IN HER MAJESTY'S COURT OF APPEAL IN ENGLAND **Court ref: C1 2020 0822**

CIVIL DIVISION

ON APPEAL FROM THE DIVISIONAL COURT (Claim CO/1402/20202)

(SINGH LJ AND CHAMBERLAIN J)

APPEAL AGAINST REFUSAL OF PERMISSION FOR JUDICIAL REVIEW

BETWEEN:

R (CHRISTIAN CONCERN)

Claimant/Appellant

-v-

SECRETARY OF STATE FOR HEALTH AND SOCIAL CARE

Defendant/Respondent

SECOND WITNESS STATEMENT OF KEVIN DUFFY

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*References within square brackets are to exhibits attached my witness statement, and are given as **[KDX/XX]** where KDX refers to the exhibit number and **XX** is the page number within my statement.*

Introduction

1. This is my second witness statement, I previously provided a witness statement in the course of these proceedings May 18th, 2020. I make this witness statement to provide information relevant to this claim, about the events which took place after the initial hearing before the Divisional Court.

2. Save where otherwise indicated, all facts and matters set out in this witness statement are within my own knowledge and are true. Where I refer to a fact or matter that is not within my own knowledge, I identify the source of my information.

3. After making the first statement, I approached Christian Concern with a proposal to use a 'mystery shopper survey' to explore the telemedicine services of the independent abortion providers, focusing on certain aspects of regulatory compliance, clinical safety, and the quality of care of the new pills-by-post abortion services.

4. In 2018-19, I conducted mystery shopper surveys of overseas pharmacies to explore the provision of abortion pills. These surveys were used to help inform changes that might be needed to improve the quality of advice given to the shoppers by pharmacy staff.

5. I was asked by Christian Concern to first outline how mystery shopping works and the ethics of using this in healthcare.

An Introduction to Mystery Shopper Surveys

6. Mystery Shopping is an evaluation strategy commonly used for independent market research and by organisations to self-assess staff performance. There are many different terms used for this, including: mystery shopper; mystery diner; mystery guest; standardised patient; simulated patient; covert patient; and under-cover care seeker. I decided to use the term mystery client, since the abortion providers often refer to the women using their services as 'clients'.

7. A Mystery Client is acting a role, a persona. She (or he) pretends to be a client and presents herself to a business to assess how well staff are adhering to company policy and guidelines, as well as the laws of the land. Many service organisations engage firms to conduct regular mystery visits and assessments, the results of which are then used to refine and focus ongoing staff training and performance management.

8. The Care Quality Commission (CQC) and NHS Trusts use simulated patients to assess aspects of clinical safety and quality of care at hospitals, clinics, and pharmacies. Trusts will typically ask those attending as actual patients and carers to also participate in the completion of the mystery shopper survey. The latter is done in secret and in confidence, but the shopper is not acting or pretending to be somebody they are not.

9. A study using mystery medical shoppers on the phone, "Mystery shopping in health service evaluation", evaluated the use of simulated patients in the assessment of aspects of clinical safety in a New Zealand primary care telephone triage service. The study concluded: "*Simulated patients can be used to evaluate the limitations of health services and to identify areas that could be addressed to improve patient safety."* [KD1/13]

10. In 2019, an organisation used mystery medical shoppers to assess how NHS GP surgeries handled registration requests for persons with no fixed abode or no proof of identification. [KD1/14] When asked about the resulting survey report, Jackie Doyle-Price, the Parliamentary Under-Secretary for Health and Social Care, said she welcomed the report and noted the importance of raising critical issues in this way. [KD1/18]

The Ethics of Mystery Shopping.

11. Mystery shopping involves subterfuge and the obtaining of information under false pretences. For some, this can seem to be unethical. To come to a definitive conclusion, we need to consider the purposes of such practices and weigh these appropriately. In

some cases, we find that organisations will do this to themselves, to discover their own service strengths and weaknesses. In some cases, we find regulators doing it to assess the safety and quality of public services. One could argue that these are both ethically permissible given who the initiator is and how the findings are used.

12. In a study published by the Oxford University Press in association with the London School of Hygiene and Tropical Medicine, King et al discuss the ethics of using a mystery client in healthcare settings. They conclude that "*the deception of healthcare service providers can be ethically justified where (1) other options cannot answer the research questions; (2) risks to the mystery clients and service providers are minimal; and (3) the knowledge generated is of value to society."* [KD1/21]

13. I considered it necessary to use a mystery client survey because it is not possible for me to directly observe a consultation between a woman and her abortion service provider. Nor can I access the medical records and abstract data and findings from these. Given the sensitivities and stigma surrounding abortion, it would be difficult for me to conduct patient exit interviews, and this in any case would raise some ethical challenges.

14. I determined that there was no risk of harm to my volunteers who only participated after making their own fully informed choice. The context of this being a remote, phone-based survey of telemedicine, enabled avoidance of any potential harm to my volunteers as there would be no physical examinations and none of the medicines received would be administered. There was no question of harm to the service providers, I had decided that the project would not disclose any personal identifying data related to any of the service providers and my volunteers would not create a need for a SP to extend beyond the remit of their normal call handling processes.

15. I conducted this survey without first obtaining consent from the service provider nor from the provider organisations. This is in contravention of ethical norms in medical research which require the fully informed, freely given consent of all participants. In doing so, I relied on this rationale presented by King et al:

    a. Services are freely accessible by the public and collecting data has minimal risk to providers. Obtaining consent would increase the risk of detection, thereby reducing the quality of data and harming study aims. [KD1/25]

    b. Performing the mystery client survey without first notifying the providers allows care to be observed when the providers believe they are treating a real client and, therefore, the survey results are not influenced by the Hawthorne effect. [KD1/21]

16. I considered that the knowledge generated by this mystery client survey would be of value to this judicial review.

Aims of This Mystery Client Survey.

17. In paragraph 12 of my first witness statement I noted that before the Covid-19 changes, women would have presented at a clinic where they would be assessed by a service provider for eligibility for an early medical abortion (EMA), routinely using an ultrasound scan and blood tests. My paragraph 13 noted that in its updated guidelines, The Royal College of Obstetricians and Gynaecologists (RCOG) referred to the pre-procedure ultrasound as a routine element of abortion care.

18. In paragraph 15, I said, certainty of gestational age (GA) is important because the new regulations limit EMA at-home to a maximum GA of 9 weeks and 6 days by the day on which the mifepristone is self-administered. Also, it is accepted that the efficacy of the medical abortion treatment reduces as GA increases, with an increase in potential side-effects experienced; British Pregnancy Advisory Service (BPAS) notes this on its website. [KD1/30]

19. In paragraph 16, I said, these new regulations mean that the assessment of GA is solely dependent upon the woman's accurate and honest recall of the first day of her Last Menstrual Period (LMP). The prior use of ultrasound scan was to overcome any lack of provider's confidence in the woman's recall.

20. I designed this mystery client survey to show that these new telemedicine regulations mean that service providers are solely reliant on their clients' accurate and honest recall of the first day of their last period, and so to test the hypotheses of my earlier statement.

Mystery Client Survey

21. I recruited a small number of non-pregnant women aged 18-40 as volunteers for this survey. Each volunteer was asked to take on a specific persona, the role which would be acted during the calls to a service provider. Each volunteer completed a checklist with all the specific data and answers which she would use during each of her calls.

22. All calls were recorded, and the recordings have been transcribed. I also have video evidence of the volunteers making these calls.

23. For most of the calls, I used three personas, as follows:

    a. A woman who is already beyond the ten-week GA limit for early medical abortion and so she provides a false LMP to the service provider to present as being about seven weeks pregnant.

b. A mother of a fifteen-year-old daughter who is pregnant. The mother does not want her daughter to go through the system and so she makes a call to the service provider, pretends to be seven weeks pregnant and asks for the abortion pills at-home. When received, she administers these to her daughter.

c. A woman who first gives a date for her LMP which would indicate nine weeks GA, and then she changes this date on her next call to present as just seven weeks, thus remaining within the GA limit for the abortion pills at-home.

24. It should be noted that apart from providing a false statement about being pregnant and thus about the date of their last period, each of the mystery clients provided a false name, date of birth, and contact details. They also provided false registration data when asked for details of their GP surgery. The only real data given was the address to which the abortion pills should be posted, so that I could ensure the safe receipt, handling, and disposal of the treatment packs.

25. A total of nineteen sets of calls were made to BPAS (9), Marie Stopes UK (MSUK) (8), and National Unplanned Pregnancy Advisory Service (NUPAS) (2) over the period June 19th, 2020 to July 14th, 2020. Each of these followed the providers' own scripted process, with the mystery clients simply providing answers to whatever questions were asked. The BPAS and NUPAS process involves two phone calls and for MSUK three. After making nineteen sets of calls, we received nineteen treatment packs – for women who do not exist and based on a set of false personal and medical data.

26. Calls were made from various locations using addresses across nine counties, Berkshire, Cambridgeshire, Essex, Hertfordshire, Kent, Lancashire, London, Middlesex, and Sussex.

Validating Client Registration for the NHS Contract

27. The first thing that a service provider should do, is to check for the NHS contract in the client's area; this is to ensure that the termination of pregnancy will be funded by the NHS rather than the client needing to pay privately. The service provider will ask the client for her home address and for the name and address of the GP surgery at which she is registered. The SP will try to find a match on their internal system for the data provided by the mystery client but of course since this is false there will be no match. When faced with this, in nineteen out of nineteen cases, the SP offered to input the data manually, thus bypassing the system lookup.

28. Since the women were self-referring, NHS registration was validated only by the client's accurate and honest self-disclosure.

- *SP: Okay. Do you want to give me your previous postcode? It might be that they've still got the old one. I can have a look.*

  Lisa: Well, my previous postcode would be parents, but I'm not sure that they would have me under that. Well, we've been traveling for a little bit, so I don't know if we would have dropped off the system.

  SP: Give me the previous one. I'll have a quick look. It might very well be under that one. Otherwise, if not, I'll just put everything in manually. [KD1/42]

- *SP: Okay. That's fine. Not to worry. I'll enter the details manually for you. So what's the first line of your home address?* [KD1/53]

29. In this longer exchange, the SP confirms that the contract is available and that they can proceed without an NHS number and without notifying the GP, noting this as a self-referral.

- *SP: That's fine. So you can be seen under this area. Okay. This is self-referral. You don't need paperwork. Can I ask, do you have your NHS number?*

  Nicola: I don't actually have it on me. Sorry about that.

  SP: That's okay. If you haven't got it. Don't worry. Okay. All right. And will you like to contact your doctor about your medical information if we need to?

  Nicola: Probably, rather just keep it confidential if that's okay. So, not to contact my GP.

  SP: Well, your post code and your date of birth may need to be shared with the NHS, if they pay for your treatment, is this okay?

  Nicola: Okay. Yeah.

  SP: I mean, if not, you would either need to pay privately or you would need to seek another provider who will likely share the same information.

  Nicola: No, that's okay then. Don't worry, yeah, that's okay.

SP: So, we can put no to contact with your doctor. We can put that, but I just need to let you know that we have to tell you that your post code and date of birth may need to be shared for funding.

Nicola: Oh, okay. Sure. Yeah. That's okay. Sorry. Yeah.

SP: So, we'll still put no to contact with doctor, but just so... It's anonymized. So, it would only be your postcode and date of birth, if they want to see where their funding's going. Okay.

Nicola: Oh, I see. Okay. Oh yeah. Sorry. I didn't understand that. Thanks.

SP: So we'll still put the no contact with doctor but we'll, you know, like I said, it will be anonymized information, but they may look to see where funding goes.

Nicola: Sure. That makes sense. Thanks.

SP: Okay. Now, no to contact with GP, do you have any support needs or any disabilities? [KD1/65-67]

❝ *SP: Do you have your NHS number at all?*

Laura: I don't know if I can find it-

SP: Don't worry, its not needed... That's fine. [KD1/75]

Assessment of Eligibility Using LMP

30. Every woman is asked by the service provider for the first day of her last period; this is to determine the gestational age of her pregnancy and hence her eligibility for an early medical abortion. The volunteers were coached to provide false dates for their LMP, and these dates were accepted on all nineteen calls; there were no calls in which the mystery client was asked to present at a clinic for an ultrasound scan. Sometimes the SP will ask the woman to say how she can be sure of that date, and will readily accept answers such as “using an app” or “I mark it in my diary” or “I'm very regular”. The SP will query the last period, making sure that this was a normal bleed, and on all the survey calls readily accepts the confirmatory answers given by my mystery clients.

31. This means that the service provider is solely reliant on the woman's accurate and honest self-disclosure of her LMP to assess eligibility for EMA within the ten-week GA limit.

> *SP: Okay, Lisa could you tell me when the first day of your last period was please?*
>
> *Lisa: Yeah, it was the 4th of May, just gone.*
>
> *SP: 4th of May. And then what's your approximate height and weight?* [KD1/47]

> *SP: Don't worry, its not needed for that. That's fine. Can you state the first day of your last period?*
>
> *Laura: That would be fourth of May.*
>
> *SP: The fourth of May. Okay, so that makes you about seven weeks and two days pregnant. Have you taken a pregnancy test?* [KD1/75]

> *SP: Perfect. Thank you. Now, if we go into some medical questions. Do you know roughly when the first day of your last period might have been?*
>
> *N: Yeah, I usually put it in my calendar, so 11th of May. So I think about seven weeks.*
>
> *SP: 11th of May. Yeah, that's fine. Not to worry. And can I take your height and your weight approximately?* [KD1/57]

> *SP: All right. Could you confirm the first day of your last period, please?*
>
> *Hannah: Yeah. It was the 11th of May.*
>
> *M: Okay. Thank you. And how accurate do you feel that that is?*

Hannah: It's definitely right because I always put it in my diary.

M: Okay. Lovely. [KD1/82]

32. CT6 was using the persona On the Boundary. On her first call with BPAS she gives one date for her LMP and on the consultation call with the clinician she changes this, which is readily accepted by the SP. Her first call was on 19th June, so the date first given would indicate a GA of nine weeks and by the time of taking the mifepristone she would have been more than 9.6. On the consultation call, on June 20th, the mystery client changes her LMP to May 1st, the SP is heard counting, and then accepts this change – which sets the GA at 7.1. Later in this call the SP confirms that "…we're quite sure of your dates…".

33. I asked CT6 to repeat this persona on three more calls, one again with BPAS and the other two with MSUK and NUPAS; on each call we had the same result, acceptance by the clinician of the change to LMP, even when noting that the previously given date would have set GA at nine weeks plus.

> *SP: That's fine. So we just need to go through a few medical questions. So when was the first day of your last period?*
>
> *Anna: It was on the 17th of April.*
>
> *B: Okay. And what was your height and your weight?* [KD1/98]

> *SP: Lovely. Cool. And then what was the first day of your last period?*
>
> *Anna: It was the 1st of May. Yesterday I gave a different date but actually I've looked at my app and actually I made a mistake and it was the 1st of May.*
>
> *SP: That's okay. I'll change that in just a second. So one, two, three, four, five ... Okay. How was that period? Was it normal? Would you say it was shorter or lighter than usual?*
>
> *Anna: I think it was normal.*
>
> *SP: Okay. Normal period, and came at the time it was expected, was it?*

Anna: Yeah.

SP: Okay. As expected. Okay, lovely. You're sure of that date because you've got a period tracker app. How long does your period usually last for? How many days do you bleed for usually?

Anna: Between 28 and 30 days usually.

