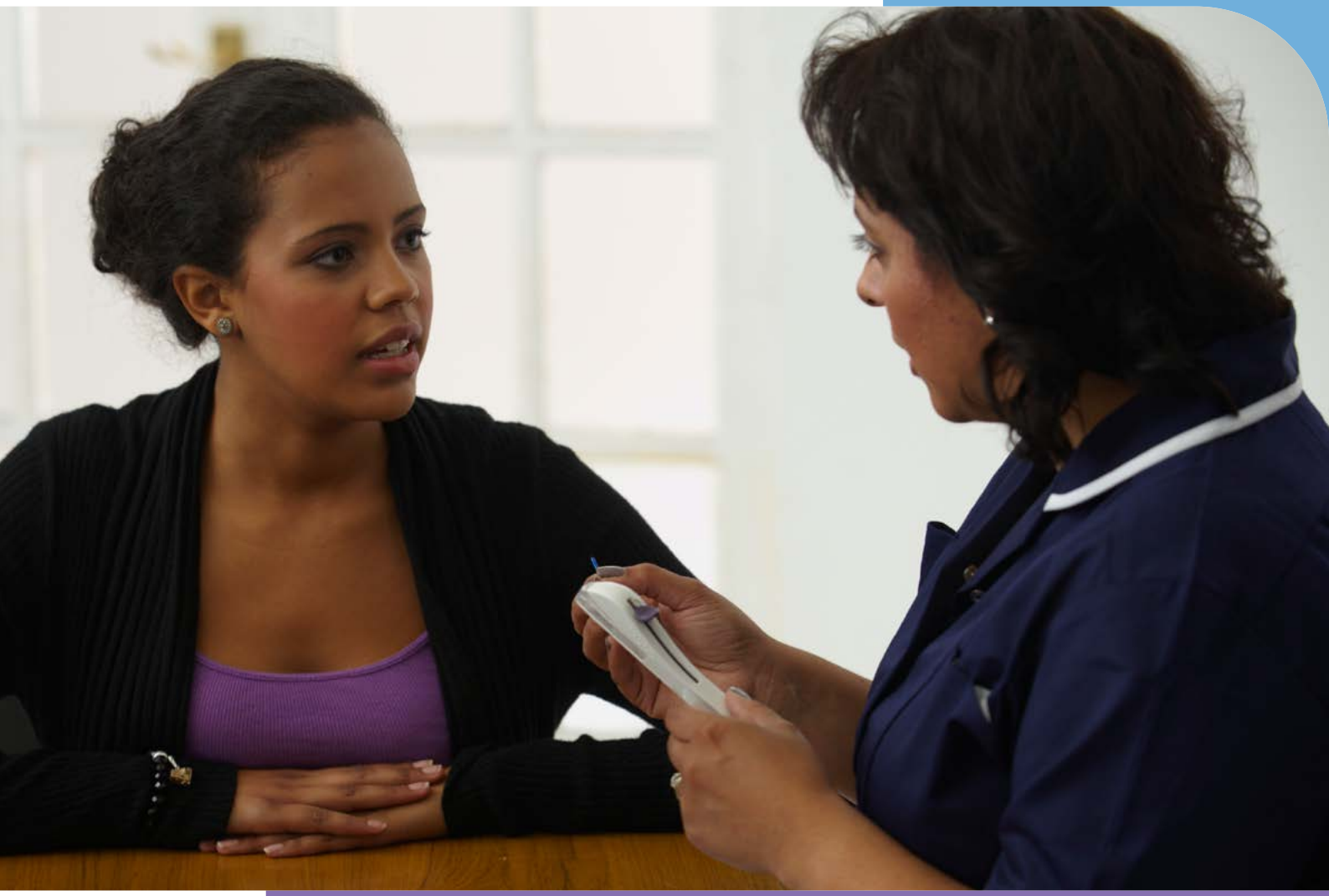
BPAS
British Pregnancy Advisory Service

Safeguarding Annual Report 2024/25



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Foreword

Whilst it would be wonderful to live in a society that is free of harm, abuse and neglect sadly that is not the case. Whilst this remains the status quo, BPAS (British Pregnancy Advisory Service) will continue to invest in our skilled and experienced Safeguarding Team to ensure we protect those that cannot protect themselves.

Heidi Stewart
Chief Executive Officer

At BPAS, safeguarding is not just a statutory responsibility, it is a cornerstone of compassionate, person-centred care. Each year, we support thousands of people navigating complex, often distressing circumstances. Behind every risk assessment or referral lies a unique individual whose safety, dignity, and rights must be protected. This report reflects our steadfast commitment to doing exactly that.

The 2024–25 reporting year has marked a period of significant transformation in safeguarding across BPAS. We have strengthened our governance, grown our safeguarding team from three to ten multidisciplinary professionals, and launched a national Duty Safeguarding Support function.

This function ensures rapid, expert advice is available Monday to Friday to those delivering care at the front line. These developments have not only enhanced our ability to respond to risk but also supported earlier intervention and improved outcomes for our patients.

I am deeply proud of our teams. Their professional curiosity, resilience, and dedication have ensured that patients, whether seen in a clinic, via telemedicine, or at first contact in our Booking and Information Centre, receive responsive and trauma-informed safeguarding support. Our work with external partners, including social services, the police, MARACs, GPs, and maternity services, remains critical to delivering joined-up care for those most at risk.

This year's report highlights powerful examples of best practice, including complex case management, rising rates of appropriate referrals, and improved staff training. The introduction of tailored audit tools, new policies, and increased access to national safeguarding information systems all demonstrate a service that is maturing, reflective, and continually improving.

I want to thank every colleague across BPAS for their continued commitment to safeguarding. Your efforts, whether supporting a survivor of abuse, identifying hidden harm, or advocating for change, create a safer, more equitable healthcare environment for everyone we serve.

Together, we continue to lead the way in delivering safe, effective, and compassionate reproductive healthcare. Thank you.

Executive Summary

BPAS
British Pregnancy Advisory Service
Safeguarding

Promoting and advocating for patient safety and choice, free from coercion and fear.

The 2024–25 reporting year marked a period of significant transformation in safeguarding practice, with a strengthened governance structure and improved outcomes across the organisation.

A key milestone was the establishment of a corporate safeguarding team in April 2024, expanding from three to a multidisciplinary team of ten, including a named doctor and head of safeguarding, delivering oversight across our services in England and Wales.

The launch of a national Daily Safeguarding Support (DSS) service provided accessible expert advice via helpline, email, and webchat for both internal and external professionals. Governance was further enhanced with the introduction of regional exception reports in June 2025, improving communication from the frontline to board level.

New policies and standard operating procedures SOPs were developed, covering adult safeguarding, allegations regarding professionals, later gestation attendance, female genital mutilation (FGM), and use of national information systems.

Operational vigilance remained strong, with consistent safeguarding risk assessments and a fivefold increase in MARAC referrals, evidencing our improved identification of domestic abuse.

All safeguarding midwives received NSPCC Level 4 and DASH trainer certification, delivering tailored training that reached 85% of clinicians within six months. Supervision and training compliance exceeded targets, supported by a refreshed training needs analysis and new learning packages.

Additional achievements included:

- Stronger multi-agency partnerships
- Safeguarding specialists embedded in telemedical hubs.
- Updated SOPs and supervision for our contact centre staff
- Access to the NHS Child Protection and FGM information systems

This year reflects the successful embedding of a new safeguarding model, marked by improved practice, greater staff capability, and more effective risk identification and response.

Introduction

I am pleased to share the safeguarding annual report for 2024-25. Safeguarding remains a core priority for BPAS. This report reflects our ongoing commitment to protecting the welfare of children, young people, and adults at risk.

We know that people access our service in a time of need. Their safety, dignity, and wellbeing are at the heart of everything we do. Our approach is grounded in a culture of vigilance, continuous improvement, and shared responsibility across all levels of our workforce.

