Original Paper

Safeguarding During Remote Sexual and Reproductive Health Consultations in England and Wales: Qualitative Study

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Abstract

Background: Remote consultations, including telephone, video, text, or web-based consultations, are now common in sexual and reproductive health services in England and Wales, offering convenience and efficiency but also raising concerns about the safeguarding of service users compared with in-person care. While guidance exists, evidence on how safeguarding is enacted remotely is limited.

Objective: This research examines how safeguarding is managed remotely in sexual and reproductive health services, including associated challenges, benefits, and perceptions of acceptability. As part of the Connect study (NIHR153151), qualitative data were collected across 3 diverse case study areas in England and Wales.

Methods: Semistructured interviews were conducted with service users/potential service users and professional stakeholders, who were recruited using maximum variation sampling through multiple recruitment methods, including clinic-based approaches, established networks, email and text invitations, and the Connect study website (March 2024-January 2025). Data were thematically analyzed using inductive and deductive approaches. A total of 89 interviews were conducted with 54 service users/potential service users and 35 professional stakeholders across the 3 study sites.

Results: Four themes were identified: (1) challenges of delivering remote safeguarding in practice, (2) importance of a safe space for patients, (3) limitations of a one-size-fits-all approach, and (4) strategies to support remote safeguarding. Participants reported challenges, including limited access to visual cues, variable comfort with disclosure, and privacy concerns. Professional stakeholders used adaptive approaches to build trust, ensure safety, and tailor safeguarding to individual circumstances, emphasizing that effective remote safeguarding relies on clinician judgment and sensitive communication.

Conclusions: Remote consultations offer flexibility, but safeguarding depends on access to a safe, private space. Those with language barriers or limited ability to create such a space at home, such as people experiencing housing instability or coercive control, may have greater safeguarding needs. Ensuring access to in-person options, clear safeguarding protocols, and appropriate clinician training is essential to address these challenges.

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Introduction

Remote consultations, conducted via telephone, video, text, or web-based consultations, are now routine in sexual and reproductive health services (SRHS) in England and Wales [1]. This form of consultation has been shown to provide benefits such as convenience, privacy, and anonymity [1,2] and the potential to address capacity and resource constraints and increase efficiency [3]. However, evidence suggests remote consultations may miss important information compared to in-person appointments, such as the ability to perform physical examinations and to identify safeguarding concerns and confidentiality issues [4-6].

Safeguarding is a fundamental part of the UK health and social care system, with service providers responsible for protecting individuals from harm, abuse, and neglect [7]. It encompasses activities designed to protect individuals, guided by principles of empowerment, protection from harm, proportionality through the least intrusive response, and accountability [8]. While all patients may be at risk, the National Health Service (NHS) identifies "vulnerable groups," who require particular attention due to factors such as age, disability, cognitive or mental health impairment, dependence on others, social displacement, experiences of abuse or exploitation, or structural marginalization [9].

Within SRHS, safeguarding is a key aspect of delivering care by ensuring safety, well-being, and access to appropriate support. This includes routine screening of those younger than 18 years for child sexual abuse [10], as well as assessing whether they are competent to make decisions about medical treatment, such as abortion care [11]. In addition, adults are routinely screened for intimate partner violence. During the COVID-19 pandemic, UK abortion provision shifted to remote consultations and at-home use of abortion medication, a change introduced in 2020 and made permanent in England and Wales in 2022 [12]. However, some groups have raised concerns about remote consultations for abortion on safeguarding grounds, arguing that remote provision may limit health care professionals' ability to identify abuse or neglect [12].

Existing research indicates that in online SRHS, safeguarding referrals for individuals younger than 18 years are most often triggered by drug or alcohol use, partner age imbalances, or involvement with social or mental health services [2]. However, findings have been mixed regarding how effectively safeguarding operates in remote SRHS contexts. Much of the existing SRHS literature focuses on online asynchronous interactions, such as online assessment questions used for postal self-sampling. Online sexual history taking may encourage individuals, particularly young people, to disclose personal or embarrassing information, suggesting that remote services could facilitate reporting of safeguarding-related concerns [10].

The COVID-19 pandemic highlighted both the potential strengths and limitations of remote safeguarding, with concerns that certain safeguarding issues may have remained undisclosed during lockdown periods [13]. Research from primary care indicates that remote consultations can complicate history-taking and dialogue, potentially exacerbating inequities for vulnerable groups, particularly for those with intersecting factors, such as older adults with limited English and digital literacy or individuals facing poverty alongside multiple health conditions [14]. Existing literature has focused on individuals younger than 18 years, reflecting the legal framework governing safeguarding in SRHS, but research exploring remote safeguarding from the perspective of vulnerable adults remains limited.

Several SRHS organizations provide guidance to support safe remote safeguarding practices. The Faculty of Sexual and Reproductive Healthcare (now the College of Sexual and Reproductive Healthcare; CoSRH) and the British Association for Sexual Health and HIV (BASHH) [15] emphasize that thorough risk assessments, combined with clear escalation pathways, are important for addressing safeguarding concerns [15]. The British HIV Association (BHIVA) [16] highlights the importance of confirming patient identity, safety to talk, and a secure location at the start of consultations, while the Royal College of Obstetricians and Gynaecologists (RCOG) [17] stresses the importance of remaining alert to verbal cues and conducting robust assessments, particularly for vulnerable groups defined by the NHS, such as individuals younger than 18 years, individuals with disabilities, or those misusing substances. The CoSRH and BASHH [18] emphasize staff training to recognize risks and ensure remote triage protocols include guidance for timely in-person referrals or safeguarding actions. Despite this guidance, understanding how safeguarding is navigated in practice from both professional stakeholders and service user perspectives requires further exploration. The aim of this study was to explore safeguarding practices and the challenges, benefits, and acceptability of these processes in remote service delivery.