SP: Okay. But how many days do you bleed for when you have a period?

Anna: Oh. For about five days.

SP: Five days. That's fine. Lovely. Would you describe them as regular?

Anna: Yeah.

SP: Yeah. Lovely. Is this the first time you've been pregnant?

Anna: Yeah, it is.

SP: Have you had a scan at all for this pregnancy?

Anna: No. [KD1/106]

> *SP: Perfect. Okay. So what it would be, because we're quite sure of your dates, it's about seven weeks-ish, so that would mean that you would have the early medical abortion, which is using the tablets.* [KD1/110]

Potential Safety Concern - Codeine

34. During my review of the survey data, I noted that each of the provider organisations post out different doses of codeine phosphate; MSUK sends 2x30mg, NUPAS 4x30mg and BPAS 28x15mg. This is provided for pain management and the mystery clients were told that they could take it as and when needed.

35. On the survey calls, service providers often describe the expected pain during the passing of the pregnancy to be similar to or a little worse than that which the woman might normally experience during a heavy period. It is therefore worth noting that codeine is

not normally a drug of choice for managing dysmenorrhea. Women presenting at a pharmacy counter, without a prescription, will often be advised to use paracetamol, ibuprofen, naproxen, or mefenamic acid. Occasionally a pharmacist might suggest co-codamol but because of its addictive nature this is not the first line and would not usually be recommended. Codeine phosphate is a Class B controlled drug liable to abuse and so it is rarely prescribed alone and prescribing it for pain relief is inappropriate and unsafe.

36. Service providers tell us that women calling them are often in a vulnerable emotional state. I question whether it is therefore safe to send 28x15mg of codeine phosphate to these women. The maximum safe daily dosage is 240mg, compared to the 420mg supplied in the BPAS treatment pack. Taking all 28 tablets at once would be a toxic dose for any of these women and would result in her presenting with bluish lips, drowsiness, chest pain, drowsiness, and a slow heart rate. When taken together with alcohol it is extremely dangerous and this would certainly intensify the risk. There is a significant risk that one of these vulnerable women might use the suppled tablets for an overdose.

Real World Examples of These Scenarios

37. I do not consider the personas used in my mystery client survey to be extreme or unlikely scenarios in the real world, nor do I accept that it is only my mystery clients who have used subterfuge with the service providers in order to obtain the abortion pills at home. On May 22nd, the Sun published news that the police were investigating the death of an unborn baby after a woman took the abortion pills received through the pills-by-post telemedicine process, when 28 weeks pregnant. In the same article a BPAS spokesperson confirmed it was investigating eight other cases in which women received pills-by-post from BPAS even though they were beyond the ten-week limit. [KD1/33-36]

38. I am aware of an internal email from NHS England & NHS Improvement - X24, on May 21st, which discusses concerns raised by the CQC with regional CMOs about the 'Pills by Post' process, noting 13 incidents under investigation at that point in time. [KD1/37-38] Incidents discussed in this email are all more extreme than my mystery client survey, eg this email sadly notes 2 maternal deaths which are being linked to pills-by-post. The email suggests that there may have been a total of 16,000 Termination of Pregnancy (ToP) procedures using pills-by-post since March; this rate of associated deaths (2 in 16,000) is significantly higher than the previously published expected rate of one death in 100,000 termination of pregnancies. [KD1/32]

39. Incidents noted in this email, involve women with much more advanced GA than I used in my survey, up to 30 weeks, and women who have used the pills-by-post presenting at hospital with major haemorrhage or ruptured ectopic pregnancies. Some of these cases are being investigated by the police and by a Home Office pathologist. The email notes

that these cases have only become known to the CQC and the CMOs because these women have presented at hospital; there's no doubt that there will have been many other cases with complications which have not come to their attention because these are not routinely reported by the abortion provider organisations.

40. The email was provided to Christian Concern by a confidential source who works for the NHS, on the condition that his or her name will not be disclosed, for the fear of retribution from the employer. I have no doubt as to its authenticity. It is, of course, easily verifiable by the Respondent.

Concluding Remarks.

41. None of the scenarios revealed by my survey, nor the cases reported by the Sun, nor the incidents noted in the NHS email would have happened under the pre-lockdown process. These cases are a direct result of the move to abortion-at-home, and in particular to the removal of the clinic visit and routine assessment, by the service provider, of the woman's eligibility for EMA before consenting her and prescribing the abortion pills; specifically, the removal of the assessment of the gestational age of the pregnancy which was previously routinely performed using an ultrasound scan.

42. After this clinic-based assessment the woman could, if she chooses, safely self-administer both the abortion tablets (mifepristone and misoprostol) at home. SPs could use telemedicine for the initial call with the woman and for any subsequent follow-up, but it is simply not possible to replace the critical clinic-based consultation and examination with a telephone call. Relying on telemedicine for the entire process must be quickly withdrawn.

I believe that the facts stated in this statement are true.

[redacted]

July 17th, 2020

Multicenter Study > Br J Gen Pract 2003 Dec;53(497):942-6.

Mystery shopping in health service evaluation

Helen Moriarty [1], Deborah McLeod, Anthony Dowell

Affiliations

PMID: 14960218 PMCID: PMC1314747

Free PMC article

Abstract

Background: Over the last 5 years, primary care telephone triage systems have been introduced in the United Kingdom, United States, Australia, and most recently in New Zealand. Evaluation of the clinical safety of such systems poses a challenge for health planners and researchers.

Aim: To evaluate the use of simulated patients in the assessment of aspects of clinical safety in a pilot New Zealand primary care telephone triage service.

Design of study: 'Mystery shopping', an evaluation strategy commonly used in market research, was adapted by using simulated patients for telephone triage service evaluation.

Setting: New Zealand.

Methods: Four scripted clinical scenarios were developed by academic general practitioners, validated in student teaching situations, and then used by simulated patients to make 101 telephone calls. The scenarios were designed to necessitate a referral to a medical practitioner for further investigation. The documentation kept by the callers was compared with the call records from the telephone triage company, and both were analysed for capture and handling of the clinical safety features of each scenario. In cases where the endpoint was not a medical assessment, possible reasons for this were explored.

Results: Records were retrieved for 85 telephone calls. Considerable triage variability was discovered. There were discrepancies between expected and actual triage outcomes with 51% of analysed calls resulting in a self-care recommendation. A number of reasons were identified both for the triage variability and the unpredicted outcomes. Audiotaping of consultations would have enhanced the credibility of the evaluation but it would have carried ethical constraints.

Conclusion: Simulated patients can be used to evaluate the limitations of health services and to identify areas that could be addressed to improve patient safety. Evaluation of patient satisfaction with services is not sufficient alone to evaluate safety.

LinkOut – more resources

FRIENDS FAMILIES AND TRAVELLERS CALLS ON GOVERNMENT TO ADDRESS ISSUES FOR TRAVELLERS REGISTERING AT GP PRACTICES ONCE AND FOR ALL

March 20, 2019 (https://www.gypsy-traveller.org/news/friends-families-and-travellers-calls-on-government-to-address-issues-for-travellers-registering-at-gp-

practices-once-and-for-all/)

Today, Friends Families and Travellers released the findings of a mystery shopping exercise in which they contacted 50 GP practices posing as a patient wishing to register who didn't have a fixed address or proof of identity and found that almost half of practices would not register them. Despite this, every GP practice was rated 'good' or 'outstanding' by the Care Quality Commission for their work with 'People whose circumstances may make them vulnerable'.

The first guiding principle of the NHS is that it provides a comprehensive service, available to all and NHS guidelines say, "When applying to become a patient there is no regulatory requirement to prove identity, address, immigration status or the provision of an NHS number in order to register". However, the experiences of people on the ground can often be very different. Speaking about her experience of being refused registration at a GP practice when her one year old daughter fell ill, Danielle from the Romany Gypsy community said,

"It makes you feel like you're alien from everyone else. Just because of who you are, you don't get the same treatment as everyone else. You know full well that if you were someone else, if you had this document or that, you'd be able to get the help you need, but because you don't you're left with no help at all."

The report found that of the 50 GP practices contacted, 24 would not register the mystery shopper either as a permanent patient or as a temporary patient. Of these, 17 GP practices said they would not register people without proof of identification, 12 GP practices said they would not register people without an address, one GP practice said they would only register people online and two GP practices never picked up the phone, despite multiple calls on different days. Speaking about her experience of being refused healthcare, Kit, who lives on board a boat and travels the canals of England, trading antique china said,

"I only persisted with attempting to register because I knew I actually had cancer. It has turned out to be a stage 3 cancer. There were three tumours and five affected lymph nodes. Despite the fact that I knew my rights, provided information on registering at a GP's address and articulated my case, I had to compromise my confidentiality on two occasions to access belated care for an aggressive, life threatening disease which could have been caught years earlier."

Whilst the piece of research focusses on the experiences of over 80,000 nomadic Gypsies and Travellers in England, this is not a problem unique to Gypsies and Travellers. Groups experiencing similar problems include asylum seekers and refugees,

people in contact with the criminal justice system, homeless people, vulnerable migrants and people fleeing from domestic violence. Sharing her experience of being refused healthcare in Stroud, Glen, from the New Traveller community said,

"I was surprised that within the NHS they wouldn't see me without filling all the forms, even when I was clearly in pain. I was upset that people can put form filling in front of someone's wellbeing."

Today, Matt Hancock MP and Secretary of State for Health and Social Care will receive a letter signed by more than 30 charities and human rights organisations including Homeless Link, Liberty, Mind and Race Equality Foundation asking for the Department of Health and Social Care to make commitments to address the recommendations in the report.

The report calls on the Department of Health and Social Care to set up a taskforce to lead the delivery of the recommendations outlined in the report so that nobody is ever wrongfully denied access to healthcare again. Commenting on the report, Sarah Sweeney, Communications and Health Policy Co-ordinator at Friends Families and Travellers said,

"The communities affected by this issue are caught in a catch 22 where they are both at high risk of poor health and also find it much harder to access healthcare. We want to work with the Department of Health and Social Care and with the Care Quality Commission to address longstanding and stubborn issues around access to primary care so that once and for all everyone can access the healthcare they need."

Notes for Editor

About Friends, Families and Travellers (FFT)

Friends, Families and Travellers is a leading national charity that works on behalf of all Gypsies, Roma and Travellers regardless of ethnicity, culture or background.

Media Contact

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Relevant Resources

Patient Registration: GP Surgeries

Health and Social Care – in the House of Commons on 7th May 2019 *(/debates/?d=2019-05-07)*.

Kate Green

Chair, Committee on Standards, Chair, Committee of Privileges, Chair, Committee of Privileges, Chair, Committee on Standards, Chair, Committee on Standards

What steps his Department is taking to ensure that patients with no (a) fixed address and (b) proof of identity can register at GP surgeries.

Link to this speech

In context *(/debates/?id=2019-05-07a.423.5#g423.6)* Individually *(/debates/?id=2019-05-07a.423.6)*

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(https://twitter.com/share?url=https%3A%2F%2Fwww.theyworkforyou.com%2Fdebates%2F%3Fid%3D2019-05-07a.423.6&text=Kate+Green+on+Health+and+Social+Care%2C+at+TheyWorkForYou&related=theyworkforyou%2Cmysociety)

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(Citation: HC Deb, 7 May 2019, c423)

Jackie Doyle-Price

The Parliamentary Under-Secretary for Health and Social Care

We are very clear that GP surgeries cannot refuse to register somebody who is of no fixed abode or has no proof of identification. Where a practice does not properly provide correct access to vulnerable groups, the commissioner will intervene to ensure that it corrects that. Ultimately, the commissioner can issue a remedial notice and can terminate a contract or practice that still does not abide by its obligations.

Link to this speech

In context *(/debates/?id=2019-05-07a.423.5#g423.7)* Individually *(/debates/?id=2019-05-07a.423.7)*

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(Citation: HC Deb, 7 May 2019, c423)

Kate Green

Chair, Committee on Standards, Chair, Committee of Privileges, Chair, Committee of Privileges, Chair, Committee on Standards, Chair, Committee on Standards

Has the Minister *(/glossary/?gl=35)* seen the report by a mystery shopper from Friends, Families and Travellers who attempted to register with 50 GP practices without ID *(https://en.wikipedia.org/wiki/ID)* or proof of address? Twenty-four refused to register her or would not register her; all but two of those were rated outstanding by the Care Quality Commission

(https://en.wikipedia.org/wiki/Care_Quality_Commission). The Minister *(https://en.wikipedia.org/wiki/The_Minister)* says GPs must properly follow the guidance, but does she agree that the CQC *(https://en.wikipedia.org/wiki/CQC)* needs to ensure that it uses the inspection regime to enforce that guidance?

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(Citation: HC Deb, 7 May 2019, c423)

Jackie Doyle-Price

The Parliamentary Under-Secretary for Health and Social Care

I totally agree. I have seen the report, which I welcome; I will certainly take it up with the CQC *(https://en.wikipedia.org/wiki/CQC)*. It is very important that we use all tools to ensure that everyone has access to the healthcare they deserve, because it is all too easy for some groups to remain discriminated against. I am grateful to the hon. Lady for shining a light on this important issue.

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(Citation: HC Deb, 7 May 2019, c423)

Andrew Bridgen

Conservative, North West Leicestershire

We have one of the very few free at point of need health services in the world. Does the Minister *(/glossary/?gl=35)* agree, however, that checks are important in cracking down on health tourism? Does she have the latest assessment of the cost of health tourism to our NHS *(https://en.wikipedia.org/wiki/NHS)*?

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(Citation: HC Deb, 7 May 2019, c423)

Jackie Doyle-Price

The Parliamentary Under-Secretary for Health and Social Care

My hon. Friend is absolutely right—health tourism is a major cost to the taxpayer, so it is important that we establish that people are entitled to care. However, it is important to ensure that people without proof of ID *(https://en.wikipedia.org/wiki/ID)* and of residence are still entitled to healthcare. Where someone is not entitled to it, we will, of course, pursue them for payment.

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How to do (or not to do)

How to do (or not to do) . . . using the standardized patient method to measure clinical quality of care in LMIC health facilities

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Abstract

Standardized patients (SPs), i.e. mystery shoppers for healthcare providers, are increasingly used as a tool to measure quality of clinical care, particularly in low- and middle-income countries where medical record abstraction is unlikely to be feasible. The SP method allows care to be observed without the provider's knowledge, removing concerns about the Hawthorne effect, and means that providers can be directly compared against each other. However, their undercover nature means that there are methodological and ethical challenges beyond those found in normal fieldwork. We draw on a systematic review and our own experience of implementing such studies to discuss six key steps in designing and executing SP studies in healthcare facilities, which are more complex than those in retail settings. Researchers must carefully choose the symptoms or conditions the SPs will present in order to minimize potential harm to fieldworkers, reduce the risk of detection and ensure that there is a meaningful measure of clinical care. They must carefully define the types of outcomes to be documented, develop the study scripts and questionnaires, and adopt an appropriate sampling strategy. Particular attention is required to ethical considerations and to assessing detection by providers. Such studies require thorough planning, piloting and training, and a dedicated and engaged field team. With sufficient effort, SP studies can provide uniquely rich data, giving insights into how care is provided which is of great value to both researchers and policymakers.