Amy Bucknall RN, BSc, MSc
Head of Safeguarding

The Safeguarding Annual Report 2024–25 outlines the safeguarding activity, achievements, and ongoing development at the British Pregnancy Advisory Service (BPAS).

Many people seeking abortion care are navigating complex challenges, including coercion, domestic abuse, exploitation, and mental health issues. Our role in safeguarding is to identify risk, respond appropriately, and provide support that is timely, sensitive, and in line with legal, regulatory and professional standards.

Demand for abortion care continues to grow. In 2024–25, BPAS provided 128,705 consultations to patients, which was a 16% increase from the previous year.

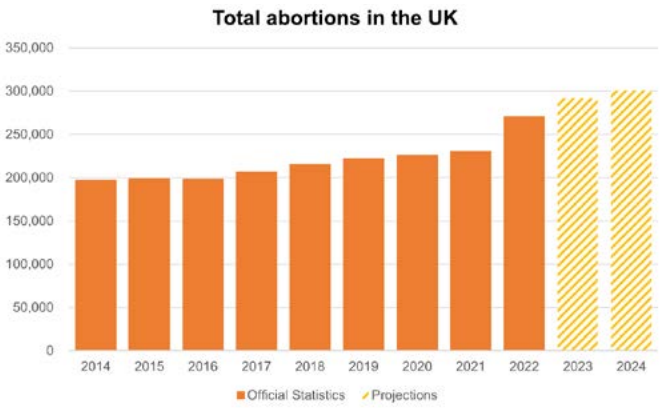
Projections indicate that UK abortion figures may exceed 300,000 annually, reflecting sustained pressures on reproductive healthcare and the increasing complexity of patients' lives. The graph demonstrates the projected number of abortions for 2023-24 (Percuity, 2024).

These rising figures highlight the essential role of safeguarding in abortion care. Our staff must be equipped to identify vulnerability early, provide trauma-informed care, and ensure patients are protected and empowered through effective referral and support pathways.

The wider context remains challenging. The overturning of Roe v. Wade in the US and ongoing international threats to abortion access have had a ripple effect, creating increased anxiety among patients in the UK- especially young women, migrants, survivors of violence, and those facing healthcare inequalities.

This report reaffirms our commitment to creating safe, responsive environments that support both patients and staff. It outlines our progress in safeguarding practice, shares key data and themes, and identifies areas for ongoing improvement.

We remain deeply grateful to our staff and multi-agency partners across the UK for their dedication to delivering compassionate and effective care.



Patient Story

We begin this year's safeguarding report with a patient story. The case of Anise (not her real name) reflects the real-life experiences of the individuals we support, as well as the challenges faced by the staff working alongside them.

The voices of our patients are central to our work, not only because they guide our responses, but because they remind us that behind every policy, risk assessment, and referral, there is a person navigating complex, often hidden, realities.

We work in a unique sector where health, safety, and social factors are deeply intertwined. Sharing stories like Anise's helps us reflect on the importance of trauma-informed care, the value of persistence and empathy in frontline safeguarding, and the need for a coordinated, respectful approach to supporting those at risk.

Anise was a 16-year-old who attended BPAS with a man introduced as her uncle, an unusual chaperone for a young person. A young person's safeguarding risk assessment, focused on child sexual exploitation took place. While Anise disclosed no immediate safeguarding concerns, the attending midwife had a strong gut instinct that something was not right. Notably, Anise did not know the surname of the father of the pregnancy, and the chaperone took an unusual interest in the scan.

Acting on her concerns, the midwife immediately escalated the case to the safeguarding team. An internal strategy meeting was held immediately, and treatment was paused while external enquiries were made. Subsequent information from police revealed that the man accompanying Anise was not her uncle but potentially her partner, and under bail conditions for assaulting her. The police were requested to complete an immediate welfare check as the patient left the clinic with the uncle.

A strategy meeting followed with Children's Social Care following urgent referrals made by BPAS. Due to the immediate risk, professionals coordinated attendance at Anise's next appointment. Police made an arrest on site to protect her. She later returned with her mother, and care was safely completed.

This case highlights the importance of professional curiosity, timely escalation, and effective multi-agency working. The actions taken ensured Anise's safety and demonstrated the value of trauma-informed, safeguarding-led care.

Leadership and accountability

The Safeguarding Structure

BPAS has a well-established, multi-disciplinary safeguarding team, in place for over a year, providing expert guidance and assurance across the organisation.

The team is led by the Head of Safeguarding, who oversees key areas including child sexual exploitation, looked after children, prevent, domestic abuse, and female genital mutilation. The Named Safeguarding Doctor leads on the Mental Capacity Act, bringing vital clinical oversight.

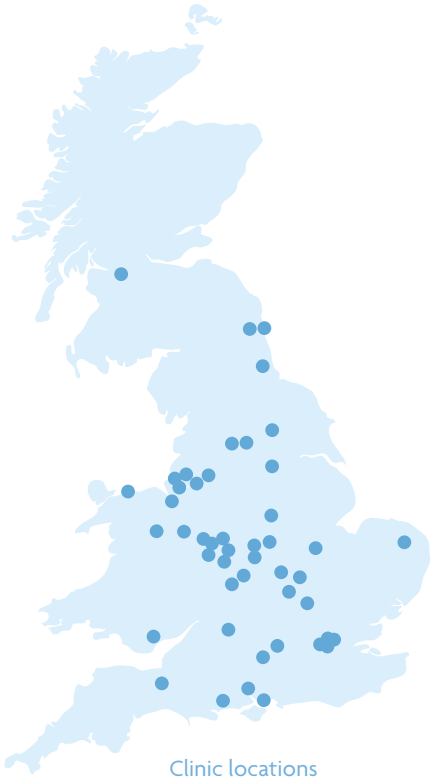
The team comprises seven Safeguarding Specialist Midwives (SSMs) and a Safeguarding Advisor with a social care background.

Team stability has been a strength this year, with ongoing efforts to enhance safeguarding support for both professionals and patients. We are grateful to Amanda Palmer, Kayleigh Gould, and Heidi Robinson for their valued contributions during periods of maternity and sabbatical cover.

We remain committed to building safeguarding capability across BPAS. Staff are encouraged to shadow the safeguarding team, and development days are regularly offered to grow confidence and practice. We are actively embedding succession planning and supporting colleagues with an interest in safeguarding to develop into future leadership roles.

Safeguarding assurance is delivered through a structured regional framework, covering the North West, North East, Midlands, South East/London, South West, Telemedicine, and Support Services. Each SSM leads safeguarding in their region, reporting into the Head of Safeguarding and through the quarterly Safeguarding Group.

Governance is strong, with the Head of Safeguarding reporting directly to the Chief Clinical Officer, who acts as the Executive Lead for Safeguarding. This structure ensures that safeguarding issues and risks are escalated to board level, supporting accountability and informed oversight at the highest level.



Clinic locations

Julie Miller
Named Doctor for Safeguarding

Amy Bucknall
Head of Safeguarding

Valencia Anderson
Safeguarding Specialist Midwife - Telemedicine

Alice Fairman
Safeguarding Specialist Midwife - Southwest

Cindi Fraser-Langton
Safeguarding Specialist Midwife - Northeast

Heidi Robinson
Safeguarding Specialist Midwife - Midlands

Amanda Shurvinton
Safeguarding Lead BIC

Louise Critchley
Safeguarding Specialist Midwife - Northeast

Emma Bell
Safeguarding Specialist Midwife - Southeast

Carla Fletcher
Safeguarding Specialist Midwife - Support Services

Additional Roles

Within the year, there has been the development of a safeguarding support initiative within the telemedical hubs. This has been created as a pilot to provide operational support to the busy hubs with the management of complex and high-risk cases. The pilot has been extended within the year due to success of the roles.