Methods

Study Design

This study forms part of the Connect study (NIHR153151), which explored the impact of remote consultations on health inequalities in SRHS. We conducted semistructured interviews in 3 case study areas (CSAs) in England and Wales. A section of the interview focused on safeguarding, and the associated findings are discussed in this paper. Semistructured interviews were appropriate for this study as they enabled in-depth exploration of participants' experiences, perceptions, and beliefs about the use of remote consultations in SRHS [19]. In this context, interviews offer privacy, opportunities to build rapport, and participant control, facilitating disclosure when discussing sensitive topics related to SRH and safeguarding [20]. This study was reported according to the COREQ (Consolidated Criteria

for Reporting Qualitative Research) guidelines [21]. The completed checklist is provided in Checklist 1.

The 3 CSAs were selected to capture sociodemographic diversity and to explore contrasts between rural and urban settings. Table 1 summarizes the appointment types across the 3 CSAs, highlighting each area's approach to in-person and remote consultations. Interviews lasted 60 minutes and were conducted between March 2024 and January 2025.

For the purposes of this study, remote consultations are defined as synchronous interactions between patients and clinicians that do not require in-person contact. These include telephone or video consultations, as well as secure 2-way written communication (eg, SMS, email, or online messaging platforms). Asynchronous consultations delivered through online postal self-sampling were excluded, as they have been examined previously [22].

Table 1. Overview of appointment and consultation options by service.

Service characteristics	CSA[a] A	CSA B	CSA C
Walk-ins	Under 25s only	þ[b]	X[c]
Booked appointments	þ	þ	þ
Online postal self-sampling	X	þ (in-house provision)	þ (external provider)
F2F[d] consultation	þ	þ	þ
Remote consultation	Limited telephone appointments	þ	þ

[a]CSA: case study area.
[b]þ: available at the service.
[c]X: not offered/not available from the service.
[d]F2F: in-person face-to-face consultation.

Sampling and Recruitment

The study used a maximum variation sampling technique and included service users from a diverse range of backgrounds, including ethnicity, age, gender, sexual orientation, socioeconomic status, and disability [23]. This helped to capture a breadth of experiences across participant characteristics and settings. Potential service users were included to capture diversity of experiences and reasons for nonuse. A similarly wide range of professional stakeholders, including service providers, managers, and commissioners, were included, representing different clinical and nonclinical roles, levels of experience, and perspectives.

Our recruitment target was 15 to 20 service users/potential service users and 10 to 15 professional stakeholders from each of the 3 CSAs, with recruitment continuing until data saturation was achieved. Participants were recruited through multiple methods including posters displayed in SRHS clinics, in-person approaches by interviewers and local research teams in clinic settings, outreach via established networks, email invitations, text messages to recent service users, and the Connect study website. All recruitment materials were provided in English and Welsh.

Service users/potential service users were eligible if they were aged 16 years or older and resided within one of the CSAs. Participants also needed to have the capacity to provide informed consent and to speak and read English, as interviews could not be conducted in other languages. Professional stakeholders were eligible if they were currently involved in delivering SRHS within the 3 CSAs. Eligible professional stakeholders included consultants, nurses, health advisers, other physicians or clinicians, counselors, managers, commissioners, or others involved in SRHS delivery.

Data Collection

Participants were invited to take part in an interview after reviewing the participant information leaflet and providing informed consent. Participants also completed a screening questionnaire to capture sociodemographic information to support sample diversity. Most of the questions were optional, and participants could select "prefer not to say" for any question.

Interviews were conducted by an experienced qualitative researcher (CS or TW), who has a background in social science and applied health science. The researchers had no prior relationships with service user participants. Researchers reflected on how their disciplinary backgrounds, assumptions, and interactions with participants may have shaped data collection and interpretation, and this was supported by ongoing discussion within the research team. A detailed reflexivity statement can be found in Multimedia Appendix 1. To encourage participation, interviews were conducted in participants' preferred format, in person at an SRHS, on university premises, or remotely via telephone, Microsoft Teams, or Zoom. No one else was present during the interviews. All interviews were audio-recorded using an encrypted Dictaphone or the built-in recording functions of Microsoft Teams or Zoom, and field notes were made during and/or immediately after each interview.

Interviews with service users/potential service users followed a topic guide exploring experiences of SRHS, including access, the use of remote vs in-person consultations, and barriers to care. The topic guide for service users/potential service users was piloted with the Connect Voices patient and public involvement panel. Participants who had never used the service were asked about their reasons for nonuse, including lack of need, barriers to access, or alternative service use, and what might improve access. For professional stakeholders, interviews focused on their

perspectives on SRHS consultations in both remote and in-person formats. The findings from this component of the study are reported and discussed in a separate paper [24].

The safeguarding component examined participants' experiences of being asked about, or asking about, domestic and/or sexual violence during remote consultations, as well as their comfort with such questions. For professional stakeholders, this included discussing their experiences of asking safeguarding questions, while those without direct consultation experience, such as other stakeholders and commissioners, were asked about their perceptions, knowledge, and thoughts.