Keywords: Standardized patients, quality of care

Introduction

Clinical quality of care, the process through which inputs from the health system are transformed into health outcomes (Donabedian, 1988), is arguably the most informative dimension of quality, as it is the key point where provider behaviour influences case management. However, it is also highly challenging to measure (Hanefeld *et al.*, 2017), and many commonly used methods for measuring clinical quality have significant disadvantages. Direct observation cannot control the types of patients and cases observed (Peabody *et al.*, 2000), clinical vignettes measure knowledge rather than practice (Leonard *et al.*, 2007; Mohanan *et al.*, 2015), and both suffer from Hawthorne effects (Leonard and Masatu, 2010). Medical record abstraction is usually unfeasible in LMICs especially in the private sector where record keeping is often poor or non existent (Aung *et al.*, 2012). Patient exit interviews suffer from recall bias and poor response rates, and may require the patient to understand clinical procedures (Onishi *et al.*, 2010).

Key Messages

- Standardized patients are a uniquely valuable tool for measuring quality of care.
- Multiple recent studies have successfully addressed scientific, ethical and practical challenges when implementing large N standardized patient studies in health facilities.
- Future studies can not only build on the increasing expertise and experience of others but also innovate and develop the tool.

A key advance in the measurement of clinical quality is the use of standardized patients (SPs) in primary care settings. Healthy people, employed by a research study, pose as real patients, responding to the clinician's actions as a real patient would. Alternative terms include mystery client, simulated patient, covert patient and undercover careseeker. SPs have a long history in medical education (Peabody *et al.*, 2000), where the clinician knows that she is being tested outside a real world milieu. The method is increasingly being used as a research tool in large field studies to assess deficits in care (Das *et al.*, 2012; Kohler *et al.*, 2017; Christian *et al.*, 2018), evaluate quality improvement strategies (Harrison *et al.*, 2000; Mathews *et al.*, 2009; Das *et al.*, 2016a), and identify how financial incentives influence quality (Currie *et al.*, 2014; Das *et al.*, 2016b).

The SP method has a number of advantages. In a high quality SP study, clinicians believe they are treating a real patient and, therefore, measures are not influenced by the Hawthorne effect (Leonard and Masatu, 2010). Because each case is completely standardized, care can be benchmarked against pre determined standards for a specific condition. We can say that an antibiotic was incorrectly used because we know the SP presented with symptoms of a viral pharyngitis rather than pneumonia. The ability to control patient mix avoids confounding and allows for the investigation of rarer conditions, such as tuberculosis (TB), which might otherwise require long observation periods to gather a sufficient sample (Peabody *et al.*, 2000). Where the objective is to compare across different types of patients, the SP presentation can be altered (or different types of SPs such as men and women can present the same condition) to assess how provider behaviour responds to patient characteristics (Currie *et al.*, 2011; Planas *et al.*, 2015). Finally, in evaluations of interventions, SPs provide scope for double blinding, whereby providers cannot tell which patients are SPs, and the SPs themselves are blinded to the treatment arm of providers they visit (Das *et al.*, 2016a).

The main downsides are that the disease cases suitable for SPs are limited, thereby restricting their applicability, and developing SPs for use in the field is complex, which may limit their scalability. There is ongoing debate on the ethics of SP research, though the 'deception' of clinicians can be ethically justified where (1) other options cannot answer the research questions (Alderman *et al.*, 2014); (2) risks to SPs and providers are minimal; and (3) the knowledge generated is of value to society (Rhodes and Miller, 2012).

In this article, we provide a step by step guide on using SPs to measure the quality of care in health facilities (dispensaries, health centres or clinics). The guide is based on a review of SP studies in low and middle income countries (LMICs) (full details in Supplementary Appendix), as well as our experiences implementing this approach in public and private health facilities in China, India, Kenya, South Africa and Tanzania. The SP method is also frequently used in the retail sector, e.g. in pharmacies or informal drug sellers (Fitzpatrick and Tumlinson, 2017), but our focus on health facilities reflects the particular challenges faced in documenting clinician–patient interactions and handling requests for exams and diagnostic tests.

Step 1: choosing a suitable SP case

The first choice made when designing an SP study is case selection, i.e. the condition or symptoms SPs present to providers. The major considerations are whether the case is technically feasible, whether it is ethically acceptable to ask SPs to present the case, and whether the case will be suitable both to the local context and the purpose of the study. We list 10 questions which researchers should ask when assessing cases for inclusion in Table 1. Some cases will never be feasible and are likely to be excluded by all studies, e g. any case requiring inpatient care would be deemed too high a risk to a fieldworker, and an SP with a wound would be practically impossible to falsify. Perceptions of feasibility may change over time; e.g. TB was once perceived as a condition which could not be measured using the SP method, but has now been validated as an assessment of quality (Das *et al.*, 2015).

It is useful to refer to and sometimes replicate SP cases developed by previous studies. We conducted a scoping review of all SP studies in LMIC health facilities up to December 2016, and identified 17 conditions across 63 articles, covering 45 studies (Table 2). One advantage of replicating such cases is the opportunities to share SP scripts and tools and learn from the experience of others. Colleagues can advise on the feasibility of implementing certain SP cases, and how effectively they measured the quality of care. Secondly, if multiple studies share SP cases, direct comparisons are possible across settings. Examples of such comparisons to date include: (1) dispensing practices for suspected TB patients in multiple settings in urban India (Miller *et al.*, 2018) and (2) treatment of asthma, chest pain, diarrhoea and TB across China, India and Kenya (Daniels *et al.*, 2017; Das *et al.*, 2018). However, as Table 2 shows, the range of SP cases used is currently limited. This may reflect not only the need and scope for the development of more cases but also the challenges of identifying cases meeting the requirements discussed in Table 1.

If resources allow, choosing more than one case so that each provider receives multiple visits allows more quality dimensions to be assessed and increases statistical power. One might consider using a range of different SP cases, mixing:

- Infectious diseases with non communicable diseases (NCDs)
- Uncommon but severe conditions with common, non critical, but high burden diseases
- Conditions requiring laboratory diagnostics with those requiring only history taking to diagnose
- Conditions for which there is typically overprovision with conditions where there is underprovision
- Different stages of disease progression or experimental variants, such as some patients already having a laboratory report whereas others do not, for the same disease

Step 2: defining correct management

Once conditions are chosen, an indicator of correct management should be pre defined for each SP case. Correct management should

Table 1 Ten questions to consider when assessing suitability as an SP case

Key question	Explanation and examples
Technical feasibility	
Can a trained SP portray the case?	Conditions which have visible symptoms are unlikely to be suitable SP cases, as are conditions where patients would be expected to be acutely unwell. For example, an asthma SP could describe a previous attack but would not be expected to mimic one during the visit.
Do national or international guidelines exist for correct management or treatment?	If the aim is to assess quality of care against specific standards there will be a need for agreed-upon guidelines to provide a clear definition of the correct treatment outcome.
Can expected management be performed within one visit?	There is unlikely to be scope within the study design for the SP to return to the facility for follow-up visits.
Ethical acceptability	
Does the case choice minimize potential harm to fieldworkers?	Conditions should be chosen to avoid the need for invasive tests. Although cases requiring finger-prick blood tests have been used (Mathews *et al.*, 2009), it would be inappropriate to use a suspected sexually transmitted infection (STI) case which is likely to require a genital exam, or suspected typhoid which may require a venous blood draw for a Widal test. It should be noted that unexpected invasive tests may be requested: in one study in Senegal, almost all SPs requesting family planning were told they needed a vaginal exam. Researchers should consider whether the SP can avoid such unexpected tests or exams without raising undue suspicion.
Does the case require the involvement of children?	Some studies may choose not to use child SPs due to concerns over potential harm to and exploitation of children.
Appropriateness to context and research question	
Is the case appropriate to the study objective?	For example, in a study to measure the effect of a quality improvement intervention, the treatment of the case chosen should be sensitive to the intervention. In addition, one might select a 'control' condition which should not show improvement as a result of the intervention.
Do stakeholders agree the case is a 'fair test'?	Ensuring buy-in from funders, partners, implementers and government before implementation improves confidence in the validity of results and can enhance the study's potential to inform practice and policy.
Is the case applicable to all health facilities and regions in the study?	Certain small or specialist facilities may offer a limited range of services. Religious faith may preclude some facilities from offering certain care (e.g. Roman Catholic run facilities might not provide family planning services). A word of caution though—we often come across facilities who say they do not provide care for certain categories of patients, but in practice do provide care when visited by the SP. Service availability should, therefore, be investigated empirically by an SP visit or a scoping exercise rather than relying on researcher assumptions or stated practices.
Does the case represent a public health concern?	Cases should be a public health concern at the individual or population level. This could reflect high prevalence (e.g. malaria); potentially severe consequences such as a high case fatality rate (e.g. heart attack); or the likelihood of unsafe or inappropriate treatment (e.g. overuse of antibiotics for common cold).
Does the case match local epidemiology?	Rare conditions may raise provider suspicion or have very low rates of recognition or correct management.

Table 2 Conditions used in SP studies in health facilities in LMICs

Category	Condition	Number of studies
Sexual and reproductive health	Family planning client	20
	STI symptoms	7
	HIV testing	2
	Suspected pregnancy, seeking abortion	1
	STI screening after partner notification	1
Other infectious diseases	Common cold, respiratory tract infection or influenza-like illness	5
	Malaria	3
	Tuberculosis	1
	Diarrhoea	1
NCDs	Angina	3
	Asthma	2
	Back pain	1
Psychological	Anxiety	2
	Depression	1
Childhood infectious diseases	Diarrhoea (child absent)	4
	Pneumonia (child absent)	1
	Diarrhoea (child present)	1

Source: Review of SP studies in LMIC health facilities, up to December 2016. For further details see Supplementary Appendix.

Table 3 Outcomes to consider in definition of correct management

Outcome	Example
Prescription or dispensing of appropriate drugs	Salbutamol inhaler for asthma
Carrying out or ordering necessary diagnostic tests	mRDT or blood slide for suspected malaria
Referral for further testing (to another facility if necessary)	Suspected TB
No inappropriate testing	No urinalysis for cases without symptoms of urinary tract infection
No harmful treatments	No beta-blockers for asthma
No provision of unnecessary drugs	No antibiotics for upper respiratory tract infection

be based upon national standard treatment guidelines to ensure appropriateness to the study setting, but may need to incorporate international recommendations (such as WHO guidelines) where national guidelines are unavailable. A technical advisory group including clinicians and public health professionals, with knowledge of best practice and experience of local health systems, can also be convened to advise on correct management. Suggested types of outcomes are given in Table 3 covering both actions required, such as the provision of certain drugs or referral, and actions that are not only not required but also may be considered harmful to the patient, or unnecessary care which is not dangerous but nonetheless has an opportunity cost. An alternative to a binary correct management definition is to construct a continuous index by assigning points for different elements of management. However, any such measure will be critically sensitive to the weighting of the different possible correct, incorrect and neutral components of care. Our experience has shown that the types of unnecessary and harmful care provided can be highly unpredictable, so collecting outcomes based solely on a preconceived checklist of what *should* happen may miss much of the care that is actually provided. Researchers should therefore ensure that data collection tools are sufficiently open and flexible to collect data on all laboratory tests, medicines and recommendations provided.

If the sample includes a wide range of providers or facilities, the definition of correct management may need to accommodate a range of potentially correct outcomes, depending on provider qualifications or facility level. For example, in facilities with on site TB testing, correct management for suspected TB should be defined as the ordering of appropriate diagnostic tests. In smaller facilities without such capacity, correct management may be defined as referral to a higher level facility.

Regardless of the provider type, researchers will need to make judgements on how lenient or strict/comprehensive the definition of correct management should be, and this can have a dramatic impact on results (Sylvia *et al.*, 2017). Box 1 uses data from Kwan *et al.* (2018) to construct the flowchart of provider actions for 765 SP interactions with providers without a medical degree. If we define correct management as 'asking for a TB related test', 17.0% are classified as correctly managed. But, of these, 21.5% also gave a contraindicated drug, 42.3% did not mention TB to the patient and 30.8% gave unnecessary (but not contraindicated) drugs, including antibiotics. A stringent definition of correct management as 'asked for a TB related test without giving contraindicated or unnecessary drugs and discussed the prognosis with the patient' reduces the fraction correctly managed to 0.9%.

Further, the classification of correct management may be conditional on the results of diagnostic tests. For example, correct management of suspected malaria has two steps, the second of which is conditional on the first: a malaria test must be carried out, then an appropriate antimalarial prescribed if the test is positive, or no antimalarial prescribed if the test is negative. Researchers may also wish to consider the true status of the patient in the definition of correct management. For example, if an SP is known not to have malaria, any antimalarial provision could be considered inappropriate even if the provider reports a positive test, though as such tests are not 100% accurate even under ideal conditions, this may identify both faults with the provider and with the test itself.

This complexity of defining correct management is not a flaw of the SP method per se; instead, it highlights the importance of paying close attention to the definitions selected, and the utility of presenting a range of definitions. Finally, while correct management is typically the primary study outcome, it is relatively easy to also collect other outcomes related to the consultation (e.g. history taking) or the patient experience (e.g. waiting time), which provide important context for understanding correct management outcomes. Some suggestions are given in Box 2.

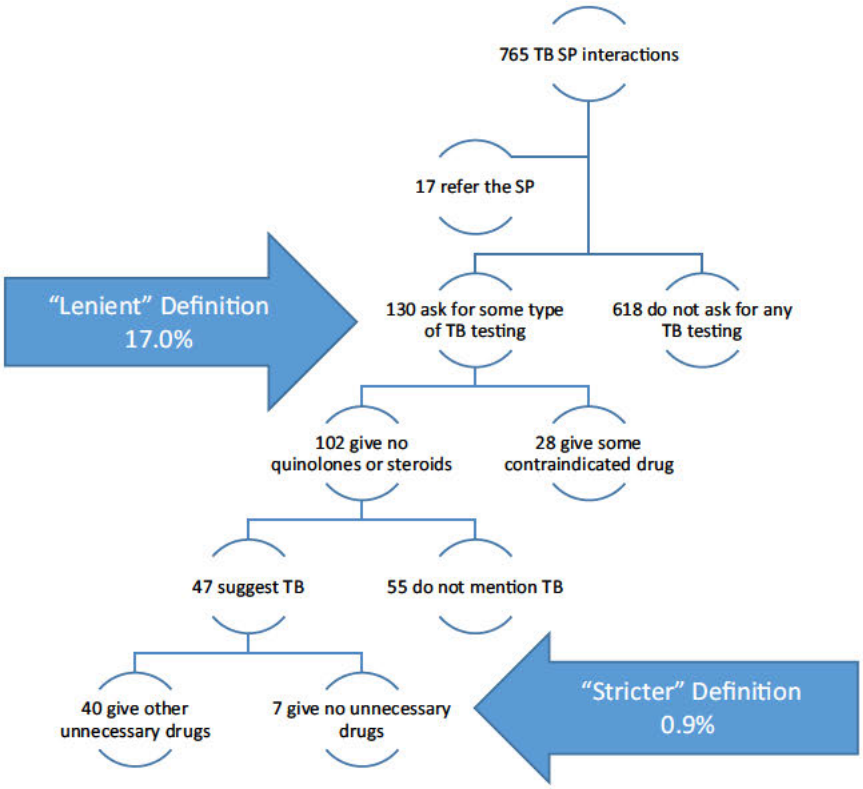
Step 3: designing tools and planning the study

The SP scripts define each case in detail and are the primary means for standardizing the case to ensure comparability across providers. A script begins with a short opening statement which the SP delivers to each provider describing the symptoms (such as 'Doctor, I have a cough and some fever' for suspected TB), which is followed by scripted responses to history questions, which the provider may or may not ask. The SP must not give additional information to the provider outside this script, nor give information from the history question section unprompted. The script should also include a short biography describing the social background, age, occupation, family details and the circumstances of the illness presented.