Due to the increase in workload of the Booking information centre safeguarding advisor, a business case was developed to recruit an additional advisor. This was successful and the role will be filled in June 2025.

Action:
Recruitment and onboarding of an additional safeguarding role within the BIC

The Daily Safeguarding Support Service

In June 2024, the Daily Safeguarding Support (DSS) service was launched, following increased capacity within the safeguarding team. This service was developed in direct response to staff feedback and learning from incidents, which highlighted the complexity and level of risk often associated with safeguarding disclosures in the abortion sector.

The DSS service was introduced to provide a single, accessible point of contact for safeguarding advice and support- minimising delays in response and ensuring timely, expert guidance for both internal and external professionals.

The DSS service is managed by two safeguarding specialist midwives per day. This service provides expert advice and guidance through a national helpline, dedicated email address, and via the electronic medical record- ensuring accessible and responsive support across the organisation and beyond.

The service was introduced with a comprehensive internal and external communications campaign, ensuring strong awareness across the organisation and among partner agencies.

As demonstrated in the chart: Requests for Corporate Team Support Via Telephone, there was significant engagement in the new initiative in the first four months. This was positive as it evidenced that the communications programme was effective and that the need for the service was there.

Since November 2024 the number of contacts has stabilised, with an average of approximately 125 calls per month, reflecting what we now consider to be the typical level of ongoing activity.

As demonstrated in the Chart: Request via Electronic Methods, the rate of contact via email and the electronic medical record have sat consistently at an average of 177 per month. This has been the usual mechanism for requesting support and has been in place for two years with contacts remaining stable throughout the launch.

This evidences that staff value the ability to seek support throughout a variety of means, depending on the urgency of the concern, their preference of communication and their working location. For example, when an emergency is taking place on a phone call, electronic methods are sometimes preferable to keep a patient engaged on the phone.

Chart: Requests For Corporate Team Support Via Telephone

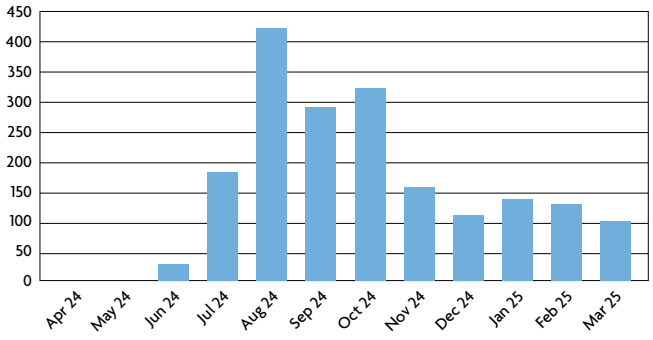
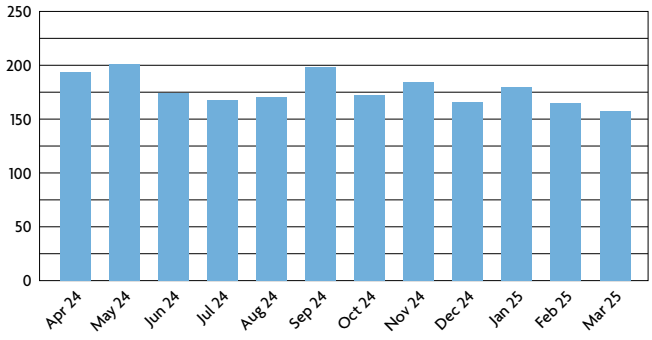


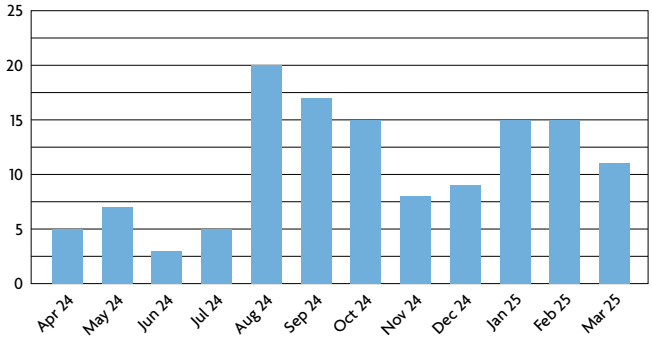
Chart: Requests For Corporate Team Support Via Electronic Methods



The DSS has been a huge asset to BPAS with internal staff and external partners alike sending positive evaluation of the service. Staff have reported feeling more supported, able to access support quickly and to request urgent advice for complex and/or immediate concerns.

This has been further evidenced in the requests for internal strategy discussions as shown in chart: Requests for Internal Strategy Discussion. This is an internal mechanism where the multi-disciplinary team including safeguarding specialist, midwives, doctors and operations colleagues come together within 24 hours to discuss the most complex cases.

Chart: Requests for Internal Strategy Discussion



In these meetings safeguarding and care planning is discussed to ensure reasonable adjustments are made. This has increased to an average of 11 per month from 3 per month in 2023-24 - a 267% increase. These meetings are in addition to external safeguarding strategy meetings. External partners are invited to our internal strategy meetings where required.

Audit, monitoring and assurance

Safeguarding Audits

In June 2024, BPAS launched Safeguarding Audits Phase 2, a pilot project aimed at enhancing the quality, consistency, and independence of safeguarding assurance across the organisation.

Previously audits were conducted monthly by clinic and telemedical hub leads, audits are now completed **quarterly by Safeguarding Specialist Midwives (SSMs)** for their designated regions. This shift introduced **independent scrutiny** and **subject matter expertise**, enabling a deeper and more consistent review of safeguarding practice.

Audit frequency moved from monthly to **quarterly submissions**, allowing for the examination of **entire patient journeys** and improved data quality. **Sample sizes** were refined to reflect patient volumes, proportionality, and regional confidence levels.

To better reflect the diversity of care settings and patient needs, **four new, tailored audit tools** were developed:

- Safeguarding Under-18 via Telemedicine
- Safeguarding Under-18 in Clinic
- Safeguarding Adult via Telemedicine
- Safeguarding Adult in Clinic

These tools have improved the **specificity and relevance** of audits, enabled targeted support and learning while strengthened governance across the service.

An initial dip in compliance was observed during the first quarter as the new process embedded, as expected. However, audits have since shown **sustained improvement**, with **annual trends indicating over 90% compliance across all regions**, a strong reflection of the **growing maturity and consistency** of safeguarding practice at BPAS.

The table Annual Audit Performance Rate presents regional compliance rates and underscores the organisation's commitment to continuous improvement and safeguarding excellence.

Table: Annual Audit Performance Rate

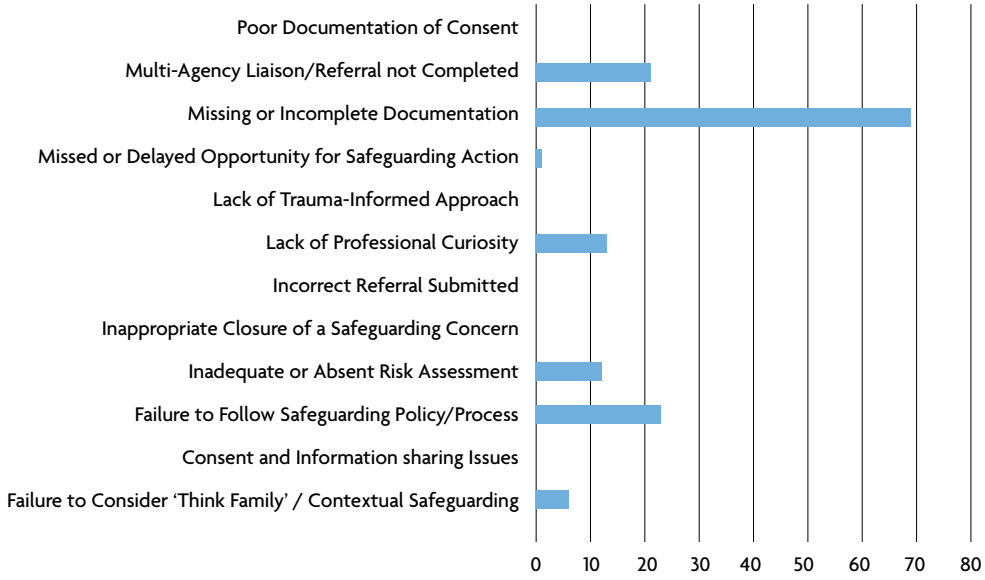
Division	Annual Audit Performance Rate
North East	94%
North West	94%
Midlands	91%
London/ South East	92%
South West	99%
Telemedical Hubs	96%

The themes of the issues being identified in the safeguarding audits are seen in the chart: Safeguarding Audit Action Themes 2024-25. They demonstrate that missing or incomplete documentation was the highest recurring issue.