Data Analysis

Audio recordings were transcribed verbatim by a university-approved transcription company and were pseudonymized prior to analysis. A thematic analysis was conducted in 2 stages [25]. First, as part of a broader qualitative study, transcripts were coded by CS and TW using combined inductive and deductive approaches. Broad coding categories were predefined based on the study aims, including safeguarding, while data within these categories were coded inductively to capture participants' experiences and perspectives [26]. During this initial coding phase, data relating to safeguarding were labeled under a broad safeguarding code and did not form the main focus of the primary analysis. This approach enabled the analysis to remain focused on the broader study aims while identifying content specific to safeguarding for later in-depth analysis.

Second, for the purposes of the present paper, all data previously coded as relating to safeguarding were reexamined and analyzed in greater depth in relation to this paper's research aims. This analysis focused on the previously identified safeguarding data rather than reanalyzing the full dataset. This subset of data was recoded inductively to generate initial codes capturing participants' safeguarding-related experiences and perspectives.

Codes were reviewed across the dataset and grouped into initial themes based on patterns and similarities in participants' accounts. These themes were discussed within the wider research team and iteratively refined and grouped into broader analytic themes, which form the basis of the findings presented here. This collaborative and iterative process provided opportunities to challenge individual researchers' interpretations and enhance the credibility of the analysis. NVivo (version 14; Lumivero) was used for data management and analysis.

Ethical Considerations

The study received ethical approval from the NHS Research Ethics Committee (REC: 23/NS/0128). Participants gave informed consent before participation, either in person using paper forms or electronically via REDCap (Vanderbilt University), in accordance with the approved ethical protocol. A £20 (£1=US $1.25 as of December 20, 2024) shopping voucher was provided to service users/potential service users in acknowledgment of their contribution.

Results

In total, we carried out 89 interviews with 54 service users/potential service users and 35 professional stakeholders across the 3 CSAs. Tables 2 and 3 display the characteristics of participants who took part in the study.

Four key themes were identified: (1) challenges of remote safeguarding in practice; (2) importance of a safe space; (3) limitations of a one-size-fits-all approach; and (4) strategies to support remote safeguarding.

Table 2. Service user/potential service user characteristics.

Characteristics	CSA[a] A, n	CSA B, n	CSA C, n	Overall, n
Age (y)				
16-20	2	3	3	8
21-24	2	4	2	8
25-34	10	5	8	23
35-44	1	2	3	6
45+	6	3	0	9
Gender				
Cisgender man	8	4	4	16
Cisgender woman	9	10	8	27
Transgender man	1	0	1	2
Transgender woman	2	0	1	3
Nonbinary person	1	2	1	4
Prefer not to say	0	1	1	2
Ethnicity				
Asian or Asian British	2	4	0	6
Black/African/Caribbean/Black British	3	4	0	7

Characteristics	CSA[a] A, n	CSA B, n	CSA C, n	Overall, n
Mixed/multiple ethnic groups/other	3	1	2	6
White	13	8	14	35
Prefer not to say	0	0	0	0
Sexuality				
Heterosexual or straight	9	6	9	24
Gay or lesbian	6	7	2	15
Bisexual	6	2	3	11
Other	0	2	2	4
Prefer not to say	0	0	0	0
Disability[b]				
Yes	7	8	3	18
No	14	9	12	35
Prefer not to say	0	0	1	1
Education				
Secondary or earlier	1	0	1	2
Further education	3	4	4	11
University/postgraduate	17	13	11	41
Prefer not to say	0	0	0	0
Ever used SRHS[c] services				
Yes	20	12	11	43
No	1	4	5	10
Prefer not to say	0	1	0	1
Prior diagnosis of an STI[d]				
Yes	10	3	2	15
No	11	14	13	38
Prefer not to say	0	0	1	1
Overall	21	17	16	54

[a]CSA: case study area.
[b]Participants' response to the question, "Do you have any physical or mental health conditions, or illnesses lasting or expected to last, 12 months or more?"
[c]SRHS: sexual and reproductive health services.
[d]STI: sexually transmitted infection.

Table 3. Professional stakeholder characteristics.

Characteristics	CSA[a] A, n	CSA B, n	CSA C, n	Overall, n
Role				
Consultant/medical doctor	4	5	1	10
Nurse/health advisor	4	3	4	11
Health care assistant	1	0	2	3
Counselor	0	1	0	1
Manager	1	3	1	5
Commissioner	1	2	0	3
Other	1	0	1	2
Gender				
Man (including transgender man)	7	2	0	9
Woman (including transgender woman)	5	12	8	25
Nonbinary	0	0	0	0
Prefer not to say	0	1	1	1
Ethnicity				
Asian or Asian British	2	3	0	5
Black/African/Caribbean/Black British	1	2	0	3

Characteristics	CSA[a] A, n	CSA B, n	CSA C, n	Overall, n
Mixed/multiple ethnic groups	0	0	0	0
White	9	8	9	26
Other ethnic group	0	0	0	0
Prefer not to say	0	1	0	1
Overall	12	14	9	35

[a]CSA: case study area.

Challenges of Remote Safeguarding in Practice

Safeguarding assessments were routinely included in both in-person and remote consultations, often at the end of sexual history taking. While experiences varied by modality, some providers felt that effectiveness depended more on clinicians' professional curiosity than the consultation format. As 1 participant explained:

> *I don't think virtual working has a detrimental effect on safeguarding whatsoever. I think our staff are really good at using their professional curiosity whether it's in a virtual consultation or a face-to-face consultation to get to the bottom of what's going on.* [HCP07, nurse/health advisor]

However, some clinicians reported greater avoidance of safeguarding-related questions during remote consultations than when in-person. Over the phone, it was easier to skip questions if the conversation felt rushed or uncomfortable, or if the clinician was unsure how to frame them.