The corresponding structured questionnaire, which the SP completes after each interaction, captures all information needed to define correct management (physical exams, diagnostic tests, drugs and other treatments), as well as other outcomes of interest and general comments on the visit. It should be completed soon after the visit, either as a self completed questionnaire by the SP or through an interview of the SP by a supervisor. Developing these tools is an iterative process, and numerous changes will likely be made during piloting and training, with SP trainees themselves playing integral roles throughout this process. Steps to take when developing tools are described in Box 3.

Once the design of cases and tools are underway, the researcher must define a sampling frame and decide on the unit of analysis. Analysis of SP studies can be done at the level of the clinician or the facility. Facility level analysis is likely to be appropriate when the research questions do not relate to the performance of specific providers, e.g. when evaluating an intervention randomized at the facility level. Provider level analysis has the advantage of allowing investigators to address additional questions such as the know do gap of individual providers (Mohanan *et al.*, 2015), or the effect of provider cadre or training on quality. However, provider level data are more challenging to collect because SPs must visit specific

Box 1. Using a lenient versus stricter definition of correct management for TB has a substantial effect on the proportion defined as correctly managed (data from Kwan *et al.*, 2018)



Box 2. Other possible outcomes

- Waiting time and consultation time
- History taking
- Correct diagnosis
- Total fees paid and fees by type (consultation, laboratory tests, drugs)
- Subjective outcomes such as provider manner and patient centeredness
- Intervention specific elements (e.g. voucher received)

clinicians identified a priori, which presents two practical challenges: first, the production of a sampling frame of all eligible providers (facility staff lists may be incomplete and providers may work at multiple facilities) and second, the identification of providers by SPs in contexts where name badges are rare and asking for a name may be considered unusual or rude.

Step 4: addressing ethical concerns

Ethical norms in medical research require informed, freely given consent of participants. However, the SP method, by its very nature, requires that providers do not have full information on when or how data collection occurs (Madden *et al.*, 1997). Furthermore, because providers are likely to have substantial knowledge about the quality of their own practice, selective refusal may hamper a study's ability to produce representative data on care real patients receive (Rhodes and Miller, 2012).

Several approaches to provider consent have been used (Table 4), though it should be noted that many studies identified in the literature review (21/45) did not report their consent process.

Where consent is obtained, researchers still need to withhold certain information from participants. The participant should be given a broad window of time during which an SP will visit, not a date or appointment. For example, if SP visits are planned six weeks after consent, the provider can be informed that the visit will occur 'at some point in the next three months'. If the provider asks for a specific date, they should be told that to give one would compromise the nature of the research. A similar explanation should be given if they ask about the type of patient who will visit, or the condition they suffer from. To avoid providers unintentionally being given such sensitive details, ideally the team members conducting the consent process should be blinded to the SP conditions, or the consent process carried out by a senior researcher who will be able to resist pressure from providers to disclose such details. The consent process may be combined with other, non SP aspects of a study, such as a survey of the health facility or provider knowledge.

Box 3. Key stages in developing scripts and questionnaires

Preliminary observation in health facilities to inform tool design

- How do patients with the condition(s) of interest behave? What vernacular is used to describe symptoms and treatments?
- What questions are asked of patients and what information is collected on them?
- What is the route of a patient through a health facility (e.g. through reception, triage, consultation, laboratory, etc.)? Where and when do they pay (if applicable)?

Writing SP script

- Decide on symptoms, history and biographical details of SP
- Begin with an opening statement giving key information, which should be delivered in a natural manner
- Specify answers to questions which providers typically ask
- Give appropriate amount of information to enable diagnosis, but only in response to appropriate prompting
- Check that language used is appropriate for a typical patient (i.e. not overly medicalized)

Developing questionnaire

- Draft questionnaire content, ensuring that all required outcomes are covered
- Consider using a standardized questionnaire which can be adapted to the case, allowing comparison across cases and studies
- Decide how the questionnaire will be administered:
  - Self administered questionnaires minimize the time lag between the end of the interaction and debrief, reducing recall bias. Supervisor administered may allow for probing and checking responses but is more resource intensive.
  - Smartphone or tablet questionnaire removes need for later data entry. In some settings, smartphones can be carried in the facility without attracting attention

Piloting

- Start with observed role plays, where a member of the study team or trusted fieldworker performs the script with a pro vider outside the study who has agreed to assist
- Next, approach other providers outside of the study for consent to do undercover piloting
- Record experiences from each visit, including history questions asked and diagnostic tests ordered, amending the script and questionnaire as necessary
- Piloting visits can also be used to forecast SP fee costs for the study
- Conduct repeated pilots during training

Table 4 Approaches to provider consent in SP studies

Approach	Rationale	Resource-intensiveness of consent process	Number of studies[a]
Waiver of consent	Services are freely accessible by the public and collecting data has minimal risk to providers. Obtaining consent would increase risk of detection, thereby reducing quality of data and harming study aims.	Low: • Submit justification for waiver of consent to ethics committees • Possibly contact providers after completion to inform them that study has been carried out	4
Consent from over-arching entity	If providers or facilities in the study come under the control of an entity (such as a Ministry of Health, a diocese or a chain), a representative of the organization can consent on their behalf.	Low: • Contact representative(s) of organization(s) to inform of study and ask for consent	0
Consent from facility in-charge prior to SP visit	If the data collection and analysis are carried out at the facility (rather than provider) level, the owner and/or manager of the facility can give consent.	Middle: • Contact in-charge of each facility to in-form of study and ask for consent	8
Consent from individual providers prior to SP visit	Providers are the participants whose behaviour is observed in the course of the research, and so consent should be obtained from them. This may be considered particularly important if the data collection and analysis are carried out at the provider level.	High: • Identify all individual providers in study • Inform and obtain consent from individual providers • Ensure that SPs only seek care from providers who have consented	12

[a]Studies in review of SP studies in LMIC health facilities for which the consent process was described.

If the waiver of consent approach is chosen, this must be justified to ethics committees, who may not be familiar with the SP method and may be wary of such waivers. Committees may only be prepared to approve such an approach if there are government approvals for the study, and/or a commitment to inform providers that they received an SP by letter or public meeting after data collection is completed. Further risks associated with using a waiver of consent are loss of the trust of a provider if an SP is discovered and risk of aggression towards that SP.

Working as an SP exposes fieldworkers to risks they would not experience during ordinary survey data collection, and it is the responsibility of the study team to minimize and mitigate these risks to the greatest possible extent. This can be achieved through two main pathways. Firstly, the study should be designed to minimize such risks. This must be considered throughout the design process, and has been discussed under other Steps, such as choosing SP conditions that minimize the risk of fieldworkers undergoing invasive tests. Secondly, fieldworkers should be trained intensively to avoid risks which cannot be removed by design (Table 5). One risk minimizing strategy SPs will frequently need to use is the refusal of invasive tests; a particular challenge is ensuring that the reasons given for refusals come across as normal behaviour and do not raise suspicions. Despite these challenges, experience has shown that the SP method has minimal risk to fieldworkers equipped with proper training (Daniels *et al.*, 2017) and need not inconvenience real patients (Das *et al.*, 2015).

Step 5: training fieldworkers and organizing fieldwork

Playing the role of an SP is more complex and demanding than standard fieldwork, so we recommend recruiting experienced and proven fieldworkers. Although some studies have recruited trained actors, experience indicates that while actors may perform well in improvisation and staying in character, adherence to protocol and precise recall of information are equally important. Many studies have, therefore, drawn from the same population they would use for any survey enumerator position and dedicated several weeks to selecting and training on SP skills.

The mix of SPs may also matter if quality is expected to vary by age, social group or other characteristics. For example, male and female SPs may receive different treatment (Borkhoff *et al.*, 2009), so for cases relevant to both genders, hiring an even mix of men and women and randomly assigning them to facilities should be considered. Alternatively, cases may be portrayed by one gender only; this may be appropriate for cases such as family planning clients, but for other conditions may make the study less generalizable. Researchers should consider whether SPs will need a certain physical appearance to portray the case (e.g. a 60 year old woman could not portray a family planning client), and the languages spoken by typical patients in the geographical areas of interest.

Administering a background health questionnaire at the start of training is a crucial first step for protecting fieldworkers, maintaining consistency of SP case presentation, and ensuring that real health conditions do not confound the interpretation of results. For example, the physical symptoms of poorly controlled asthma or hypertension may lead a provider to dismiss a possible diagnosis of TB in an SP with a cough and chest pain. This may require consultation with your institution's Human Resources department to check that equal opportunity requirements are balanced with study needs.

Training should begin with an introduction to the concept of SPs, followed by fieldworkers reading and role playing scripts. They should work in small groups to discuss the patient narrative and identify difficulties with phrasing or context specific inconsistencies. For example, in a Tanzanian training session run by some of the authors, an initial draft of a script instructed the SP to say that they had never had an HIV test, but trainees noted that this would be implausible for female SPs with children, since HIV testing is ubiquitous in antenatal care there.

Emphasis should be placed on playing the role consistently, never giving more initial information than the opening statement,

Table 5 Strategies for minimizing harm to fieldworkers

Risk	Design choices to minimize harm	Training strategies to minimize harm
Exposure to surface pathogens		• Not touching surfaces unnecessarily • Refusing oral thermometers and reusable tongue depressors • Using alcohol hand rub after each visit
Exposure to blood-borne infections	Avoiding SP cases which will require a venous blood draw	• Refusing injections and venous blood draws on the grounds of not being able to pay, disliking needles or not having time for the procedure
Exposure to airborne infections	Condition should not require extended period of time in areas of higher risk (e.g. TB clinics)	• Not remaining in high-risk areas for long
Harassment/abuse by providers		• Develop strategies during training to avoid or remove self from the situation • Carry letter from study in case the SP needs to reveal self in order to avoid any harm
Invasive physical examinations	Avoiding SP cases which are likely to require intimate exams, e.g. STIs	• Role-play assertively refusing providers who insist on invasive physical exams
Anxiety over health based on diagnoses received	Fieldworker pre-screening health form to establish no pre-existing conditions	• Reassure SPs that diagnoses given by doctor are not real, but given on the basis of fictional symptoms
Treatment or admission	Avoiding SP cases which are serious enough to require immediate treatment or admission	• Train to refuse treatment with excuses such as not being able to pay, to leave the facility if necessary and to reveal role as SP as a last resort

and then providing answers to only the questions the provider asks, which is essential for ensuring measurement reliability. As they learn about the study condition it can be tempting for SPs to help or guide the provider to a correct diagnosis, so training must explain why it is important to avoid this. Comparison across SP studies has con firmed that the amount of information provided heavily influences treatment choices by providers (Miller *et al.*, 2018).

In most studies, each fieldworker performs only one SP case throughout the study. However, training fieldworkers in two roles gives the team more flexibility, though SPs should be randomly allo cated to a role at each facility to avoid bias. In studies covering large geographies, it may not be possible for SPs to be randomly allocated to facilities, and an SP specific variable should be controlled for as a fixed effect in the analysis (Das *et al.*, 2016a). There should be no systematic differences in time of day or week of the visit by condi tion or SP e.g. avoid the male SPs always visiting in the morning and female in the afternoon.

In studies in rural or remote locations, particular attention should be paid to 'cover stories', or how SPs explain their presence as an outsider if questioned. One resource intensive approach is to research in advance the names of villages and people who SPs can say they are visiting, specific to every location. Alternatively, a num ber of stories can be developed for use in different contexts: e.g. that they are buying cash crops or livestock or researching places to sell second hand clothing. Experience in the field has taught us that SPs should not improvise: some members of a team were detected after telling one provider they were agents for the government.

Once SPs understand their script and role, introduce them to the questionnaire. A useful training exercise is to have fieldworkers ob serve the same role play, then complete the questionnaire separately. Comparing answers highlights difficult parts of the consultation to remember. The final stage of training is SPs practising their roles and questionnaires by making undercover visits to providers who have agreed to take part. It may be helpful for this to initially be done in pairs (e.g. posing as husband and wife) so that peer feedback can be provided.

If SPs are permitted to undergo certain diagnostic tests (e.g. fin gerprick blood tests or urinalysis), we recommend that supervisors retest any fieldworker who receives a positive result for malaria or urinary tract infection. This will give peace of mind to the fieldwork er (or allow for treatment if a true positive) and validate the facility's test for the purpose of analysis. Supervisors can be trained to con duct malaria rapid diagnostic tests (mRDTs) and urine dipstick tests and be provided with a supply for the field.

SPs should purchase all drugs prescribed, if the budget allows, as this will reduce recall bias when recording drugs prescribed, improve the comprehensiveness of data on medicines, allow for the collection of drug costs and reduce the risk of raising provider suspicion. In addition, it may be possible to incorporate drug quality testing into the study (Wafula *et al.*, 2017). To test the reliability of recall, SPs can carry covert audio recorders, although this may introduce add itional ethical issues (Das *et al.*, 2015).

Step 6: assessing detection

A follow up study to assess the detection rate of SPs (i.e. the propor tion of SPs identified by providers as being SPs and not genuine patients) is seen as an important step in ensuring the validity of results. Detection rates from recent health facility LMIC studies have typically varied from 0% to 5% (Das *et al.*, 2015; Daniels *et al.*, 2017; Sylvia *et al.*, 2017), but there is no consensus on a max imum acceptable rate. Higher detection rates can be expected in rural settings compared with urban ones, where outsiders are likely to raise more suspicion. False positive rates (providers report sus pecting real patients to be SPs) varied from 1% to 6% in the same studies.

It may be advantageous to inform providers when obtaining con sent that there will be a follow up study and ask them to make a note of the name, description, symptoms and date if they receive any patients they suspect are SPs. This will allow for easy distinction be tween true and false detections at follow up. However, priming pro viders in this way may increase the risk of detection, so the study team must decide whether they are willing to take this risk for the benefit of ease of classification. In addition, priming is not possible where a waiver of consent or institutional consent is used.

Dependent on setting and resources, the detection survey can be conducted as a face to face interview, or remotely by telephone or email. If face to face, the survey can be combined with other ele ments of the study, such as vignettes to measure provider knowledge and compare with SP performance to measure the know do gap (Das *et al.*, 2015; Mohanan *et al.*, 2015; Sylvia *et al.*, 2017). Carrying out such knowledge assessments after completion of SP visits has the advantage of being less likely to influence provider be haviour than if done before SP visits. In addition, if a waiver of con sent has been used, the detection survey is an opportunity to inform providers that SP visits have taken place and allow them to ask ques tions and provide feedback.

The detection survey should start by briefly reminding (or in the case of a waiver of consent, informing) providers of the SP study's aims and methods, then asking if the provider recalls receiving patients they suspected were SPs. For every suspected SP, the follow ing information should be collected:

- Date and time of visit (approximate if necessary)
- Name, age (approximate) and gender of SP
- Symptoms of SP
- Diagnosis and treatment given by provider
- The reason the provider suspected the patient was an SP
- Whether the provider became suspicious during the visit or after it was complete
- Whether the provider changed their treatment or confronted the SP due to their suspicions

These data should then be used to classify suspected SPs as true or false positives at the analysis stage. The stringency of a true posi tive definition will depend on setting, conditions and whether pro viders are primed. Some studies may require that the name of the SP is reported, but others may only require that the provider correctly identifies the gender and symptoms of the SP and gives a date of visit correct to within 1 week.