In December 2024, the **BPAS Record Keeping Policy** was reviewed and strengthened with **active input from the safeguarding team**. All safeguarding policies have since been updated to align with the revised policy, reinforcing a consistent approach to documentation standards across the organisation.

Safeguarding audits continue to play a key role in monitoring record keeping, ensuring improvements are embedded and sustained. Additionally, **standalone record keeping audits** are being reviewed and refined to ensure full alignment with the updated policy throughout 2025.

Chart: Safeguarding Audit Action Themes 2024-25



Current safeguarding audits show an **11% action rate**, with any dips in compliance addressed promptly at a local level. **Tailored action plans** may include:

- Targeted supervision
- Reflective practice
- Additional training
- Shadowing opportunities
- Enhanced support

These interventions promote **continuous improvement** and ensure staff remain confident and competent in their safeguarding responsibilities.

Looking ahead, in 2025 BPAS will implement a **national, patient-centred audit model**, shifting from clinic- and hub-level reporting to a **unified approach** focused on service user experience and consistent quality standards.

This evolution aims to drive:

- Improved oversight
- Enhanced service delivery
- Greater consistency in safeguarding practice across all care settings

We also intend to broaden the reach of safeguarding audit by including the support services division (booking and information centres, counselling and aftercare department) in the next improvement phase.

Action:

Further strengthen safeguarding audits through the development and implementation of a national, patient-centred audit, ensuring consistent standards, improved service user experience, and continuous quality improvement.

Action:

Implement safeguarding audits for the support services division (BIC, counselling and aftercare department).

Exception Reports

Safeguarding Specialist Midwives (SSMs) now complete a quarterly exception report, which is submitted to the Head of Safeguarding, the Quality Matron, and the Operational Manager for their respective division. These reports provide strategic oversight of key safeguarding activity, including:

- Training (delivery and compliance)
- Supervision compliance (delivery and uptake)
- Multidisciplinary liaison and partnership networking
- Audit activity and outcomes.
- Safeguarding incidents and emerging themes
- Relevant entries and updates to the risk register

This structured reporting approach enhances accountability, ensures visibility of safeguarding performance at divisional and organisational levels, and supports continuous improvement through data-driven insight.

These are discussed at the Safeguarding Group meeting and items requiring attention and resolution are escalated.

Safeguarding, monitoring and assurance

The Booking and Information Centre

The Booking and Information Centre (BIC) is the first point of contact for individuals seeking pregnancy-related care, handling over **350,000 enquiries annually** via phone and online forms. As the gateway to BPAS services, the BIC plays a vital role in delivering timely, compassionate, and person-centred support.

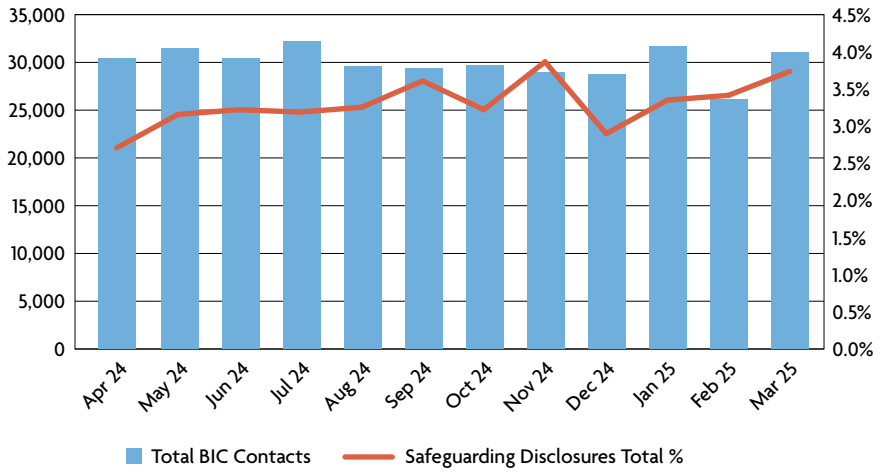
Safeguarding is a **core function** of the BIC, ensuring that risks are identified and addressed from the very first interaction. This supports the **'golden thread' of safeguarding** that runs throughout the patient journey, from initial contact to discharge. Aligned with the **'Make Every Contact Count'** principle, the BIC integrates safeguarding awareness and action into every stage of engagement.

The BIC safeguarding team remains stable and effective, supported by **robust tools** including SOPs, scripts, flowcharts, and escalation pathways. To ensure continued excellence and resilience, **plans are in place to expand the safeguarding team** in 2025–26.

Since the BIC safeguarding function was introduced in 2023, data has shown that around **3% of all contacts involve a safeguarding disclosure**, either through direct reports or concerns identified during calls. This reinforces the **critical role of the BIC in early safeguarding intervention**.

The graph Total BIC Contacts and Safeguarding Disclosures (2024–25) illustrates the overall volume of patient interactions alongside safeguarding disclosures, evidencing the team's ongoing contribution to **early risk identification and patient protection**.

Chart: Total BIC Contacts and Safeguarding Disclosures (2024-25)



Safeguarding Adults at Risk of Harm

In 2024–25, 97% of patients accessing care through BPAS were adults, a figure that remains consistent with previous years.

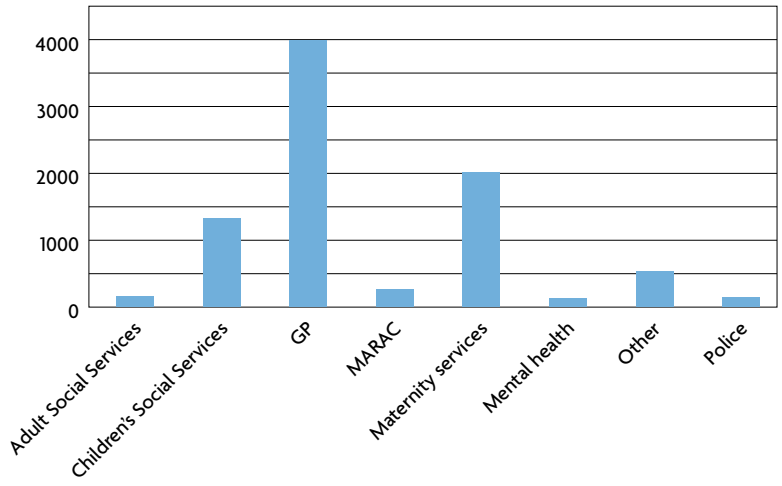
Of the adults supported this year:

- **11%** required a full safeguarding risk assessment following initial screening (consistent with the previous year)
- **7%** required onward referrals or liaison to ensure their safety (also consistent with the previous year)

This stability in safeguarding data from 2023–24 suggests a maturing of the service following previous years of active transformation. It is reassuring to see consistency in key indicators, reflecting sustained quality in triage, risk identification, and support pathways. Notably, there has been an increase in MARAC (Multi-Agency Risk Assessment Conference) referrals this year, which will be explored in a separate section.