> *But I think sometimes it's a bit of a get out clause from asking what can be quite difficult questions and it's, oh well I couldn't confirm they were alone because they were over the phone, you know.* [HCP03, nurse/health advisor]

Remote consultations also raised concerns about incomplete context and reduced privacy. Some worried that remote consultations could miss important nonverbal cues, such as body language, facial expressions, and tone of voice that help identify underlying concerns. One clinician highlighted that remote consultations could limit opportunities to ask safeguarding questions, particularly when there was uncertainty about a patient's privacy. Considering the potential for missing information during remote consultations, participants emphasized that disclosure is voluntary for those with capacity and that further intervention is not always possible without explicit consent.

> *Ultimately, if you've done everything you can do to keep them safe, if you've done the referrals and made sure that everything is in place for them, then...we've just got to accept that there's nothing else that you can do at that point.* [HCP21, nurse/health advisor]

Service users/potential service users expressed mixed views. Some were skeptical about disclosing concerns over the phone or online, worrying that these formats lack sufficient support. As 1 participant explained, the absence of in-person support can leave users feeling vulnerable:

> *You could answer those questions and be a gibbering wreck at the end of it and then you hang up the phone...Whereas I think if you're doing it in a room with a bunch of professionals and it did trigger a meltdown there's people there to comfort you and support you.* [SU04, cisgender man, aged 45 years or older]

Across both groups, trust was central to disclosure. One-off questions were seen as insufficient, and disclosure depended on timing, rapport, and readiness. Remote modalities, especially short calls, were described as less conducive to building the trust and relationship needed for people to feel able to disclose.

> *I keep asking about domestic violence on a telephone appointment they say, "No." and they said, "Well you ask me every single time....The day I see you face-to-face I'll tell you all about it." and it took someone two years to come back and tell me.* [HCP32, consultant/medical doctor]

Importance of a Safe Space

Participants emphasized that in-person consultations offered privacy, confidentiality, and security that supported trust-building and open communication. Being in a clinical environment, away from home, made disclosure feel safer, especially for those experiencing control, coercion, or abuse.

> *I think possibly I would feel more comfortable in a face-to-face appointment. Also I mean having distance, being in a separate location.* [SU39, cisgender woman, aged 25-34 years]

Clinicians similarly highlighted that in-person settings allowed them to create and manage a safe environment, for example, by ensuring privacy or asking a partner to wait outside. This physical separation was essential for maintaining confidentiality and facilitating safeguarding conversations. In contrast, remote consultations made it harder to guarantee privacy or control the setting, meaning providers

could not always be sure that a patient was alone or able to speak freely.

> *We don't know who's listening in on the virtual consultation, sometimes there's someone visibly in the background and you can't really do anything about that you know? You can't control that like you can in the clinic*. [HCP36, consultant/medical doctor]

This concern was further highlighted by another clinician, who noted that when others were present during remote consultations, they relied on "gut feeling" to prompt further enquiry.

> *And also, sometimes I find somebody else might be in the room with them, and you may not know who that person is...Or they'll just say, "oh, it's my friend". But then that friend is sometimes a little bit older than them, and- You know, yeah. And then you have this gut feeling*. [HCP04, nurse/health advisor]

Service users'/potential service users' perspectives varied. While many valued the security and structure of clinical settings, others felt more comfortable disclosing sensitive information remotely. For these individuals, physical distance reduced embarrassment and intimidation, creating a sense of psychological safety and control that allowed them to open up at their own pace in a familiar environment.

> *I think a remote consultation would, at least for me, make it more able and less like distressing for me to like get into detail about this kind of stuff because I think it can feel quite overwhelming if it's like a person in front of me asking me*. [SU65, cisgender woman, aged 21-24 years]

One Size Does Not Fit All

The interviews found differences in how adults and individuals younger than 18 years are managed across all the CSAs. For individuals younger than 18 years, in-person appointments were prioritized regardless of the reason for consultation, a practice underpinned by legal safeguarding responsibilities. As 1 clinician explained:

> *We do try and attempt numerous times, but there's only so much you can do. They're an adult at the end of the day, so there's limits to what we can do, whereas with under-18s we can do a safeguarding referral without their permission*. [HCP19, consultant/medical doctor]

In cases involving individuals younger than 18 years, any safeguarding concerns raised during a remote consultation were more likely to prompt a follow-up in-person appointment. This reflects a lower threshold for in-person assessment for younger patients, whose needs and risks require closer observation and intervention.

> *I think with young people, if a young person made a disclosure that was concerning around safeguarding over the phone, then we would probably aim to get them to come in for a face-to-face appointment with our health advisors...* [HCP29, consultant/medical doctor]

Remote consultations can offer discreet access to services for all users. Participants noted that for someone experiencing domestic violence, remote appointments might allow them to seek help when alone or at lower risk. However, they also imagined that in severe cases, constant monitoring could make private access impossible.

> *Right now, on one side that person might be able to just organise the call with you at a time when the risk is lowest or when they are on their own. I mean it really depends on how severe the situation is*. [SU24, cisgender man, aged 45 years or older]

Service users reflected that comfort with remote consultations depends on personal risk and past experiences. Those without experiences of domestic abuse, sexual violence, exploitation, sex work, or substance use generally felt confident answering safeguarding questions remotely and perceived little difference between the formats.