Conclusion

SPs are a valuable research tool, with enormous potential to improve the measurement of clinical quality in primary care settings. However, their undercover nature means that there are methodo logical and ethical challenges beyond those found in normal field work. Moreover, SPs in health facilities are much more complex to implement than those in retail outlets. There is growing experience of developing and implementing a range of SP cases in diverse set tings, and we hope that this article can help make such learning ac cessible to those planning similar studies.

The choices made when undertaking an SP study are highly de pendent on the setting, purpose and resources. A well designed

Box 4. Avenues for methodological developments

- Can SPs be trained to make follow up visits and, therefore, be used to investigate continuity of care in more complex conditions? The principal difficulty here is that in the first round, each SP will likely receive different recommendations, so a single SP condition can morph into multiple pathways when visits are repeated.
- Should correct treatment vary by context? For instance, under what circumstances should referral to a higher level facil ity be defined as correct management? Is referral a useful action in remote settings where patients are unlikely to access other facilities?
- How should false positive diagnostic test results be managed? Are these accepted as part of random testing error or are they indicative of poor quality care?
- How representative can SPs be of real patients and their interactions with doctors?
- How can variability caused by SP characteristics be addressed in power calculations? Simulations have suggested that the number of individual SPs may be a critical factor for power calculations (Daniels *et al.*, 2019).

study will draw on a thorough understanding of the health system in question. It will also capitalize on the contribution of fieldworkers during tool development, training and piloting to ensure cases are credible, rarely detected and minimize risk. The task of developing the script, backstory, symptoms and behaviour of an SP should not be underestimated. The process of implementing SPs must therefore be collaborative, incorporating both local knowledge and technical expertise on the SP method.

The absence of Hawthorne effects and the ability to observe healthcare as it is delivered, when controlling the condition and characteristics of that patient, make SPs a valuable tool, which can answer research questions no other method can. We also recognize that the SP method, as currently implemented, has its limitations. With this in mind, we conclude by offering a number of avenues for future methodological development (Box 4). These relate to chal lenges in investigating the continuity of care, defining correct treat ment in different contexts, dealing with false positive diagnostic tests, conducting power calculations and representativeness of the population of patients.

Ethical approval. No ethical approval was required for this study.

Supplementary data

Supplementary data are available at *Health Policy and Planning* online.

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Conflict of interest statement. None declared.

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Accessed on July 16th, 2020

Medical abortion:

The Abortion pill up to 10 weeks

Click here to find out about 'Pills by Post' early medical abortion (/abortion-care/abortion-treatments/the-abortion-pill/remote-treatment/)

Early medical abortion is the routine treatment method for pregnancy of up to 10 weeks, unless it is not suitable or safe for the client to complete an abortion at home. For pregnancies under 10 weeks gestation if the client cannot have pills by post they may collect their medications from the clinic and use them at home. Click for more information (/abortion-care/abortion-treatments/the-abortion-pill/covid-19/)

For pregnancies at 10 weeks' gestation, you will take the first medicine mifepristone in clinic and will return to the clinic for misoprostol 1 or 2 days later.

You will be given pain medicine with instructions for use and advice on how to care for yourself. You will complete the abortion at home.

The abortion pill up to 10 weeks at a glance

	Up to 9 weeks	9-10 weeks
Take 1st medication (mifepristone)	In clinic, by mouth	In clinic, by mouth
Take 2nd medication (misoprostol)	1-2 days interval in the vagina or between cheek and gum	1-2 days interval in the vagina or between cheek and gum
Complete abortion	97 in 100	93 in 100
Potential risks		
Continuing pregnancy	1 in 100	3 in 100
Retained pregnancy tissue	2 in 100	3 in 100
Needing surgical treatment to complete abortion	3 in 100	7 in 100
Side effects		
Nausea	29 in 100	50 in 100
Vomiting	9 in 100	46 in 100
Diarrhoea	5 in 100	17 in 100
Warmth/chills	15 in 100	33 in 100
Headache	18 in 100	18 in 100
Dizziness	9 in 100	7 in 100
Follow-up	Self assessment with pregnancy test in 2 weeks or In-clinic ultrasound scan in 1-2 weeks	In-clinic ultrasound scan in 1-2 weeks

Treatment

Medical abortion: The abortion pill up to 10 weeks

Pills by Post - Remote Abortion Pill Treatment

For women from England, Scotland and Wales

(and NI in certain circumstances)

Medical abortion: The abortion pill by post

This service is a safe and legal way to end a pregnancy at an early gestation without needing to attend a clinic for treatment. You should contact BPAS on our bookings and information line 03457 30 40 30 (or if you are from Northern Ireland call 0300 500 8086) (/abortion-care/considering-abortion/northern-ireland-pills-by-post/) to book a telephone consultation and full medical assessment with a trained nurse or midwife who will assess your suitability for treatment. Most women are eligible for NHS funded treatment and we can discuss whether this applies to you when you call. If treatment is suitable and safe, you will receive abortion pills by post a few days later, or we can book you for an alternative treatment in clinic.

Medical assessment

You will have your consultation and medical assessment over the telephone and have opted for remote abortion pill treatment (pills by post).

Consent

We will explain the known risks and complications of your treatment during your telephone assessment. The risks and complications of this treatment are shown below.

Risks and complications of the abortion pill

Significant, unavoidable or frequently occurring risks

These are usually easy to treat and rarely have any long-term health effects.

- Unpredictable time to complete the procedure (variable)
- Side effects of drugs such as nausea, vomiting, diarrhoea, headache, dizziness, fever/chills (common)
- Retained products of conception - where the pregnancy is no longer growing, but some of the pregnancy tissue is left behind in the womb (2 in 100 ≤ 9 weeks. 3 in 100 between 9-10 weeks' gestation.)
- Infection (2 in 1,000)
- Unpredictable, irregular or prolonged bleeding after the abortion (variable)
- Pain during the procedure (common)

These may require transfer to hospital or surgical procedures, and may have serious long-term health effects.

- Continuing pregnancy (less than up to 1 in 100, up to 3 in 100 between 9 and 10 weeks' gestation)
- Haemorrhage - very heavy bleeding (2 in 1,000)
- Undiagnosed ectopic pregnancy (1 in 7,000)
- Death (1 in 100,000)
- Psychological problems (variable)

Extra procedures that may be necessary

- Surgical abortion or uterine aspiration (3 in 100 up to 9 weeks'. Between 9 and 10 weeks' gestation 7 in 100)
- Blood transfusion
- Laparoscopy or laparotomy - operation to look inside the abdomen
- Hysterectomy - surgical removal of the womb (2 in 100,000)

Treatment

You will receive your treatment package direct from the pharmacy from 1 to 3 days from your telephone consultation. If your package is delayed in the post for a few days you should still take the tablets as directed once they arrive. The package is plain with no indication of its contents, it will be tracked but not signed for. Your pack will contain:

Abortion pill medication (1 tablet mifepristone and 6 tablets of misoprostol - packaged together or separately)
Pregnancy test
Codeine (only provided if suitable)
Progestogen only contraceptive pills (if requested and suitable)

Click here to see what your package will look like (/media/3336/ema-pbp-example-packaging.pdf) (contents and medication brand names may vary)

weeks past limit

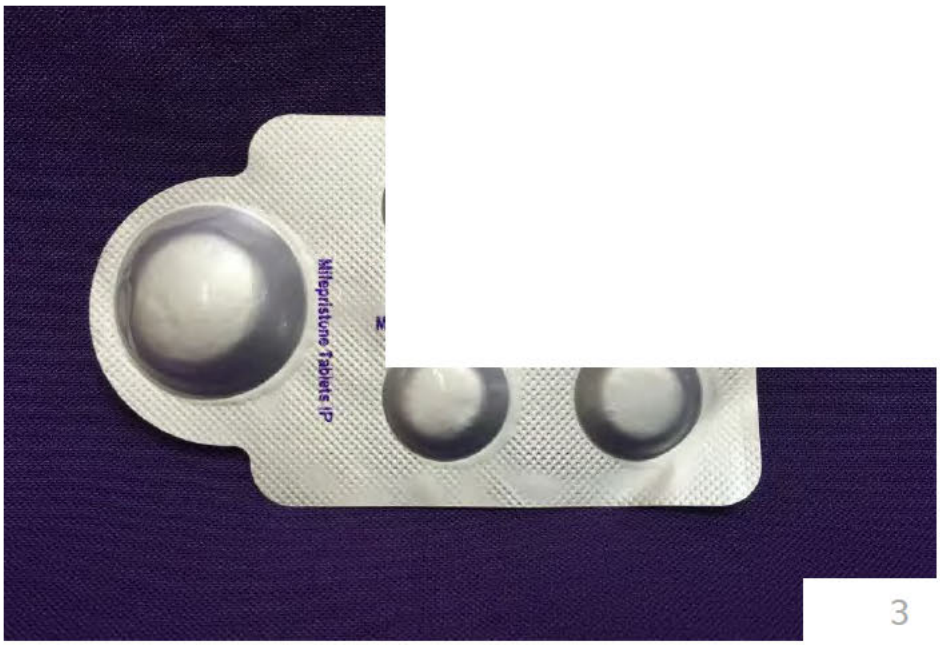
EXCLUSIVE

Tom Wells, Chief Reporter
22 May 2020, 22:24 Updated: 22 May 2020, 22:24

POLICE are probing the death of an unborn baby after a woman took "pills by post" abortion drugs while 28 weeks pregnant.

They were mailed under a new "home abortion" scheme set up after laws were relaxed because of the pandemic.

⚠ **Read our coronavirus live blog for the**



3

A woman was able to take abortion pills four weeks past the legal limit - and 18 weeks past the limit for medical terminations at home Credit: AFP or licensors

But she was already four weeks past the legal 24-week termination limit – and 18 weeks past a new ten-week limit for medical abortions at home under Covid-19 regulations. Her baby was stillborn.

Babies born prematurely at 28 weeks typically have a 90 per cent chance of survival.

The British Pregnancy Advisory Service (Bpas), which runs the "pills by post" service, has confirmed it is investigating the case, plus eight more where women were beyond the ten-week limit.

A Midlands coroner is investigating the 28-week death and police have also been informed.

Last night a whistleblower said: "The 'pills by post' system has been brought in but a 40-minute phone call can never be the same as a proper medical consultation.

"There needs to be a proper investigation to find out just what went wrong."

to get a prescription, with the pills mailed out.

But critics have warned the system is ripe for abuse or error.

How the rules were changed

RULES brought in last month mean women can now have a medical abortion at home up until week ten of pregnancy.

But they must consult a medic over the phone or video chat to get a prescription, with the pills sent by post.

Previously, abortions in England could be carried out only in a hospital, by a specialist provider or by a licensed clinic.

They also had to be approved by two doctors.

The new law lasts for two years under Covid-19 measures.

And pro-life groups have claimed abortion rights campaigners have taken "advantage of this crisis" to lobby for the "backdoor policy".

Charity Bpas typically carries out 60,000 abortions each year in the UK, with around 97 per cent referred to them from the NHS.

The new home abortions have been allowed since March 31 because of the coronavirus crisis.

It was estimated 44,000 women would need abortions in the 12 weeks from April 1.

Bpas said it has issued more than 8,000 "pills by post" treatments since the scheme began.

Medical abortions require two pills — mifepristone

could happen only in a hospital, licensed clinic or at a specialist provider.

Two doctors would also need to certify it did not breach the terms of the 1967 Abortion Act.

Last night Clare Murphy, of Bpas, said: "The swift establishment of a telemedical early medical abortion service at the start of this crisis has been a phenomenal achievement in women's healthcare, enabling women to safely access the care they need at home.

MOST READ IN NEWS

KING'S HEIR GONE Same looks, same love of music & like grandad Elvis, Ben's gone too soon

BRISTOPPLED BLM sculpture that replaced Bristol's Colston statue REMOVED in dawn raid

JAIL WAIL Cesc Fabregas' wife's ex-husband wails as he's jailed for ignoring court orders

"It has meant women have been able to end pregnancies at the earliest gestations, protecting their health and those around them by removing the need to travel long distances to clinics where social distancing is simply not possible.

"For women who are and remain unable to leave their homes due to underlying health conditions or coercive relationships, this scheme has quite simply been life-saving.

"We are aware of a vanishingly small number of pregnancies which were treated beyond the ten week gestational band, with just one over 24 weeks."

Kevin Duffy

Subject: FW: URGENT Information and Action re: Pills in the Post ToP service

From: [redacted]

Sent: 21 May 2020 09:34
Subject: FW: URGENT Information and Action re: Pills in the Post ToP service
Importance: High

Please be vigilant when reading emails. To reduce the risk of virus infections, only access links that you are confident are safe and are from known sources.

To: GM CYP Clinical Director's and Heads of Nursing

Dear All,

Below is some feedback from the CMO in the Midlands about an issues which is building linked to the Pills in the Post ToP service.

[redacted]he CMO for [redacted]met with the CQC on behalf of all Regional CMO's yesterday and has since shared that the CQC have been aware of an escalating risk around the 'Pills by Post' process for TOP during Covid, especially the process linked to 3 independent providers, BPAS, Marie Stopes and NPAS, since the 1st May 2020. This led to an abortion task force meeting last week and a review by the RCOG also last Friday. There was an indication that there had been a judicial review that Ministers are also being kept updated.

[redacted]shared that the CQC indicated that they are aware of 13 incidents related to this process, which when compared to the number of TOPs using Pills by Post (circa 16,000 since March) is a very small number, though recognising that the impact of poor outcomes for women is tragic.

[redacted]herself had been made aware of 10 incidents across 6 organisations on her DOMs calls and forwarded the list of those incidents to the CQC so that they can x-ref with their list if they are already known. In [redacted]we are aware that there have been 2 maternal deaths linked to this issue also. One case where a woman was found at home the morning after starting the process and the second where a woman presented with sepsis and died very quickly in the A&E dept. Neither of these women were known to our maternity or gynae services as far as we are aware.

The incidents in [redacted]between women attending ED with significant pain and bleeding related to the process through to ruptured ectopics, major resuscitation for major haemorrhage and the delivery of infants who are up to 30 weeks gestation. There was also a near miss where a woman had received the pills by post and then wished for a scan so attended a trust and was found to be 32 weeks. There are 3 police investigations in [redacted]linked to these incidents and one of those is currently a murder investigation as there is a concern that the baby was live born. The PM is being undertaken by a home office pathologist.

[redacted] reports that it was clear on the call that the only reporting of incidents, to the CQC, from this sector are those that are significant i.e. babies that are found to be a late TOP, as all the other outcomes are seen to be a complication of the process which could occur in any setting. There is therefore no data to compare current outcomes to.

Given the perceived small numbers of incidents there is concern that there is a risk of changing the process and that having a greater impact on women and girls choices. There is therefore a real need for us to better understand the outcomes for the women who are presenting to NHS services. The balance of risk both physically , mentally and for safeguarding is challenging especially without data.

The CQC will present the issue to Nigel Acheson as Deputy Chief Inspector of Hospitals and the link to the RCOG to consider a joint letter being sent to all NHS Trusts about this concern and will be setting up a reporting process. As this may take some time to set up, therefore an interim process is needed.

I have therefore been asked as the Regional Chief Midwife to:

1. Request that the D/HoMs alert the ED, EPAU, Obstetric team and paediatric services within the trust to be aware of any presentations of girls and women to their services with complications of this process

2. Ask if the D/HOMs would capture any reports from their organisation

3. Request that all the incidents collected by the D/HoMs is passed to the Regional Chief Midwife who can pass the incident to me for onward dissemination to the team who are working on this

I would be grateful for your support with this request.