The graph titled Safeguarding Adults Referral/Liaison 2024–25 illustrates the range of agencies BPAS engaged with to ensure the safety and wellbeing of adults at risk, reflecting our continued commitment to multi-agency safeguarding practice.

Graph: Safeguarding Adults Referral and Liaison 2024-25



Safeguarding Children and Young People

In 2024–25, **3% of BPAS patients were under 18**, a consistent figure compared to previous years. Safeguarding support for this group remains a key priority.

- **100%** of young people received a **full safeguarding risk assessment**, in line with BPAS's Safeguarding Children and Young People Policy.
- **62%** required **onward referral or liaison** to ensure safety, an increase from 55% in 2022–23.

This upward trend reflects the **growing confidence and consistency of staff** in identifying and responding to safeguarding concerns, supported by the implementation of a new safeguarding policy in 2023, alongside enhanced training and multi-agency working.

The increase in referrals may also reflect wider **societal challenges**, including rising rates of abuse, reduced public service capacity, and the impact of s**ocial media and online harm**, contributing to **contextual safeguarding concerns**.

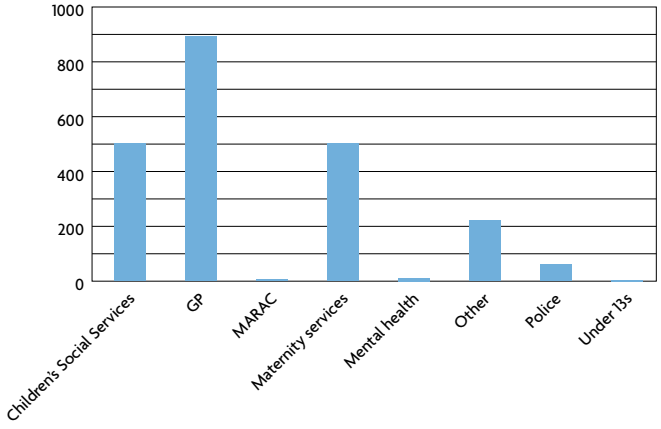
BPAS is committed to:

- Ongoing investment in **staff training and awareness**
- Strengthening **early intervention**
- Enhancing **partnership working** with external agencies

We are also working to **improve data reporting** and trend analysis to better understand the needs of young people and target safeguarding responses more effectively.

The graph *Safeguarding Children and Young People Referral and Liaison (2024–25)* highlights our most frequent referral pathways, with the highest rates of liaison to **maternity services, GPs, and children's social care**. These patterns reflect our commitment to multi-agency safeguarding and ensuring appropriate maternity care for young people continuing a pregnancy.

Graph: Safeguarding Children and Young People Referral and Liaison 2024-25



In the UK, abortion care for individuals under the age of 13 is e**xtremely rare** and governed by **strict legal and safeguarding protocols**. At BPAS, these cases are managed with **the highest level of oversight and sensitivity**, ensuring the **child's welfare** remains the central focus throughout.

In 2024–25, BPAS supported four **under-13 patients**, consistent with previous years. Each case followed a **specialised safeguarding pathway**, including:

- **Comprehensive risk assessment** and **mandatory in-person consultation**
- **Immediate internal and external strategy meetings**
- **Multi-agency collaboratio**n with police, social care, and healthcare professionals
- **Individualised care planning**, led by a **dedicated Safeguarding Specialist Midwife**

These procedures are delivered in BPAS sites, where clinical teams are trained and equipped to manage the complex needs of children in these circumstances- medically, emotionally, and socially.

BPAS continues to work in partnership with **Integrated Care Boards (ICBs)** and **health boards** across England and Wales to support the development and implementation of robust under-13 care pathways, ensuring national consistency, legal compliance, and safe access to care.

Action:

The safeguarding risk assessment to be reviewed within the electronic medical record to improve understanding reporting of themes and outcomes of safeguarding referrals.

Domestic Abuse

Women of childbearing age (typically 15-44) are statistically the most likely to experience domestic abuse. This overlap means that many women seeking reproductive healthcare, especially abortion, may also be experiencing or have experienced abuse. We know that **pregnancy is a risk factor** for the onset or escalation of domestic abuse.

In response to this, in 2022–23 we set a strategic objective to implement **DASH (Domestic Abuse, Stalking and Honour-Based Violence) risk assessment training** to improve the identification, support, and referral of high-risk patients. This training is delivered in addition to the standard Level 1, 2, and 3 safeguarding training required of all clinical staff.

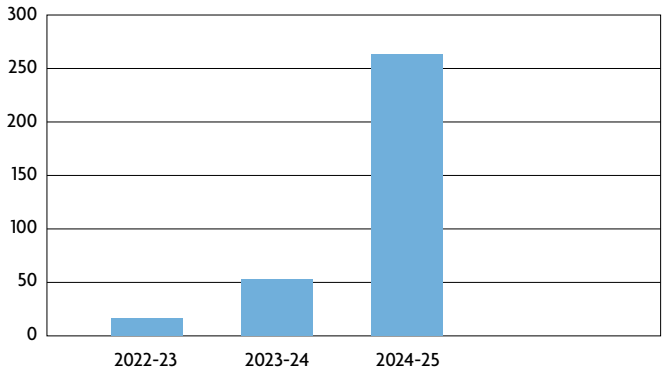
The DASH training package was developed and launched in **October 2023**, initially rolled out to all lead nurses and midwives. Following positive feedback and the expansion of the corporate safeguarding team, the training was extended in collaboration with operational colleagues to include **all nurses and midwives across BPAS**.

To ensure quality and consistency, all safeguarding team members became **accredited DASH 'train-the-trainer' facilitators**, and the content was further refined. The **Phase 2 DASH training project** was launched in **October 2024**, making the course accessible to 508 staff members.

By **March 2025, 85%** of the targeted staff had completed the DASH risk assessment training. The accompanying table illustrates the rate of DASH assessments that have led to **MARAC (Multi-Agency Risk Assessment Conference) referrals**. These referrals are made for the most serious cases—where there is a significant risk of harm or fatality.

The upward trend in MARAC referrals over time evidences the effectiveness of this three-year transformation programme and demonstrates a measurable improvement in the early identification and escalation of high-risk domestic abuse cases.

Graph: DASH risk assessments leading to MARAC referral



We want to continue to strengthen our domestic abuse offer to at risk patients, and plans are in place for the **DASH risk assessment to be built into the electronic medical record to enable reporting of themes and outcomes of MARAC referrals**.

Action:

The DASH risk assessment to be built into the electronic medical record to enable reporting of themes and outcomes of MARAC referrals.

Policies, procedures and projects

Policies reviewed in year.

Several policies and procedures were reviewed in the year. These included:

- Policy For Safeguarding Adults at Risk of Harm
- Policy For the Management of Safeguarding Allegations Against Staff and Persons in A Position of Trust
- SOP For the Management of Patients Presenting At 20+ Weeks Gestation or Unable to Have Abortion Before Legal Limit
- SOP For the Management of Female Genital Mutilation
- SOP For the Use of The Child Protection Information System and The Female Genital Mutilation Information System

Following staff feedback, the separate domestic abuse and prevent policies have been retired and are now included in the safeguarding adults and risk and safeguarding children and young people polices.

Policies pending

There are currently no safeguarding policies pending review, aside from the routine updates aligned with changes to national legislation and guidance, which form part of our standard review cycle.

A new policy is planned to be authored in 2025-26 which will focus on safeguarding concerns involving staff. This will be authored in collaboration with human resources colleagues.

Action:

Author and launch new policy regarding safeguarding concerns involving staff. This will be authored in collaboration with human resources colleagues.

Projects

In 2024, BPAS worked in close partnership with **NHS Digital** to gain access to the **Child Protection – Information Sharing (CP-IS)** and **Female Genital Mutilation – Information Sharing (FGM-IS)** systems. While abortion services are not currently mandated users of these systems, BPAS proactively pursued access to **enhance safeguarding for children and young people**.