> *For me, it didn't really make a difference, because I haven't experienced domestic abuse or anything. I didn't think anything of it. It's the same for me, whether it's face-to-face or over the phone. Those kinds of questions. I just think it might be different if you were actually affected by that*. [SU22, cisgender woman, aged 35-44 years]

Participants noted that preferences for the mode of consultation varied. From a practical perspective, remote consultations could facilitate disclosure for those facing barriers to attending in person, such as childcare, mobility, or mental health challenges.

> *Although we talk about the bad parts of missing vulnerabilities and things if we do remote consultations, it can also be helpful. So if you have young children or you're in a coercive relationship, it might be beneficial*. [HCP31, consultant/medical doctor]

Strategies to Support Remote Safeguarding

Professional stakeholders described using various strategies to identify and respond to safeguarding concerns remotely. They cautiously introduced sensitive topics after assessing privacy, safety, and the individual's environment, attended to verbal cues such as tone, background noise, and hesitations, and adjusted their approach accordingly. Building rapport was considered important, with some delaying safeguarding discussions until trust was established.

> *I would normally wait and build a rapport with the patient...Then I would normally give people a warning and say, "I'm going to be asking you some questions about domestic violence and sexual abuse are you still somewhere safe and private to speak where you can answer freely?* [HCP31, consultant/medical doctor]

Participants supported a collaborative, patient-centered approach, discussing concerns openly, explaining the limits of confidentiality, cocreating safety plans where possible, and working carefully to minimize harm through joint decision-making. Flexibility and creativity were also seen as important. Alternative communication methods such as text messages, letters, or follow-up calls were suggested. These were seen as helping to maintain contact, ensuring information and support are accessible, and addressing barriers to safe disclosure.

> *I suppose like if someone isn't the best with their phone, you could send them a letter if you were doing it remotely and then they'll have the information and any support available. There's ways around it. You just have to think a little bit differently.* [HCP21, nurse/health advisor]

In response to safeguarding concerns, some clinicians arranged in-person appointments under alternative pretenses, allowing discreet in-clinic conversations.

> *The whole thing was engineered round a smear. To get the woman in to be able to discuss it. She didn't need to smear but it was broached in that that would have been very difficult to do. Have access to...he wouldn't give access to a phone.* [HCP08, nurse/health advisor]

One participant suggested that remote safeguarding could be improved by offering greater flexibility and availability, allowing individuals to engage at times when they feel safe to talk.

> *I think it's just a matter of scheduling and being available to having more availabilities around when the person might be safe to talk.* [SU81, "prefer not to say," aged 16-20 years]

Discussion

Principal Findings

This study identified 4 key themes related to safeguarding in remotely delivered SRHS across 3 CSAs. Both service users/potential service users, as well as professional stakeholders, recognized the complexities of safeguarding in remote contexts. Many participants did not express strong preferences for remote or in-person consultations; rather, the perceived effectiveness of remote safeguarding depended on clinicians' professional curiosity and responsiveness. However, it is important to note that preferences are not always entirely free choices, particularly for young people or those experiencing abuse, as they may be shaped by coercion, trauma, or practical constraints. Making space for these influences is important for designing services that are responsive to patient needs. This corresponds with existing evidence that professional judgment and training remain central to effective safeguarding across all modalities, although applying this judgment may be more challenging remotely [27]. Remote delivery can also introduce barriers that affect clinicians' confidence and consistency when raising safeguarding concerns, especially during sensitive or time-pressured conversations. Strategies such as structured questioning, sensitive communication, and attentive listening can support disclosure remotely [28].

Despite these strategies, participants also described obstacles that affect safeguarding in practice. These include failures to identify relevant information and the lack of nonverbal cues. Professional stakeholders in this study reported that remote consultations can make it harder to be completely confident that service users are able to disclose safeguarding concerns fully, echoing prior research suggesting that risk assessments conducted remotely are less reliable than those conducted in-person [29,30]. This has important implications for SRHS that do not offer in-person appointments, for example, in remote abortion care pathways where potential risks may be greater. However, providers noted that safeguarding in SRHS is an ongoing process and that, when needed, further assessment can be deferred to a later in-person appointment after an initial remote consultation.

For adults, disclosure remains dependent on their willingness and ability to share information; if a patient who has the capacity chooses not to disclose safeguarding-related matters, SRHS are limited in the actions they can take. The consultation environment, patients' sense of privacy, and confidence in the service can influence their ability to share sensitive information. For example, limited private space for remote consultations, such as for people in shared housing, multigenerational households, or coercive relationships, can compromise confidentiality, as previous studies have shown [29,31,32]. One study found that predictability, such as fixed appointment times, is important for remote consultations as it allows patients to prepare and create a safe space [33].

Service users also expressed concerns about how disclosures would be handled remotely, highlighting the need for clear information about processes and expected outcomes. In-person consultations were associated with a sense of privacy and security, with the clinical setting perceived as a controlled environment that facilitates open communication. This aligns with previous work identifying consulting rooms as safe spaces for discussing sensitive issues [27]. Remote consultations, however, can offer distinct benefits, particularly in providing patients with greater control over the interaction. Service users suggested it would allow them to choose when to engage, have greater control over the pace of the conversation, and feel less constrained by an unfamiliar clinical environment. This flexibility may support disclosure, especially for individuals discussing trauma, abuse, or coercive relationships [28].