Finally I would like to ask any of you who may be aware of any such similar cases already, that I am not aware of to please contact me asap so we can keep a record of the issues in the North West pertaining to this issue and if necessary inform the CQC.

BW
[redacted]

[redacted]
[redacted] Regional Chief Midwife
Professional Midwifery Advocate
NHS England & NHS Improvement

Ema[redacted]@nhs.net [redacted]

CT1 - PO1 - 2020-06-23 - BPAS - Call1 – Audio

[KD redacted client surname and address, and service provider name ###]

Lisa :
Okay, this is calling BPAS on the 23rd of June, 2020. It is currently 1:30 in the afternoon.

Automated voice:
Thank you for calling BPAS if you've not been contacted by us, assume your appointment is going ahead as planned. You will be contacted by the clinic if this changes. This booking line is used for urgent queries and bookings. We thank you for your patience during this busy period.

Automated voice:
If in the last seven days you have developed a new continuous cough or a high temperature, please inform the advisor when you are connected. If you already have an appointment booked in a clinic, please do not attend. If this affects you and you've not already done so, please seek advice from NHS 111 online and call us back to reschedule, if necessary.

Automated voice:
We provide a confidential service and any information provided will be kept on a safe and secure system. Calls may be recorded for training and quality purposes. We advise that you have your GP details to hand in order to provide your care we may need to share some information with the NHS or other providers. We would like to reassure you all information received will be kept confidential. We would generally advise that you don't bring children with you for your appointments. However, if that is difficult for you, please inform the advisor.

Automated voice:
We would like to send you communications about our other work and ask you about your experience of BPAS. An advisor will ask your permission at the end of the call. You may withdraw permission at any time.

Automated voice:
Please press one for a new booking. Two for general information. Three if you are an existing client. Four if you have had treatment and would like to speak to our after care team. Five if you are a GP or healthcare professional. Please press zero if you would like to hear these options again.

Automated voice:
We advise that you have your GP details and a pen and paper to hand. Please disclose all medical conditions. If we do not have the correct details, it may delay your treatment.

SP:
Good afternoon, you're through to [SP 00:02:41] . How can I help you?

Lisa:
Hi, I just wanted to inquire or make a booking about the pills by post option.

SP:
All right. So you're considering termination, is that right?

Lisa:
Yeah.

SP:
And the appointment, the termination, is it for yourself, or are you calling on behalf of somebody else?

Lisa:
No, it's for myself.

SP:
Okay. Have you done a positive pregnancy test already?

Lisa:
Yeah, I've done a couple of them.

SP:
Okay. And is this the first time that you're ringing us about this pregnancy?

Lisa:
Yes it is.

SP:
Okay. So I'm just going to take a few details. I'll have a quick look at the NHS contract in your area, just to make sure that we are able to help you. And then I'll have a quick look for funding for you. So could I start with taking your name and your surname?

Lisa:
Yeah, it's Lisa.

SP:
L I S A.

Lisa:
Yes.

SP:
###.

Lisa:
Yes.

SP:
And your date of birth, please.

Lisa:
Is that 21st of the fourth, 1993.

SP:
And your postcode at home please.

Lisa:
###.

SP:
###

Lisa:
###

SP:
###

Lisa:
Yes.

SP:
Okay. The line just broke up for a second. Just looking up your details, it won't take long.

Lisa:
Okay.

SP:
Okay Lisa, when I look up your details on the NHS database, there's no match coming up, which means that there's a slight difference between the information that I've got and the information that your GP would have for you. Would they have this postcode or have you moved? Have they perhaps got a different postcode? An old one?

Lisa:
I'm not quite sure, really. I don't really know, actually. I'm sorry.

SP:
Okay. Well, what was your previous postcode? It is possible that they haven't updated their records. I can have a look under the previous postcode. Or do you have a second name, perhaps? They've got a middle name after Lisa. Do you have a second name?

Lisa:
No, I don't. I'm really sorry that they're not appearing.

SP:
And ### has got an ### at the end?

Lisa:
Yes, it does.

SP:

Okay. And I've got the 21st of April, 1993?

Lisa:
Yes. That's the one.

SP:
And then your postcode ###?

Lisa:
Yes.

SP:
Okay. Do you want to give me your previous postcode? It might be that they've still got the old one. I can have a look.

Lisa:
Well, my previous postcode would be parents, but I'm not sure that they would have me under that. Well, we've been traveling for a little bit, so I don't know if we would have dropped off the system.

SP:
Give me the previous one. I'll have a quick look. It might very well be under that one. Otherwise, if not, I'll just put everything in manually.

Lisa:
Okay. I'll-

SP:
What is your parents postcode?

Lisa:
I'm going to have to look that up for you. Give me-

SP:
Okay, that's fine I can hold-

Lisa:
It's been a little while since I've looked all these up. I can give you the first. Try ###.

SP:
###.

Lisa:
###.

SP:
###.

Lisa:

Yes. That one.

SP:
Okay. Let's try that. No that's not coming up either. Okay. So I'm just going to put everything in manually, just stay with me a second. So you're currently at ###.

Lisa:
Yes that's my current address.

SP:
What's the first line of that address?

Lisa:
It's ###.

SP:
Okay, let's have a look.

Lisa:
###.

SP:
Right, I've got that. And then I'll put your GP details in manually as well. Could you give me their postcode please, the GP practice's, you registered with?

Lisa:
Yes. One second. It would be RG4 8RA.

SP:
Eight Romeo alpha.

Lisa:
That's the one, yeah.

SP:
Okay. Is that Emmer Green surgery?

Lisa:
Yes, that's the one.

SP:
Okay. If we needed to contact them for any reason, could we do so?

Lisa:
I'd really rather you didn't if possible. Do you have to?

SP:
No, that's fine.

Lisa:
Okay.

SP:
No we don't have to. I can opt out. That's fine. That's not a problem.

Lisa:
Thank you.

SP:
So I'm just going to have a quick look. How did you hear about us? How did you find our number?

Lisa:
I was just looking online actually.

SP:
Oh okay.

Lisa:
I found your website and I'd spoken to a friend before who'd, well she'd been for a normal clinic procedure, but she just recommended you guys and said you were really, really good with her.

SP:
Okay. Right, so I've had a quick look and everything is going to be fully funded by the NHS. There'll be no expense to yourself. So we can go ahead with a booking. Before we do that, I'm going to give you a reference number for this call. And it is important to write it down because you'll need to have this number with you at all time.

Lisa:
Okay.

SP:
Do you have a pen handy?

Lisa:
I do. I do. I do. Yes.

SP:
Okay. So the reference number is 235.

Lisa:
2,3 okay.

SP:
Double 4, 9, 8.

Lisa:

4498?

SP:
Eight, yes.

Lisa:
Yes. Okay.

SP:
Right. So attached to the reference, I need a password for you please. What would you like to use? It can be a word or numbers, whatever you like.

Lisa:
Ahh. Ooh. Well, put on the spot a little bit. What-

SP:
It can be a name. It can be a color. [crosstalk 00:09:24] It can be as long or short as you like.

Lisa:
Oh, let's go for blue then.

SP:
Blue?

Lisa:
Yeah. It's a color.

SP:
Just write that password down with the reference. If we rang you or you rang us, we'd always need both of those so that we can access your info. Now, if we need to get hold of you, what would be the best number for us to call you on?

Lisa:
The number, the best one would be, 075.

SP:
075.

Lisa:
986.

SP:
986.

Lisa:
366.

SP:

366.

Lisa:
64.

SP:
I didn't hear the last-

Lisa:
6,4. 64.

SP:
6,4. Right. [redacted].

Lisa:
That's it.

SP:
Is that your mobile number?

Lisa:
That's my mobile number.

SP:
Are you happy for a call at anytime? And if you don't answer for us to leave a voicemail, or send you an SMS appointment reminder?

Lisa:
An SMS would be fine. Sometimes there are people around the house, so it's probably not a good time.

SP:
Okay. And voicemail?

Lisa:
Yeah, that would be fine.

SP:
Okay. Does your phone accept calls from withheld numbers? Because if we called you, it would come up as a withheld number.

Lisa:
Yeah. I wouldn't really know how to check that, but I'm sure it would be fine.

SP:
Okay. So there'd be no caller ID. BPAS wouldn't come up. Right. Once we've booked an appointment, I can email you a confirmation letter. Would you like me to do so?

Lisa:
That would be really great. Yes please.

SP:
What's your email address?

Lisa:
It's.lisa21.

SP:
###.lisa?

Lisa:
Yeah, 21.

SP:
21.

Lisa:
@yahoo.com.

SP:
@yahoo.com. Right, I'm just going to call it back because the line has been breaking up. ###, dot, L for Lima, I for India, S for Sierra, A for alpha, two, one@yahoo.com.

Lisa:
That's it. Yes.

SP:
Okay, Lisa could you tell me when the first day of your last period was please?

Lisa:
Yeah, it was the 4th of May, just gone.

SP:
4th of May. And then what's your approximate height and weight?

Lisa:
I'm five, four and roundabout nine stone.

SP:
I didn't hear how many stone?

Lisa:
Nine.

SP:
Nine stone. Okay. Right. Do you have any medical conditions?

Lisa:
No.

SP:
Do you take medication at the moment?

Lisa:
No. None.

SP:
Do you have asthma or any allergies?

Lisa:
No. None. Nothing.

SP:
Any special needs or disabilities?

Lisa:
No.

SP:
And have you ever had a baby born via cesarean section?

Lisa:
No.

SP:
Okay. So I'm going to have a quick look at appointments. The first consultation would be done over the phone. The nurse will give you a call. She'll chat to you about your medical history, about the pregnancy. She'll speak to you about treatment options. And then when she's done that consultation, she will arrange your treatment. The consultation takes about 40 minutes. You will need to be in an area where there's good reception and make sure that your phone will accept a call from a private number, as I said. And then when she calls you, you will need your reference number and your password as well. So have that with you.

SP:
So I've had a quick look. We've got a lot of availability tomorrow afternoon from 1:30 onwards. You'd need to be free for about a half an hour before the appointment and about an hour after, just because they're busy and to allow them a good window of opportunity, because they might not be running on time. So I've got from 1:30 until, the latest is... It's just loading, just bear with me a second. The latest tomorrow would be at 10 past four.

Lisa:
1:30 would be fine, I think.

SP:

1:30 tomorrow. Right. So let's book that for you. Good. So that's all booked and confirmed. I'll pop an email through to you.

Lisa:
Thank you.

SP:
Once you've had your procedure, we'd like to contact you, either by text or email, just to ask you for a bit of feedback about the treatment. Is that okay with you?

Lisa:
Yeah that's fine. Email would be great.

SP:
Okay. It might be text. Are you happy with either?

Lisa:
Yeah, that'd be fine.

SP:
Okay. Would you be interested in finding out about any future campaigns or fundraising activities, or would you prefer to opt out of that?

Lisa:
Probably opt out I think.

SP:
No, that's fine. No problem at all. Good. So I'm going to send you that email, just confirming everything that we've spoken about. So we've booked it for now 1:30 tomorrow. Do you have any questions before we go?

Lisa:
You just said be available half an hour before and an hour after, is that right? For tomorrow.

SP:
After, yeah. Just in case they're not running on time. Though they do normally try more than once, just keep your phone with you and try and, as I said, to take the call in a nice quiet area. Because it's quite an extensive consultation, which is a legal requirement, so we can't offer treatment until you've had a consultation.

Lisa:
Yeah. That's fine.

SP:
Just keep your phone free, all right?

Lisa:
Okay. Thank you so much.

SP:
It's a pleasure. You take care of yourself. All the best.

Lisa:
You too. Thanks so much. Bye.

SP:
Bye.

[KD redacted client surname and address, and service provider name ###]

Speaker 1:
Wait, I'm only going to start filming once the calls on.

Speaker 2:
Thank you for calling BPAS. If you have not been contacted by us, assume your appointment is going ahead as planned. You will be contacted by the clinic if this changes. This booking line is used for urgent queries and bookings. We thank you for your patience during this busy period. If in the last seven days you have developed a new continuous cough or a high temperature, please inform the advisor when you're connected. If you already have an appointment booked in a clinic, please do not attend. If this affects you and you have not already done so please seek advice from NHS 111 online and call us back to reschedule if necessary. We provide a confidential service and any information provided will be kept on a safe and secure system. Calls may be recorded for training and quality purposes.

Speaker 2:
We advise that you have your GP details to hand. In order to provide your care, we may need to share some information with the NHS or other providers. We would like to reassure you all information received will be kept confidential. We would generally advise that you don't bring children with you for your appointments. However, if that is difficult for you, please inform the advisor.

Nicola :
People are going in.

Speaker 2:
We would like to send you communications [crosstalk 00:01:21] and ask you about your experience at BPAS. An advisor will ask your permission at the end of the call. You may withdraw permission at any time. Please press one for a new booking, two for general information. We advise that you have your GP details and a pen and paper to hand. Please disclose all medical conditions. If we do not have the correct details it may delay your treatment.

SP:
Good morning, SP speaking. How can I help?

Nicola :
Hi there. I'd like to get an abortion, please.

SP:
Yeah, that's fine. This appointments for yourself is it?

Nicola :
Yes.

SP:
Okay. Can I check, have you called us before for this pregnancy or is this the first time?

Nicola :
No, this is the first time.

SP:
That's fine. And have you taken a positive pregnancy test?

Nicola :
Yes, two.

SP:
You have, okay. So, I'm just going to take some details, see if we can get an appointment for you. So, can I please start by taking your first name?

Nicola :
Yeah, it's Nicola N-I-C-O-L-A.

SP:
O-L-A perfect. And what's your last name?

Nicola :
###

SP:
Perfect. And your date of birth?

Nicola :
It's 12th of February, 1987.

SP:
1987. And postcode of your home address?

Nicola :
###

SP:
Okay. So, ###?

Nicola :
Yeah.

SP:
Okay. And is this the postcode and details that the GP surgery would have on their system for you or might they have an old postcode?

Nicola :

No, they'd have this one.

SP:
They'd have this one. Okay. So, it's not matched with the NHS details. So just to repeat everything to you, we've got first name N for November, I for India, C for Charlie, O for Oscar, L for Lima, A for Alfa?

Nicola :
Yeah.

SP:
Then your last name, ###?

Nicola :
Yeah.

SP:
Date of birth, 12/02/1987?

Nicola :
Yeah.

SP:
And then postcode we said was ###?

Nicola :
Yes.

SP:
Okay. That's fine. Not to worry. I'll enter the details manually for you. So what's the first line of your home address?

Nicola :
###.

SP:
###. Let's have a little look. Oh, my system's trying to change it to a flat number. One moment. There we are, ###. Perfect. Do you know the postcode or the name of the doctor's surgery where you're registered?

Nicola :
Yeah. It's Chislehurst Medical Practice. It's on the high street, Chislehurst High Street. I think it's-

SP:
Is that going to be BR1 as well?

Nicola :
Yes, it is BR1.

SP:
BR1.

Speaker 1:
It's not BR1. It's BR7.

SP:
It's Chislehurst Medical Practice?

Nicola :
Yep, Chislehurst Medical Practice.

SP:
Oh, there we are, the one on the high street. Bear with me.

Nicola :
Yeah, that's the one.

SP:
Are you happy for us to contact anybody there if we needed to?

Nicola :
I'd rather keep it...