CP-IS provides real-time access to local authority data on:

- Children with a **Child Protection Plan (CPP)**
- **Looked After Children**
- Pregnant women with unborn babies on **pre-birth protection plans**

FGM-IS places alerts on a child's NHS Summary Care Record when they are:

- **At risk** of FGM
- **Living in a household** where FGM has occurred.
- A **survivor** of FGM (under 18)

These alerts help frontline healthcare professionals take timely and appropriate safeguarding action.

Throughout the year, BPAS ensured **data protection, patient confidentiality**, and the **sensitive nature of abortion care** were carefully addressed.

A **Standard Operating Procedure (SOP)** and **information sharing agreement** were developed to guide safe and appropriate use. **Access was formally granted at the end of 2024–25**.

Since implementation, the use of CP-IS and FGM-IS has already led to **improved safeguarding outcomes**, enabling quicker identification of risk and more effective multi-agency responses for **children and young people at risk of harm**.

Training and competency

In April 2024 the training needs analysis (TNA) was reviewed to ensure that it was aligned to the Royal College of Nursing (RCN) intercollegiate documents for:

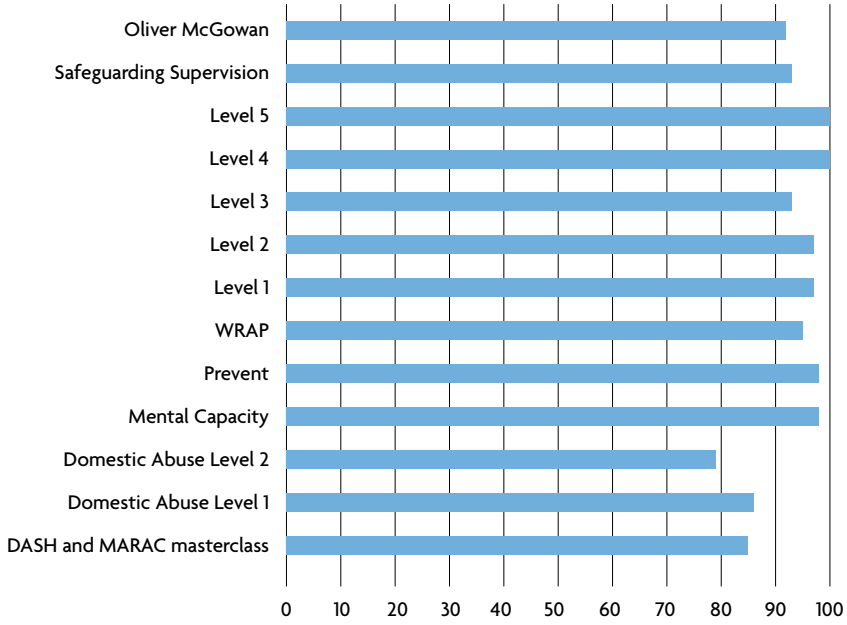
- Children and young people (RCN, 2019)
- Adults (RCN, 2024)
- Looked after children (RCN, 2019)

All training packages for safeguarding at BPAS are in line with the intercollegiate guidance and suggested hours for training compliance.

Training compliance is closely monitored on a regional level by the safeguarding specialist midwives and training is planned/delivered to address areas where compliance does not meet target levels.

Training compliance in 2024-25 reached the targeted levels of 85% in 12 out of 13 courses, which has seen improvement from previous years. The chart: Safeguarding Training Compliance 2024-25 shows the compliance rates for the year.

Chart: Safeguarding Training Compliance 2024-25



Evaluation of the safeguarding training packages continue to be positive and demonstrates staff need for bespoke abortion specific safeguarding training. Feedback has included:

> *You made safeguarding feel a lot less scary than what I'd initially anticipated. I feel a lot more informed and reassured.*
> **Telemedical midwife**

> *Thank you so much for an amazing presentation. I think this is the best safeguarding presentation I have ever had. Absolute food for thought. I feel so much more confident in completing risk assessment now.*
> **Clinic midwife**

Staff feedback gathered through training evaluations continues to indicate a clear preference for in-person, onsite delivery. As a national charity, this has had some challenges with extensive travel for some, and sourcing appropriate venues, but we have ensured that the new packages (DASH training package) can be completed in person and have offered sessions using a blended approach throughout the year of virtual and face to face taught packages to suit staff needs.

In 2025–26 we are reviewing the upcoming level 3 package with a view to introducing face-to-face, onsite sessions across the organisation now that the corporate safeguarding team is fully resourced.

The 'building blocks' approach to safeguarding has progressed with recorded webinars held on the training platform able or staff to access as they require. These include guest speakers from Solace and Karma Nirvana. The perinatal mental health training package has been developed by a subject matter expert. This has been piloted with staff and is awaiting launch in 2025-26.

Action:
Review the level 3 safeguarding packages and to deliver them with a face to face, onsite training option.

Action:
Perinatal mental health training module to be delivered as an additional 'building block' of safeguarding training.

Supervision and support

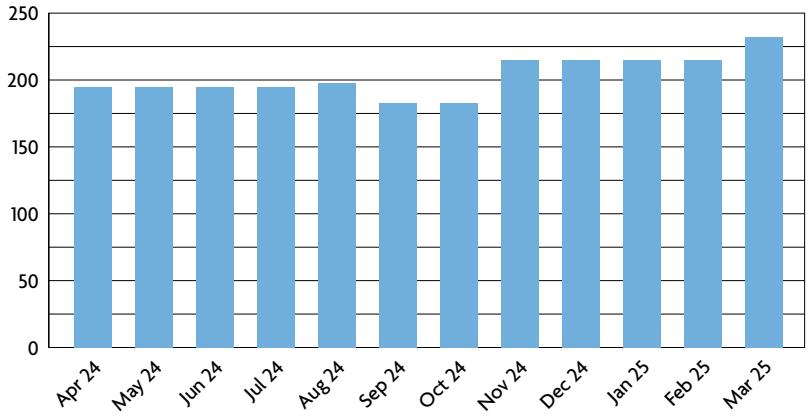
Following a year of rapid transformation, marked by the launch of the safeguarding policy and recruitment of Safeguarding Specialist Midwives, the safeguarding supervision offer at BPAS has now reached a point of stability and maturity.

By October 2024, all Safeguarding Specialist Midwives completed accredited safeguarding supervision training through the NSPCC, ensuring a consistent and high-quality supervision model across the organisation. Each midwife provides direct supervision to clinicians and staff in enhanced safeguarding roles within their region.

A total of 366 staff now receives biannual safeguarding supervision, which complements the twice-yearly Professional Nurse Advocacy (PNA) sessions. As a result, all frontline clinicians benefit from quarterly, restorative supervision focused on safeguarding both patients and them.

Previous challenges with supervision attendance have been addressed through strengthened operational support, and compliance has now met the 85% target, as illustrated in the chart Safeguarding Supervision Compliance 2024–25.

Chart: Safeguarding Supervision Compliance 2024-25



Safeguarding supervision is regularly evaluated. Feedback from staff includes:

> *Love these sessions, love case discussion as it improves and impacts on all of our practices.*
> Midwife

> *It's great to see the end-to-end process and see how all the teams have some form of a connection throughout the patient's pathway.*
> BIC Team Manager

Learning from incidents and reviews

From April to November 2024, safeguarding incidents at BPAS were reported via the Datix system. In December 2025, BPAS transitioned to a new incident reporting platform, Insight, commissioned to enhance monitoring and reporting capabilities.

This transition aligned with the organisation's adoption of the Patient Safety Incident Response Framework (PSIRF), marking a key milestone in building a robust safety management system in line with NHS contractual and compliance standards.

PSIRF underpins an effective response system through four key principles:

- Compassionate engagement with individuals affected by safety incidents.
- System-based learning approaches for continuous improvement
- Proportionate and considered responses to patient safety events.
- Supportive oversight to strengthen system functioning.