Age-specific considerations were also evident. Legal frameworks mean that safeguarding for individuals younger than 18 years allows more proactive intervention once concerns are identified, whereas safeguarding for adults generally relies on voluntary disclosure and on their consent to any intervention. This affects decisions around consultation type, follow-up, and the approach to risk assessment. Remote consultations can offer safeguarding benefits for vulnerable groups defined by the NHS, such as young people, individuals with physical, sensory, or mental impairments, and those with learning disabilities [9], by improving access when in-person visits are difficult. However, challenges remain in supporting disclosure and assessing risk effectively [27,29]. Where remote safeguarding is the only option, individuals may struggle to disclose information due to limited access to services or a lack of a private, safe space. Offering a choice of consultation type is therefore essential, with in-person services being important when privacy is needed.

Professional stakeholders described a range of strategies to support remote safeguarding, including structured questioning, ensuring patient privacy, and planning for a follow-up review or in-person consultation. While formal frameworks were not widely discussed in interviews, services have safeguarding protocols to guide clinicians. Many of these strategies align with guidance from professional bodies such as BASHH, BHIVA, and CoSRH. These recommendations emphasize thorough risk assessment, ensuring confidentiality, and having clear procedures for escalation, suggesting that provider practices reflect established professional standards. The broader findings of this study also recognize that not all patients have ready access to the digital technologies needed for remote consultations [24]. Ensuring that patients have the option for in-person contact where needed, providing clear information about safeguarding processes, and tailoring approaches to individual patient circumstances are essential to delivering safe and effective care [30]. Building on these findings, future research could examine how different remote consultation modalities impact actual safeguarding outcomes and explore which approaches best support disclosure across diverse patient groups and circumstances. Understanding these nuances can inform service design, ensuring that remote and in-person consultations complement each other and that safeguarding processes remain responsive to patient needs.

Strengths and Limitations

The large qualitative sample of 89 participants reflects the broader aims and multisite design of the wider study, which sought to capture diverse perspectives from service users, potential service users, and professional stakeholders across 3 distinct CSAs. While this enabled remote safeguarding to be explored across different settings and participant groups, large qualitative datasets can present challenges in maintaining analytical depth and the context and nuance of individual accounts [34]. However, heterogeneous samples require more data than homogeneous samples to encompass different perspectives and experiences [35]. The inclusion of multiple participant groups across diverse settings strengthens the credibility of the findings and provides contextual information to support judgments about their transferability to other settings.

Although data saturation was considered within the wider study, saturation does not necessarily indicate that all perspectives have been fully captured, particularly within a heterogeneous sample [36]. Less frequently held views or experiences, particularly among smaller participant subgroups, may be underrepresented in the findings.

This study is part of a wider investigation into the impact of remote consultations in SRHS on health inequalities. For this analysis, only data previously coded as relating to safeguarding within the wider study were reexamined, rather than the full interview dataset. As safeguarding was not the primary focus of the original analysis, it is possible that relevant data not initially identified under the broad safeguarding code might not have been included in the subsequent analysis. However, safeguarding was a predefined coding category based on the study aims and was proactively identified from the outset.

It is also important to note that service users generally had limited experience of disclosing information that triggered a safeguarding concern, as we did not specifically sample individuals with such experiences. Many participants reported that they had never raised issues related to safeguarding. In some cases, service users may have been invited to in-person consultations due to safeguarding concerns but were unaware that this was the reason for the invitation. The study also included a limited sample of individuals younger than 18 years, as participants had to be aged 16 or older to take part, and younger individuals may have different experiences of safeguarding within SRHS. In addition, people with disabilities, such as hearing or vision loss, may have found virtual consultations particularly challenging, and the study's requirement for sufficient English-language comprehension may mean that the findings underrepresent key equity concerns.

Conclusions

Safeguarding within remote SRHS consultations was shown to have benefits, but its effectiveness depends on clinician judgment, a structured approach, and clear communication. The ability to exercise such judgment may be limited by factors including training, time available, and the working environment. Remote consultations offer benefits such as flexibility, patient control, and improved access for some vulnerable populations, but challenges remain, including limited nonverbal cues, confidentiality concerns, and perceived difficulties in assessing risk. Remote safeguarding appears to be a context-specific practice shaped by structural conditions rather than a universal solution. Our findings confirm the need to retain an in-person consultation option and to have clear safeguarding processes and appropriate clinician training. Policies should ensure that remote consultations complement rather than replace in-person care, and further research should examine their impact on safeguarding outcomes and equity, with particular attention to ensuring remote options do not widen existing inequities for digitally excluded populations.

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Generative AI Use

No generative AI tools were used in the preparation of this manuscript, including for writing the manuscript or analyzing qualitative data.

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Data Availability

According to the study's ethical approvals, only the research team members responsible for analyzing the data have access to the full anonymized transcripts. The data are not publicly available due to privacy and ethical restrictions. Requests for access to the anonymized data can be submitted to the University of Birmingham Research Governance team at researchgovernance@contacts.bham.ac.uk.

Authors' Contributions

LJ, FB, IW, JDCR, AC, HM, JG, JJ, DS, and MWO designed the idea of the project and acquired funding. HM, JJ, MWO, LJ, CS, FB, and TW designed the topic guide and participant recruitment materials. LJ, FB, IW, JDCR, AC, HM, JG, JJ, DS, and MWO designed the concept of the study. CS and TW coordinated and conducted participant recruitment and interviews. CS, TW, and FB had primary oversight of the analysis. CS drafted the initial manuscript. All authors contributed to manuscript revisions, approved the final version, and had final responsibility for the decision to submit for publication. JJ coordinated the involvement of the Connect Patient and Public Involvement Voices panel.

Conflicts of Interest

None declared.