SP:
Private?

Nicola :
It if that's okay?

SP:
Yeah, no, absolutely. I'll tick for no contact for you. Don't worry.

Nicola :
Thank you.

SP:
How did you do find out about our services today?

Nicola :
Just a Google search, internet.

SP:
Just a Google... Yeah, that's fine. Not to worry. Now, I'm just having a quick check for you and I can see that you are fully funded by the NHS.

Nicola :

Oh, brilliant.

SP:
So, there'll be no cost to yourself for the appointments, okay.

Nicola :
Thank you. Yeah, that'd be great.

SP:
Now, for security on the booking I do need you to set a password for me. Any word or any number. What would you like it be?

Nicola :
Orange or something like that, if that's okay?

SP:
Yeah, no absolutely. So, I'll set your password as orange. Have you got somewhere you could just write down a reference number if I read it to you?

Nicola :
Yeah. I'll just write this down now.

SP:
Your booking reference number is going to be 235...

Nicola :
235.

SP:
6572.

Nicola :
6572.

SP:
That's it. You've got it. So keep the reference number and password safe. Don't share it with anybody. When you call us back you'll have to quote both of them to us. Now, the telephone number you're calling me on, is that the best one for us to contact you on?

Nicola :
Yes. If that's okay. Yeah. That'd be good.

SP:
Yeah, so I have it as [redacted].

Nicola :
Yeah. Perfect.

SP:
Can we leave you a voicemail and send you a text message reminder?

Nicola :
Yeah, sure.

SP:
Does your phone accept calls from withheld numbers?

Nicola :
Yes.

SP:
And have you got an email address I can send the confirmation to?

Nicola :
Yeah. It's nikki###1987@outlook.com.

SP:
Outlook.com. And for Nikki, are you spelling it N-I-C-K-I or with a double C?

Nicola :
Just N-I-C, sorry.

SP:
Oh, so, it's just Nic , is it? N-I-C?

Nicola :
Yeah. It's Nicola but I just call myself Nikki.

Speaker 1:
Nickname.

Nicola :
So, it's my nickname.

SP:
And then on the email, how are... Oh, you're just spending as N-I-C-I?

Nicola :
Oh, I'm so sorry. No, on my email is N-I-K-K, like my nickname, Nikki, and then my actual name is Nicola with a C Sorry. That's really confusing.

SP:
No, that's okay. So, on the email it's N-I-K-K-I?

Nicola :
Yes, sorry.

SP:
No, that's okay. So I do just have to read that full email back phonetically to you. I've got it as N for November, I for India, K for Kilo, K for Kilo, I for India, ### 1987@outlook.com.

Nicola :
Yeah. That's very impressive. Yeah, very...

SP:
Perfect. Thank you. Now, if we go into some medical questions. Do you know roughly when the first day of your last period might have been?

Nicola :
Yeah, I usually put it in my calendar, so 11th of May. So I think about seven weeks.

SP:
11th of May. Yeah, that's fine. Not to worry. And can I take your height and your weight approximately?

Nicola :
Yeah, I'm 5ft 7". And I think about 11 stone.

SP:
About 11 stone. That's perfect. Not to worry. Have you got any medical conditions or taking any medications?

Nicola :
No.

SP:
Any allergies, asthma?

Nicola :
No.

SP:
Any children born by c-section?

Nicola :
No, I've had three children but all natural.

SP:
All natural births. That's fine. And any special needs, physical disabilities?

Nicola :
No.

SP:

No. Okay. Now all clients do have a consultation before we go ahead with treatment. So providers may offer a telephone consultation, which might include pills by post, allowing you to have tablet treatments at home. Or it could be a face-to-face consultation with the option of treatment on the same day. What type of appointment are you hoping for?

Nicola :
The telephone one and then post would be ideal, if possible. That'd be brilliant.

SP:
No, absolutely. So what I can do I can have a look for the telephone appointment for you. I can't guarantee you the pills by post, but the nurse will discuss the option of it with you. I'll just have a little look to see what providers we can book for. So we've got ourselves here at BPAS and we can also book for Marie Stopes. I'm just having a little check for you. So I do have to offer you appointments for both of them. So, I'm just going to start with BPAS, see what can offer for you.

Nicola :
Yeah, that'd be great.

SP:
Okay. So here at BPAS, we can offer telephone consultations starting 10:30 tomorrow morning going on until about four o'clock in the afternoon, and then the same on Wednesday but starting about eight o'clock-

Nicola :
10...

SP:
... and then with Marie Stopes-

Nicola :
Oh, sorry.

SP:
Go ahead.

Nicola :
I was going to say 10:30 tomorrow would be ideal, actually. That would be perfect.

SP:
Yes. Okay. So I can certainly book you that one. I do just have to list you what Marie Stopes have.

Nicola :
Oh, sorry. Okay.

SP:
No, that's all right. So, they've got appointments available from one o'clock this afternoon through until nine o'clock tonight. And then from tomorrow in the morning through until nine o'clock at night. But just to let you know the appointments with Marie Stopes are for a telephone screening

appointment, so following on from that call you'd be booked in for a telephone consultation or face-to-face consultation at a later date.

Nicola :
Oh, I see. Yeah, I think I prefer 10:30 tomorrow just around the kids and stuff. That'd be quite...

SP:
Yeah. No, absolutely. Let's get that one booked in. Bear with me. And that was for the BPAS appointment for-

Nicola :
Yes, please.

SP:
Yeah, let's book that in. So Tuesday 30th of June. So it's going to be 10:30 tomorrow morning. Is that okay?

Nicola :
Yeah, perfect.

SP:
That's it. Let's book that in now. When the nurse calls you, it's going to come up as a withheld number. They might call you 30 minutes before that time or up to an hour after so keep your phone with you for about 10 o'clock until half 11. They will try to call as close to 10:30 as they can though. Now that call, it should last you about 30 minutes. The first thing they're going to ask for is your 235 reference number. I'm going to pop in an email as well. I'm sending this email across to nikki###1987@outlook.com.

Nicola :
Perfect, yeah.

SP:
Okay, I'll get that one sent across to you. Now, following on from that consultation tomorrow, if you do decide to go ahead with treatments, can we contact you for feedback by text and email?

Nicola :
Yeah, sure.

SP:
Can we contact you for campaigns and fundraising? Or would you prefer if we didn't?

Nicola :
Yeah, that's fine. I'm happy to be contacted.

SP:
Yes. Thank you. By email, telephone, or text message?

Nicola :

Text would be probably best.

SP:
Yeah. By text, perfect. Okay. So all booked in for telephone consultation, 10:30 tomorrow morning with BPAS. If you mention to the nurse you are hoping for the pills by post, they'll discuss the eligibility for you and see if you get that one arranged.

Nicola :
Oh, okay. Brilliant. Thanks so much for all your help. You've been really helpful.

SP:
Perfect. No, you're welcome. I wish you all the best for your future care.

Nicola :
Thank you so much. Take care. Have a good day.

SP:
Thank you.

Nicola :
Bye.

SP:
And you, thank you. Bye-bye.

Nicola :
There we go. Let's go home.

Speaker 1:
Well done. Good job.

Speaker 1:
Stopes International. So that we can direct your call more efficiently; please choose one of the following options. Press one, for termination of pregnancy. Press two, for the... If you or the person accompanying you has a high temperature or a continuous cough, please do not attend any face-to-face appointments with us. Instead, please re book your appointment and stay home for seven days, you do not need to call 111 or visit your GP.

Speaker 1:
Press one, to make a booking or check funding. Press two, to change or cancel a booking. Press three, if you have had treatment with Marie Stopes International and would like to speak... Thank you for calling Marie Stopes International. Your call will be answered by the next available advisor. All information you provide is confidential and will be processed and stored securely. Your call may be recorded for training and quality purposes, and you can access your information upon request.

Speaker 2:
You just say, "I don't want to come into a clinic and you just press this."

Speaker 2:
If you hold it up to your mouth; you can get better audio.

Speaker 1:
Thank you for holding. Please continue to hold and we will answer your call as soon as possible. Please continue to hold and we will answer your call soon as possible. Thank you for holding. Please continue to hold and we will answer your call as soon as possible. Please continue to hold and we will answer your call as soon as possible.

Nicola:
Here's my doctor.

Speaker 2:
Dr. [inaudible 00:02:13].

Nicola:
He can actually get back to me.

Speaker 2:
[inaudible 00:02:18].

Speaker 1:
Please continue to hold and we will answer your call as soon as possible.

Speaker 2:
As he said, he won't get back to them because they won't know about it-

Speaker 1:
Thank you for holding. Please continue to hold and we will answer your call as soon as possible.
Thank you for holding. Please continue to hold and we will answer your call as soon as possible.

Speaker 1:
Please continue to hold and we will answer your call as soon as possible. Thank you for holding.
Please continue to hold and we will answer your call as soon as possible. Please continue to hold and we will answer your call as soon as possible.

Nicola:
What day am I booking in for, tomorrow?

Speaker 2:
Tomorrow or Wednesday.

Nicola:
What if they can't do one of those?

Speaker 2:
Next week, Monday, Tuesday.

Speaker 1:
Thank you for holding. Please continue to hold and we will answer your call as soon as possible.

Speaker 2:
Think, if you were actually pregnant, you've got a lot of thinking time.

Speaker 1:
Please continue to hold and we will answer your call as soon as possible. Thank you for holding.
Please continue to hold and we will answer your call as soon as possible. Please continue to hold.

Speaker 2:
That's your date of birth.

Nicola:
It doesn't matter, I need to do one that I can remember. I'm not going to much remember this.

Speaker 2:
You don't need to. Just look at it.

Nicola:
No.

Speaker 1:
Please continue to hold and we will answer your call as soon as possible. Thank you for holding.
Please continue to hold and we will answer your call as soon as possible.

Speaker 1:
Please continue to hold and we will answer your call as soon as possible. Please continue to hold and we will answer your call as soon as possible. Thank you for holding. Please continue to hold and we will answer your call as soon as possible. Please continue to hold and we will answer your call as soon as possible. Thank you for holding. Please continue to hold and we will answer your call as soon as possible. Please continue to hold and we will answer your call as soon as possible. Thank you for holding. Please continue to hold and we will answer your call as soon as possible.

Speaker 2:
[Inaudible 00:00:07:32].

Speaker 1:
Thank you for holding. Please continue to hold and we answer your call as soon as possible. Please continue to hold and we will answer your call as soon as possible. Please continue to hold. And we will answer your call as soon as possible. Thank you for holding. Please continue to hold and we will answer your call as soon as possible. Please continue to hold and we will answer your call as soon as possible. Please continue to hold and we will answer your call as soon as possible. Thank you for holding. Please continue to hold and we will answer your call as soon as possible. Please continue to hold and we will answer your call as soon as possible. Please continue to hold and we will answer your call as soon as possible. Thank you for holding. Please continue to hold and we will answer your call as soon as possible.

Nicola:
It's been 11 minutes now.

Speaker 2:
I know.

Speaker 1:
Please continue to hold and we will answer your call as soon as possible.

SP:
Good morning, you've reached SP. How can I help?

Nicola:
Hi, there. I'm just calling about getting an abortion.

SP:
Okay. I would need to take some information from you to make a booking.

Nicola:
Sure.

SP:
All right. It's all confidential. Can I start with your first name?

Nicola:
Yeah. Nicola.

SP:
Is that N-I-C-H or N-I-C-O-L-A?

Nicola:
N-I-C-O-L-A.

SP:
C-E-O-L-A?

Nicola:
C-O-L-A.

SP:
So N-I-C for Charlie. What's the next letter?

Nicola:
O-L-A.

SP:
O-L-A, I thought you said something else in between. All right and your surname, Nicola?

Nicola:
###.

SP:
Thank you. And your title? Miss, Mrs?

Nicola:
Mrs.

SP:
And your date of birth please?

Nicola:
12th of February, 1987.

SP:
Thank you. And have you ever used our services before?

Nicola:
No. I've not had an abortion before.

SP:
Where did you hear about us today?

Nicola:
Just the internet.

SP:
Internet. Okay. And, can I take the best contact telephone number for you?

Nicola:
Yeah, it's probably this one, which is O754 981 7072.

SP:
Okay. So 0754 981 7072.

Nicola:
Yeah. Thanks.

SP:
Okay. And the name of your doctor's surgery and we'll check [inaudible 00:11:43] your area?

Nicola:
Yeah, it's Chiselhurst Medical.

SP:
Chisel, C-H-I-

Nicola:
S-E... Sorry, I'm just trying to think. S-E-L, C-H-I-S-L-E hurst medical Practice.

SP:
What postcode area of the country with this be in?

Nicola:
Bromley BR1.

SP:
BR1.

SP:
I have got, I don't think it's that one actually, it might be this one that's 42 High Street in Chislehurst-

Nicola:
Yeah, that's the right one. Yeah.

SP:
Okay. That's under Bromley. Let me get the contracts here. One second.

Nicola:
Thanks.

SP:
That's fine. So you can be seen under this area. Okay. This is self-referrals. You don't need

paperwork. Can I ask, do you have your NHS number?

Nicola:
I don't actually have it on me. Sorry about that.

SP:
That's okay. If you haven't got it. Don't worry. Okay. All right. And will you like to contact your doctor about your medical information if we need to?

Nicola:
Probably, rather just keep it confidential if that's okay. So, not to contact my GP.

SP:
Well, your post code and your date of birth may need to be shared with the NHS, if they pay for your treatment, is this okay?

Nicola:
Okay. Yeah.

SP:
I mean, if not, you would either need to pay privately or you would need to seek another provider who will likely share the same information.

Nicola:
No, that's okay then. Don't worry, yeah, that's okay.

SP:
So, we can put no to contact with your doctor. We can put that, but I just need to let you know that we have to tell you that your post code and date of birth may need to be shared for funding.

Nicola:
Oh, okay. Sure. Yeah. That's okay. Sorry. Yeah.

SP:
So, we'll still put no to contact with doctor, but just so... It's anonymized. So, it would only be your postcode and date of birth, if they want to see where their funding's going. Okay.

Nicola:
Oh, I see. Okay. Oh yeah. Sorry. I didn't understand that. Thanks.

SP:
So we'll still put the no contact with doctor but we'll, you know, like I said, it will be anonymized information, but they may look to see where funding goes.

Nicola:
Sure. That makes sense. Thanks.

SP:

Okay. Now, no to contact with GP, you any support needs or any disabilities?

Nicola:
No.

SP:
No. And have we got permission to ring you or contact you on your phone number, if we need to get hold of you?

Nicola:
Yeah, absolutely.

SP:
Yeah. Okay. Do you have any new continuous temperatures above 37.8 degrees or higher or changes to sense of smell or taste?

Nicola:
No.

SP:
Okay. May I take a post code, where you live?

Nicola:
Yeah. It's ###.

SP:
And the address?

Nicola:
###.

SP:
Okay. Can we send post to this address or not?

Nicola:
Yeah, that's fine.

SP:
Yeah? Okay. All right, and your first day of last period, when was this?

Nicola:
Let me just check my calendar. So I usually record it in my calendar. 11th of May, which I think, about seven weeks.

SP:
Okay. Do you feel you would like counseling for emotional support?

Nicola:

No, I think it will be okay.

SP:
Okay. Counseling is available, if you need it, at any stage. Okay. On the phone or face to face, all right.

Nicola:
Thank you.

SP:
You said the test was positive, wasn't it? Yeah.

Nicola:
Yeah.