This shift promotes a psychologically safe culture, where staff can reflect on incidents, especially safeguarding concerns, in a constructive and supportive way.

Safeguarding incidents, which often involve complex and emotionally sensitive contexts, benefit from a structured approach including:

- Staff debriefs.
- After Action Reviews (AARs)
- Learning events
- 7-minute briefings

These interventions help embed learning and improve patient outcomes. All safeguarding incidents, both internal and external, are reviewed by the BPAS Safeguarding Team. This includes:

- Child and Adult Safeguarding Practice Reviews
- Single Unified Safeguarding Reviews (Wales)
- Domestic Homicide Reviews
- Rapid Reviews
- Inquests

All staff received comprehensive training on Insight and PSIRF during the year, ensuring consistent understanding and application across the organisation.

Safeguarding Incidents - Annual Summary

Safeguarding incident reporting has undergone significant transformation at BPAS over the past three years. The chart titled Safeguarding Incidents Reported Compared to Patient Appointments illustrates the organisation's developmental journey in this critical area.

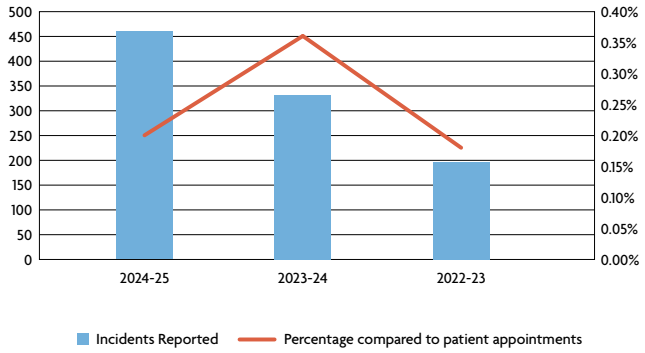
The data reflects the impact of a sustained programme of improvement across safeguarding practice- including updated policies and procedures, enhanced staff training, strengthened supervision, regular compliance audits, and the introduction of more robust incident reporting systems. These efforts have contributed to a gradual and steady increase in the number of incidents reported.

A notable rise in safeguarding reports occurred during 2023–24, which correlates with the implementation of key transformation initiatives. This spike reflected an increased awareness among staff and a stronger culture of transparency and reporting.

In the current reporting year, we observe a period of stabilisation. While the absolute number of reported incidents has increased, the rate of incidents relative to the number of patient appointments has decreased. This suggests that although staff remain vigilant and continue to report concerns, actual safeguarding incidents are becoming less frequent.

This trend indicates not only an improvement in early identification and intervention but also the positive impact of preventative measures and systemic safeguarding enhancements. It demonstrates a maturing safeguarding culture- where staff are both empowered and supported to act, and where safer care environments are being consistently delivered across the organisation.

Chart: Safeguarding Incidents Reported Compared to Patient Appointments



Most incidents (80%) were categorised as causing no harm, which is reassuring and indicates that most situations were either well-managed or low risk to begin with. 17% of incidents resulted in low harm, suggesting there were minor effects but nothing serious or lasting. We had 4% of incidents classified as moderate harm, which means they had more noticeable consequences and likely required intervention or follow-up.

Crucially, there were no incidents resulting in severe harm or death, which is a positive outcome. However, even one moderate harm case is worth learning from to prevent future escalation. We will continue to analyse these trends and work on further reducing the number of moderate and low harm cases.

Action:

Continue to analyse incident trends and work on further reducing the number of moderate and low harm cases.

Incident Themes and Trends

When reviewing safeguarding incidents, we assess them using several specific categories. These include:

- Allegations involving professionals or individuals in a position of trust.
- Complex safeguarding concerns that require escalation
- **Delay or omission of safeguarding process, action, intervention, or referral**
- Inadequate record-keeping
- Incidents that occur during contact with BPAS
- Multi-agency referral or follow-up issues
- Notifications involving pregnant individuals under the age of 13.
- Notifications of external safeguarding reviews

Currently, most safeguarding incidents (**83%**) fall under the category of **'delay or omission of safeguarding process, action, intervention, or referral.'**

Last year, we made targeted efforts to reduce reliance on the generic 'Other' category by introducing new, more specific categories to better capture the nature of incidents. While that work has improved categorisation in some areas, the dominance of the 'delay or omission' category now suggests a need for deeper analysis.

We believe this category may be acting as a catch-all for a range of issues, and it's important we now focus on breaking it down further. This will help us identify underlying causes, address recurring themes, and implement more precise improvements in safeguarding practice.

Action:

Breaking down the delay or omission of safeguarding process, action, intervention, or referral' category to identify causes, address recurring themes, and implement more precise improvements in safeguarding practice.

External Safeguarding Incidents and Reviews

In the year 2024-25, BPAS was notified of **one external safeguarding review**. This involved a **domestic homicide review** following the tragic suicide of a patient who was a victim of domestic abuse. The notification of this review was received in **February 2025**, and it is currently in the **early stages** of investigation.

BPAS is actively working with the review panel to ensure full cooperation and to provide any relevant information necessary for the review process. We are committed to supporting this important review, with the aim of learning from the incident to improve safeguarding practices and ensure better outcomes in the future.

Patient feedback

All patients are asked to complete a patient feedback survey as part of their journey with BPAS. BPAS values all feedback from patients, including concerns or complaints that highlight areas for improvement.

Positive Feedback

In 2024–25, positive feedback was received from patients that highlighted the robust safeguarding measures in place.

> *I can't say thank you to all the staff who supported me through what was a stressful time. The safeguarding measures (which although I didn't require but managed extremely sensitively) all helped and respected my decisions. I can't thank only imagine the positive impact they provide some of the most vulnerable females needing care and support.*

> *There was a lot of discussion regarding safeguarding and checks that I wasn't being pressured into it, which was good.*

Areas for Improvement

A small number of safeguarding-related concerns were raised by patients. These insights have been used to inform staff training, refine communication, and strengthen our safeguarding processes.

Some patients reported that being seen alone for their appointment was inconvenient and affected their planning of the appointments. For example, "My husband wanted to come but couldn't then come into the appointment, I understand this is for safeguarding reasons, but it would have been useful to know this in advance as it was a bit of a wasted trip for him".

Being seen alone is vital for disclosure of abuse or coercion so this will continue to be mandatory in most cases, however we will review how this is relayed to patients early on in their journey to allow them to prepare.

Some patients expressed anxiety about referrals made to external safeguarding agencies, feeling they were not fully informed. We recognise that disclosing information about pregnancy to safeguarding agencies can be worrying for patients, and they may feel that their confidence has been broken.

Patients are told about confidentiality and safeguarding implications at teleconsultation, but we will review the safeguarding risk assessments, guides and scripts to ensure patients are informed sensitively and clearly when referrals are required, in line with best practice.

Action:
Review scripts for discussion of support persons at appointments.

Action:
Review the safeguarding risk assessments, guides and scripts to ensure patients are informed sensitively and clearly when referrals are required.

Multi agency collaboration and innovation

In 2024-25, BPAS made significant strides in multi-agency working, bolstered by the regional presence of safeguarding specialist midwives.

Key initiatives and collaborations have enhanced service delivery and safeguarding outcomes, including:

- **Collaboration with Domestic Abuse Advocates** and national charities
- **Domestic abuse and MARAC colleagues** attending BPAS clinics to better understand the service.
- **Engagement with teenage pregnancy support services** and **ICB subgroups** to improve health outcomes.
- **Visits to women's prisons**, including the mother and baby unit, to strengthen relationships and discuss safeguarding.
- **Perinatal Mental Health Teams** visiting BPAS clinics to discuss improved ways of working and referral.
- **Meetings with Perinatal Trauma & Loss Services** to improve support for patients.
- Participation in **Independent Provider Network Safeguarding meetings** and **Community of Practice Health Network**
- **Delivered sessions to the NHS England Maternity Network**

External feedback highlighted the positive impact of BPAS's collaborative approach, including:

- **Multiple independent domestic violences advocates (IDVAs)** across the UK sharing that they were impressed by the level of **DASH training** being delivered to all clinicians.
- **Recognition that the** safeguarding specialist midwives are **DASH train the trainers noting a level of consistency and high standard nationally**.
- Women's prisons expressing the importance of **relationship-building** and **easy access** to services with BPAS.