Multimedia Appendix 1

Reflexivity statement.
[DOCX File (Microsoft Word File), 16 KB-Multimedia Appendix 1]

Checklist 1

COREQ checklist.
[DOCX File (Microsoft Word File), 23 KB-Checklist 1]

References

1. Gibbs J, Solomon D, Jackson L, Mullick S, Burns F, Shahmanesh M. Measuring and evaluating sexual health in the era of digital health: challenges and opportunities. Sex Health. Aug 2022;19(4):336-345. [doi: 10.1071/SH22068] [Medline: 35970766]
2. Day S, Kinsella R, Jones S, Tittle V, Suchak T, Forbes K. Safeguarding outcomes of 16 and 17-year-old service users of Sexual Health London (SHL.uk), a pan-London online sexual health service. Int J STD AIDS. Dec 2020;31(14):1373-1379. [doi: 10.1177/0956462420933462] [Medline: 33103583]
3. Bissessor M, Bradshaw CS, Fairley CK, Chen MY, Chow EP. Provision of HIV test results by telephone is both safe and efficient for men who have sex with men. Int J STD AIDS. Jan 2017;28(1):39-44. [doi: 10.1177/0956462415623912] [Medline: 26685200]
4. Lunt A, Llewellyn C, Bayley J, Nadarzynski T. Sexual healthcare professionals' views on the rapid provision of remote services at the beginning of COVID-19 pandemic: a mixed-methods study. Int J STD AIDS. Oct 2021;32(12):1138-1148. [doi: 10.1177/09564624211023018] [Medline: 34106016]
5. Bosó Pérez R, Reid D, Maxwell KJ, et al. Access to and quality of sexual and reproductive health services in Britain during the early stages of the COVID-19 pandemic: a qualitative interview study of patient experiences. BMJ Sex Reprod Health. Jan 2023;49(1):12-20. [doi: 10.1136/bmjsrh-2021-201413] [Medline: 35444001]

6. McLeod J, Estcourt CS, MacDonald J, et al. Opening the digital doorway to sexual healthcare: recommendations from a behaviour change wheel analysis of barriers and facilitators to seeking online sexual health information and support among underserved populations. PLoS One. 2025;20(1):e0315049. [doi: 10.1371/journal.pone.0315049] [Medline: 39775372]
7. Safeguarding children, young people and adults at risk in the NHS: safeguarding accountability and assurance framework. Fifth edition, 2026. NHS England; 2026. URL: https://www.england.nhs.uk/long-read/safeguarding-children-young-people-and-adults-at-risk-in-the-nhs/#2-introduction-purpose [Accessed 2026-10-29]
8. Duffy A, Browne F, Connolly M. Safeguarding adults: a concept analysis. J Adv Nurs. Jan 2025;81(1):181-197. [doi: 10.1111/jan.16306] [Medline: 38943338]
9. Safeguarding. NHS England; 2023. URL: https://www.england.nhs.uk/long-read/safeguarding [Accessed 2026-10-29]
10. Sullivan V, de Sa J, Hamlyn E, Baraitser P. How can we facilitate online disclosure of safeguarding concerns in under 18s to support transition from online to face-to-face care? Int J STD AIDS. May 2020;31(6):553-559. [doi: 10.1177/0956462420913438] [Medline: 32295476]
11. Romanis EC, Parsons JA. Early telemedical abortion, safeguarding, and under 18s: a qualitative study with care providers in England and Wales. BMJ Sex Reprod Health. Oct 2023;49(4):238-244. [doi: 10.1136/bmjsrh-2022-201762] [Medline: 36707235]
12. Parsons JA, Romanis EC. "All hands on deck": a qualitative study of safeguarding and the transition to telemedical abortion care in England and Wales. Soc Sci Med. May 2024;348:116835. [doi: 10.1016/j.socscimed.2024.116835] [Medline: 38626482]
13. Bekaert S, Azzopardi L. Safeguarding teenagers in a sexual health service during the COVID-19 pandemic. Sex Transm Infect. May 2022;98(3):219-221. [doi: 10.1136/sextrans-2021-055055] [Medline: 34226202]
14. Payne R, Clarke A, Swann N, et al. Patient safety in remote primary care encounters: multimethod qualitative study combining Safety I and Safety II analysis. BMJ Qual Saf. Aug 16, 2024;33(9):573-586. [doi: 10.1136/bmjqs-2023-016674] [Medline: 38050161]
15. Patel R, Munro H, Brito-Mutunayagam S, et al. Standards for online and remote providers of sexual and reproductive health services. British Association for Sexual Health and HIV (BASHH); Faculty of Sexual and Reproductive Healthcare (FSRH); 2019. URL: https://www.bashh.org/_userfiles/pages/files/resources/bashhfrshjointstandardsforonlineandremoteproviders2019x.pdf [Accessed 2026-10-29]
16. Thornhill J, Bailey A, van Halsema C, Nieman Sims C, Rattue M, Waters L. British HIV association (BHIVA) guidance for virtual consultations for people with HIV 2021: May 2021. British HIV Association (BHIVA); 2021. URL: https://bhiva.org/wp-content/uploads/2024/10/BHIVA-guidance-for-virtual-consultations-for-people-with-HIV.pdf [Accessed 2026-10-29]
17. Best practice in telemedicine for abortion care. The Royal College of Obstetricians and Gynaecologists; 2022. URL: https://www.rcog.org.uk/media/f32nniuk/abortion-care-telemedicine-best-practice-paper-2022.pdf [Accessed 2026-10-29]
18. Triage integration considerations & methods to prioritise vulnerable groups. British Association for Sexual Health and HIV (BASHH); 2020. URL: https://www.bashh.org/_userfiles/pages/files/resources/covid/triage_integration_considerations_and_methods_to_prioritise_vulnerable_groups.pdf [Accessed 2026-10-29]
19. DeJonckheere M, Vaughn LM. Semistructured interviewing in primary care research: a balance of relationship and rigour. Fam Med Community Health. 2019;7(2):e000057. [doi: 10.1136/fmch-2018-000057] [Medline: 32148704]
20. Dempsey L, Dowling M, Larkin P, Murphy K. Sensitive interviewing in qualitative research. Res Nurs Health. Dec 2016;39(6):480-490. [doi: 10.1002/nur.21743] [Medline: 27434172]
21. Tong A, Sainsbury P, Craig J. Consolidated Criteria for Reporting Qualitative Research (COREQ): a 32-item checklist for interviews and focus groups. Int J Qual Health Care. Dec 2007;19(6):349-357. [doi: 10.1093/intqhc/mzm042] [Medline: 17872937]
22. Spence T, Gibbs J, Wong G, et al. Evaluating the implementation of online postal self-sampling for sexually transmitted infections in England: multisite qualitative study. J Med Internet Res. Sep 9, 2025;27:e72812. [doi: 10.2196/72812] [Medline: 40924997]
23. Palinkas LA, Horwitz SM, Green CA, Wisdom JP, Duan N, Hoagwood K. Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. Adm Policy Ment Health. Sep 2015;42(5):533-544. [doi: 10.1007/s10488-013-0528-y] [Medline: 24193818]
24. Witney T, Spurway C, Gibbs J, et al. The acceptability, appropriateness, and equity of remote consultations in sexual and reproductive health services in england and wales: a qualitative study. medRxiv. Preprint posted online on Feb 7, 2026. [doi: 10.64898/2026.02.06.26345738]
25. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. Jan 2006;3(2):77-101. [doi: 10.1191/1478088706qp063oa]

26. Fereday J, Muir-Cochrane E. Demonstrating rigor using thematic analysis: a hybrid approach of inductive and deductive coding and theme development. Int J Qual Methods. Mar 2006;5(1):80-92. [doi: 10.1177/160940690600500107]
27. Dixon S, Frost L, Feder G, Ziebland S, Pope C. Challenges of safeguarding via remote consulting during the COVID-19 pandemic: a qualitative interview study. Br J Gen Pract. Mar 2022;72(716):e199-e208. [doi: 10.3399/BJGP.2021.0396] [Medline: 35074797]
28. Parsons JA, Romanis EC. The case for telemedical early medical abortion in England: dispelling adult safeguarding concerns. Health Care Anal. Mar 2022;30(1):73-96. [doi: 10.1007/s10728-021-00439-9] [Medline: 34687384]
29. McCarron R, Moore A, Foreman I, et al. Remote consultations in community mental health: a qualitative study of clinical teams. J Psychiatr Ment Health Nurs. Oct 2024;31(5):857-868. [doi: 10.1111/jpm.13044] [Medline: 38462900]
30. Rosen R, Wieringa S, Greenhalgh T, et al. Clinical risk in remote consultations in general practice: findings from in-COVID-19 pandemic qualitative research. BJGP Open. Sep 2022;6(3):BJGPO.2021.0204. [doi: 10.3399/BJGPO.2021.0204] [Medline: 35487581]
31. Reilly K, Ebersole A. Confidentiality and privacy considerations for adolescents receiving contraceptive health services via telemedicine: a narrative review. Womens Health (Lond). 2024;20:17455057241233126. [doi: 10.1177/17455057241233126] [Medline: 38424665]
32. Wood SM, Pickel J, Phillips AW, et al. Acceptability, feasibility, and quality of telehealth for adolescent health care delivery during the COVID-19 pandemic: cross-sectional study of patient and family experiences. JMIR Pediatr Parent. Nov 15, 2021;4(4):e32708. [doi: 10.2196/32708] [Medline: 34779782]
33. Humphrey A, Cummins S, May C, Stevenson F. GP remote consultations with marginalised patients and the importance of place during care: a qualitative study of the role of place in GP consultations. BJGP Open. Apr 2025;9(1):BJGPO.2024.0050. [doi: 10.3399/BJGPO.2024.0050] [Medline: 39074881]
34. Brower RL, Jones TB, Osborne-Lampkin LT, Hu S, Park-Gaghan TJ. Big Qual: defining and debating qualitative inquiry for large data sets. Int J Qual Methods. Jan 1, 2019;18:1609406919880692. [doi: 10.1177/1609406919880692]
35. Rahimi S, Khatooni M. Saturation in qualitative research: an evolutionary concept analysis. Int J Nurs Stud Adv. Jun 2024;6:100174. [doi: 10.1016/j.ijnsa.2024.100174] [Medline: 38746797]
36. Lim WM. Sample size in qualitative research: moving from data saturation to theoretical saturation. J Glob Mark. Mar 15, 2026;39(2):224-234. [doi: 10.1080/08911762.2025.2590757]

Abbreviations

BASHH: British Association for Sexual Health and HIV
BHIVA: British HIV Association
COREQ: Consolidated Criteria for Reporting Qualitative Research
CoSRH: College of Sexual and Reproductive Healthcare
CSA: case study area
NHS: National Health Service
RCOG: Royal College of Obstetricians and Gynaecologists
REC: Research Ethics Committee
SRHS: sexual and reproductive health services

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