Plan for 2025-26:

- **Proposal for a fast-track referral process** for high-risk cases, removing the need for standard forms to improve efficiency and response times.

Action:

Proposal for a fast-track referral process for high-risk cases, removing the need for standard forms to improve efficiency and response times.

Horizon scanning

Looking ahead to the next 12 months, we are committed to strengthening our safeguarding culture and ensuring our practices remain robust, inclusive, and responsive. Our key priorities for the coming year as identified in the safeguarding annual report are shown in the table below:

Table: Actions Identified 2024-25

No.	Actions Identified 2024-25
1.	Recruitment and onboarding of an additional safeguarding role within the BIC.
2.	Further strengthen safeguarding audits through the development and implementation of a national, patient-centred audit, ensuring consistent standards, improved service user experience, and continuous quality improvement.
3.	Implement safeguarding audits for the Support Services Division (Booking and Information Centres, counselling and Aftercare department).
4.	The safeguarding risk assessment to be reviewed within the electronic medical record to improve understanding reporting of themes and outcomes of safeguarding referrals.
5.	The DASH risk assessment to be built into the electronic medical record to enable reporting of themes and outcomes of MARAC referrals.
6.	Author and launch new policy regarding safeguarding concerns involving staff. This will be authored in collaboration with human resources colleagues.
7.	Review the level 3 safeguarding packages and to deliver them with a face-to-face, onsite training.
8.	Perinatal mental health training module to be delivered as an additional 'building block' of safeguarding training.
9.	Continue to analyse incident trends and work on further reducing the number of moderate and low harm cases.
10.	Breaking down the delay or omission of safeguarding process, action, intervention, or referral' category to identify causes, address recurring themes, and implement more precise improvements in safeguarding practice.
11.	Review the safeguarding risk assessments, guides and scripts to ensure patients are informed sensitively and clearly when referrals are required.
12.	Review scripts for discussion of support persons at appointments.
13.	Proposal for a fast-track referral process for high-risk cases, removing the need for standard forms to improve efficiency and response times.

Appendix 1: Progress on Actions 2023-24 provides and update on progress of the actions identified from last year's annual report. These will be combined with the key priorities for this year to create the action plan for the year ahead.

Conclusion

The 2024–25 reporting year marks a pivotal chapter in the evolution of safeguarding at BPAS, characterised by significant transformation, innovation, and strengthened assurance across the organisation. With the corporate safeguarding team fully embedded and a regional footprint now in place, BPAS has delivered a mature, responsive, and proactive safeguarding model fit for the complexities of modern reproductive healthcare.

Key achievements this year include:

- The implementation of Safeguarding Audits Phase 2, improving independence and consistency in assurance through the involvement of safeguarding specialists and patient-centred tools.
- The launch and development of the Daily Safeguarding Support service, offering national, real-time access to safeguarding advice.
- Introduction of new policies and SOPs, ensuring clarity and compliance in safeguarding practice.
- Significant investment in staff development, with all safeguarding specialist midwives now NSPCC Level 4 and DASH Train-the-Trainer certified, delivering bespoke, in-person training.
- Strong multi-agency engagement across diverse sectors including domestic abuse, teenage pregnancy, perinatal health, and the prison service—reflecting our growing influence, accessibility, and partnership working.
- A sharp increase in MARAC referrals and use of national safeguarding information systems (CP-IS and FGM-IS), resulting in improved risk identification and more effective multi-agency response.

Young people under 18 continue to receive dedicated and comprehensive support, with a 62% referral or liaison rate reflecting both greater staff vigilance and the complex safeguarding environment in which we operate. The sensitive management of under-13 cases, in accordance with strict legal and ethical standards, further demonstrates BPAS's capability and leadership in specialist care.

This year saw a focused effort to improve record keeping standards, aligning audit processes and policy with best practice. The introduction of patient-centred national audits in 2025–26 will further support our ambitions for quality, consistency, and service user experience.

Through the continued dedication of our staff and the strength of our safeguarding partnerships, BPAS has shown unwavering commitment to safe, person-centred care. As safeguarding risks become increasingly complex, we remain focused on early intervention, trauma-informed practice, and resilient service delivery.

We thank all colleagues, partners, and multi-agency professionals who have contributed to this year's progress. Together, we are creating a stronger, safer environment for every patient who turns to BPAS for care.

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Appendix 1 - Progress and Actions 2023-24

No.	Actions from 2023-24	Progress	Comment
1.	Development of divisional safeguarding reports that are reported at the safeguarding group meeting	Complete	None
2.	Development of a new audit tool and cycle to strengthen independent scrutiny of services	Complete	N/A
3.	Review outstanding policies and develop new policies and procedures to strengthen safeguarding governance	Complete	N/A
4.	All clinical staff to be trained in DASH risk assessment	Complete	N/A
5.	Face to face safeguarding training packages to be put in place	Ongoing with phased approach	Complete for new DASH package, level 3 package to be delivered face to face in 2025-26. Operational considerations being managed in collaboration with training and operations leads
6.	Creation of specific perinatal mental health training packages to support staff and to align with the mental health crisis SOP	Nearing completion May 2025	Training has been written and awaiting launch in 2025
7.	Continue to build the 'building blocks' approach to safeguarding with a portfolio of guest speakers delivering sessions/webinars/podcasts held on BPAS learn on subjects suggested by staff	Complete	
8.	BPAS's transition to PSIRF will include all safeguarding PSIs. Internal and external safeguarding incidents will include staff debrief, learning events and 7-minute briefings	Complete	
9.	Review the patient electronic medical records and safeguarding risk assessments for adults at risk	Escalated	Issues with developer time to enable coding of the safeguarding risk assessment. Is on organizational risk register to address capacity issues. Key data is able to be extrapolated
10.	Review the 'other' category of safeguarding incidents reported via DATIX and strengthen categorization to support accurate reporting	Complete	New In Phase incident reporting system has been designed to address category of 'other
11.	A safeguarding strategy for BPAS to be developed to ensure the safeguarding journey at BPAS is consistent and clear to staff at every 'safety netting' opportunity following an extended period of system change	Ongoing	A BPAS wide strategy and patient pathway modelling is in progress and was launched at the end of the financial year. The Head of Safeguarding is a key member of this group. This will be a 3-year strategy.
12.	To consider system changes to mandate safeguarding risk assessments for all patients	Ongoing	Issues with developer time to enable coding of the safeguarding risk assessment. Is on organisational risk register to address capacity issues.
Continued from 2022-23			
No.	Actions from 2023-24	Progress	Comment
13.	BPAS to ensure that CAS2 reports are designed to gain robust data to promote the reporting of themes/trends and development of the service according to patient need	Complete	Key data can be extrapolated as seen in the annual safeguarding report
14.	Work with the NHS England and Wales and the maternity networks to raise awareness of the needs of vulnerable adults accessing abortion care particularly in relation to perinatal mental health	Complete	Delivered presentations at NHS Maternity Network in 2024
15.	To offer a blended approach of in person and virtual safeguarding training and supervision following staff feedback	Complete	

BPAS
British Pregnancy Advisory Service

www.bpas.org

Head Office: Orion House, 2 Athena Drive, Tachbrook Park,
Leamington Spa, CV34 6RQ

T: 0345 365 50 50 or +44 (0)1789 508 211

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