SP:
So what we're going to look to do then, first of all Nicola is put you on medical assessment [inaudible 00:15:30] on the phone initially, and once completed, then we book you for either scan and treatment, or it might be that we can send you tablets in the post. It depends on the outcome of the assessment.

Nicola:
Okay, so-

SP:
Earliest we can ring you would be tomorrow.

Nicola:
Yeah, tomorrow, that would be good, actually.

SP:
Yeah. The only times I got left at the moment for tomorrow is afternoon or evening. So between 12 PM, 1 PM, 1 PM 2PM, 2 PM 3 PM, before?

Nicola:
12 PM would be brilliant if that's okay.

SP:
12 PM and 1 PM?

Nicola:
Yeah, thank you.

SP:
So it would be during that one hour between 12 PM and 1 PM. Is that okay?

Nicola:
Sure, okay.

SP:
Do you want a text or are you going to remember hearing it?

Nicola:
I'll remember. Thanks.

SP:
You'll remember. All right. So between 12 PM and 1 PM then tomorrow, the 30th of June. Health advisor will call through. It will show as a private, withheld number. If you miss the first call, they'll ring once more in the hour.

Nicola:
Okay.

SP:
If you miss the second call, you need to re book.

Nicola:
Okay, I'll make sure I am. Yeah.

SP:
All right. We do ask you in a quiet place that you can talk privately without any interruption.

Nicola:
Sure.

SP:
You mustn't be driving or using hands free. And have with you details of any medical conditions, any medicines that you take, we'll ask for your height and weight, to avoid alcohol or recreational drugs, 24 hours prior, or they will not proceed, and your appointment may get re booked. Sure, okay.

Nicola:
Sure, all right.

SP:
Just a couple of questions. Really for Department of Health. Can we ask your marital status?

Nicola:
Yeah. I'm married.

SP:
Married. And ethnic background?

Nicola:
White. British.

SP:

Okay. And do you have a number you want to leave for anyone else? Like trusted friend, relative, or not?

Nicola:
No, it's okay. I think, actually.

SP:
All right. Lastly, for security and confidentiality, we lock your record with a pin number and a password. And we won't speak to anyone about it, okay.

Nicola:
Okay, Great.

SP:
So, your pin number is going to be 1202. So, it's a day and the month that you're born.

Nicola:
Okay.

SP:
Okay. Password, can you choose film, color, food or sport? What would you choose for a password?

Nicola:
Probably color.

SP:
And what's your favorite color?

Nicola:
Orange.

SP:
Orange. Okay. So that is your pin and password. So the person in contact will ask you for this.

Nicola:
Great.

SP:
Now, there is lots of information on the Marie Stopes website if you want to look at that.

Nicola:
Okay.

SP:
Whenever we call out over the phone, we always refer to ourselves as MSUK. All right.

Nicola:
Okay, that's good to know.

SP:
There are nurses here 24 seven for medical advice, or if you need to change your booking, we're here from 7 AM until 11 PM every day. All right.

Nicola:
Great.

SP:
Any other questions that you wanted to ask?

Nicola:
That's really helpful. Thank you so much.

SP:
Okay. All right, well, we'll speak tomorrow, but you take care [crosstalk 00:18:17].

Nicola:
Thank you so much. Thanks, have a good day.

SP:
Bye. And you.

Nicola:
Bye.

CT4 - PO1 - 2020-06-24 - MSI - Call1 – Audio

[KD redacted client surname and address, and service provider name ###]

Laura:
Today is the 24th of June 2020, the time is 3:14pm and this is my first call to the abortion provider Marie Stopes Essex.

Speaker 2:
Welcome to Mary Stopes International. Further we can direct your call more additionally. Please choose one of the following options. Press one for termination of pregnancy. Press two for vasectomy. If you, or the person accompanying you have a high temperature or a continuous cough, please do not attend any face-to-face appointments without, instead, please rebook your appointment and stay home for seven days. You do not need to call 1-1-1 or visit your GP. Press one to make a booking or check funding. Press two to change or cancel a booking. Press three if you have had treatment with Mary Stopes International and would like to speak to a nurse. Press four for anything else.

Speaker 2:
Thank you for calling Mary Stopes International. Your call will be answered by the next available adviser. All information you provide is confidential and will be processed and stored securely. Your call may be recorded for training and quality purposes and you can access your information upon request.

SP:
Good afternoon, SP speaking, how can I help?

Laura:
Hello. I'm calling to see if it will be possible to have a home abortion?

SP:
Yeah, so what I'll do is I'll book you in for a phone consultation with one of our health advisers and they will assess you to see whether or not we can have the tablets sent to you via post or you just collect them directly from the clinic. Okay?

Laura:
Okay.

SP:
So, can I take your first and second name?

Laura:
Yes, my first name is Laura ###-

SP:
L-A-U-R-A Laura?

Laura:
Yes. And my last name is. ###.

SP:
###. Okay, and what's your date of birth, Laura?

Laura:
That's the 22nd of September 1997.

SP:
22nd of September 1997.

Laura:
Yes.

SP:
Okay. Miss or Mrs Laura?

Laura:
Miss.

SP:
Have you ever used this service before?

Laura:
No, I haven't.

SP:
No? Okay. Can I just ask you, is this a NHS or privately funded treatment?

Laura:
Any chance... I was wondering- [crosstalk 00:02:40]

SP:
NHS [crosstalk 00:02:40] yes, and just in regards to the Corona virus, do you currently have a new or existing cough.

Laura:
No I don't.

SP:
Okay, it's fine. Well if you do, will you just let us know so that we can rearrange a clinic appointment for you. If we need to contact you instead of you will contact or arrange an alternative, okay?

Laura:
Okay.

SP:

How did you hear about us today?

Laura:
I've just been doing some research online and I found out-

SP:
Yeah the internet-

Laura:
About this, yeah.

SP:
Okay. What's the best mobile number to contact you on?

Laura:
Oh, yeah. That would be [redacted].

SP:
[redacted]. And what's the name of the GP surgery that you're currently registered with?

Laura:
It's the Hamilton practice at Gates House Health Center.

SP:
Sorry, the...?

Laura:
The Hamilton Practice.

SP:
H-E-M... how do you spell that?

Laura:
H-A-M-I-L-T-O-N

SP:
So H-A-M-

Laura:
Oh sorry, yes, H-

SP:
I-L-T-O-N. Oh Hamilton. All right.

Laura:
Yeah, Hamilton.

SP:

And what town is Hamilton in?

Laura:
That's Harlow.

SP:
In Harlow. Right, let me find it on my system. Okay, here we go. Right. Let me just check the funding and you're the North West Essex Area, bear with me for a moment.

Laura:
Yes.

SP:
Okay. That's [inaudible 00:04:26], do you have your NHS number at all?

Laura:
I don't know if I can find it-

SP:
Don't worry, it’s not needed for that appointment. That's fine. Can you state the first day of your last period?

Laura:
That would be fourth of May.

SP:
The fourth of May. Okay, so that makes you about seven weeks and two days pregnant. Have you taken a pregnancy test?

Laura:
Yes. That's how I found-

SP:
Would you like...

Laura:
Sorry?

SP:
Yes. Would you like to speak to a counselor for any emotional support?

Laura:
No, I'm okay.

SP:
Yeah, that's okay. It is available if you need it. Can I take your home post code?

Laura:

That would be ###.

SP:
###?

Laura:
Yes.

SP:
Okay, all right. So that's ###?

Laura:
Yeah.

SP:
And what number is that?

Laura:
###.

SP:
###.

Laura:
###, sorry.

SP:
###. Okay. I've got here that it just goes to ### and then it goes to ###.

Laura:
Yeah so-

SP:
That's odd.

Laura:
It's a new build- [crosstalk 00:05:43]

SP:
I'm going to... [crosstalk 00:05:43] It's a new building. That's not even on this system. ### I'm going to write in, okay. ###, okay. Do you give us permission to post to that address?

Laura:
Yes.

SP:
Do you give us permission to talk to a GP about your medical history if we needed to?

Laura:
No, if that would be possible.

SP:
Yes, I will put here, "No GP contact". Just to let you know that your postcode and date of birth may need to be shared with the NHS as they pay for your treatment. Is this okay?

Laura:
Okay, yeah that's okay.

SP:
That's fine yeah. Right, let me have a look at the next available phone consultation for you.

Laura:
Okay.

SP:
[00:07:13] Okay, we have a look, we've got the 25th, which is tomorrow, okay? And could you take a phone call between the hours of 4:00 and 5:00?

Laura:
Yeah. That would be okay.

SP:
It's a 20 minute phone call in terms of without or private number, they'll ask you some questions about your medical history, any medications that you're taking, your height your weight. No medical treatment before the appointment or we would have to cancel it. If you miss a call once we try once more, just to let you know.

SP:
Now the department of health statistics, can please state your marital status?

Laura:
Its unmarried.

SP:
What best describes your ethic background?

Laura:
That will be European White.

SP:
Can you give us an alternative number if we need to contact anybody else? You don't have to if you don't want to.

Laura:
I have a friend but I didn't want to talk to her about this.

SP:
No you don't have to if you don't want to. We keep it blank. That's fine.

Laura:
Okay, thank you.

SP:
I'm going to give you a pin and a password to keep your details confidential. The pin is the year you were born, 1997, and the password, you choose from the following: a favorite color, sound, food or sport.

Laura:
Okay, could it be purple?

SP:
Favorite color is purple. Okay. So it's 1997 and your favorite color is purple. We're going to call you tomorrow between the hours of 4:00 and 5:00. Would you like us to text or your email you that or have you written that one down?

Laura:
Yeah, if you could send me an email, that would be great.

SP:
Okay. Right, email. Well, I'll just have to take your email address.

Laura:
Yes, that would be-[crosstalk 00:09:02] Sorry.

SP:
Yeah, if you could give that to me.

Laura:
That would be Laura###97@gmail.com

SP:
So L-A-U-R Laura, is it dot ###?

Laura:
No, just my name with nothing in between.

SP:
Oh, your name without a dot, okay.

Laura:
Yeah, 97.

SP:
So Laura###, yeah what was the number?

Laura:
Yeah, 97.

SP:
97@

Laura:
Gmail.com

SP:
Gmail.com, okay. Laura###97@gmail.com, right. So I will email that across to you. Is there anything else that we can help you with?

Laura:
No, that will be it, thank you very much.

SP:
Okay, we are here from 7:00am to 11:00pm, when you're booking your appointment queries and the nurse here 24/7 who will be here for the day, she's can provide you with medical advice and there's more information at [inaudible 00:10:00]. Right I'll email that to you now.

Laura:
Okay, thank you very much, I appreciate it.

SP:
Take care, bye.

Laura:
Thank you, bye.

[KD redacted client surname and address, and service provider name ###]

Hannah:
Hello? Hello?

SP:
Hell, is that Hannah?

Hannah:
Yeah, speaking.

SP:
Hi, my name's SP, I'm calling from MSUK about your appointment today.

Hannah:
Hello.

SP:
Hi, is now a good time to talk?

Hannah:
Yeah. That's fine.

SP:
Could I start by taking your pin and password please?

Hannah:
Yeah, it's 1990 and purple.

SP:
Lovely. Thank you. And then, could you confirm your full date of birth and your age please?

Hannah:
Yeah, 27th of July 1990 and I'm 29.

SP:
Lovely, thank you. Okay, so I'm a health advisor calling from Marie Stopes. So, I'm going to document your medical history ready for it to be assessed by a clinician, so I'll ask you about your legal reason for requesting a termination, as well as explain any available treatment options to you and answer any questions that you may have.

Hannah:
Okay. Yeah.

SP:

All right. Please ensure that you do provide honest and accurate information about your health and gestation, as not doing so could result in delays in your treatment or increase your risks.

Hannah:
Mm-hmm (affirmative).

SP:
And before we start gathering the information, I should advise you as well that the call is recorded and it will form part of your medical records with us.

Hannah:
Right. Yeah.

SP:
Would you be happy to proceed?

Hannah:
Yeah.

SP:
Yeah. Okay. So, do you have any conditions that would mean that you need support with your appointments?

Hannah:
No.

SP:
No. And do you take any recreational drugs?

Hannah:
No.

SP:
Okay. Is there anybody else in the room with you at the moment?

Hannah:
No.

SP:
And do you feel safe and comfortable to be having this phone call today?

Hannah:
Yeah. Yeah.

SP:
Yeah. Okay. So, could you confirm that you're sure of your decision to terminate your pregnancy?

Hannah:

Yeah.

SP:
Thank you. And for legal requirements, could you explain your reasons for requesting a termination?

Hannah:
I just don't want to be pregnant to be honest. It's not going to fit in with my life at the moment.

SP:
Okay. No problem. So, that falls under emotional reasoning under the Abortion Act. So, would you agree if I recorded that you've stated that it's not the right time for you emotionally, to continue with the pregnancy?

Hannah:
Mm-hmm (affirmative). Yeah.

SP:
Yeah. Okay. So, just to remind you as well, that counseling is available to you both before and after your treatment, if you would like that.

Hannah:
Okay.

SP:
All right. So, I'll ask questions now about your medical history. These are about you only. Please be as accurate as you can. Treatment is subject to assessment at your appointment.

Hannah:
Mm-hmm (affirmative).

SP:
All right. Could you confirm the first day of your last period, please?

Hannah:
Yeah. It was the 11th of May.

SP:
Okay. Thank you. And how accurate do you feel that that is?

Hannah:
It's definitely right because I always put it in my diary.

SP:
Okay. Lovely. So, how often do you get your period, usually?

Hannah:
It's pretty much 30 days.

SP:
30 days. Okay. And was that a normal period in May or was it any lighter than usual?

Hannah:
Just normal.

SP:
Yeah. You haven't had a scan in your pregnancy so far?

Hannah:
No.

SP:
No. When was the last time you did a positive pregnancy test?

Hannah:
Last week on, I think it was Thursday.

SP:
Thursday, thank you.

Hannah:
Yeah.

SP:
Do you have any children?

Hannah:
No.

SP:
No. And have you ever had a stillbirth or an ectopic pregnancy?

Hannah:
No.

SP:
No. Any miscarriages?

Hannah:
No.

SP:
And any previous terminations?

Hannah:
No.

SP:
Okay. Thank you. So, your first pregnancy?

Hannah:
Yeah.

SP:
Do you have any problems at all with your womb, ovaries, or cervix?

Hannah:
Nope. Don't think so.

SP:
No. Have you ever had any surgery to any of those areas?

Hannah:
No.

SP:
Okay. Thank you. Ever been told that your fallopian tubes are damaged?

Hannah:
No.

SP:
Or been sterilized?

Hannah:
No.

SP:
Lovely. Thank you. So, it's routine for our clinics to test for sexually transmitted infections, and if you were to opt into that, we'd contact you with the results within two weeks, if for any reason we were unable to contact you about a positive test result, we would contact your GP.

Hannah:
Right.

SP:
All right. Could I ask what contraception you were using when you fell pregnant?

Hannah:
Yeah. Well, condoms, but I think it might have slipped, split or something like that.

SP:
Okay. So, have you used any hormonal contraception in the last three months?

Hannah:

No.

SP:
No. Okay. Thank you. So, it is routine for us to advise you of your contraception options. So, the nurse will provide you with full information and answer any questions when you speak. And if you're looking for further information, you can visit sexwise.fpa.org.uk.

Hannah:
Okay.

SP:
All right. Have you ever had any psychiatric illnesses or mental health issues such as anxiety or depression?

Hannah:
No. No.

SP:
No. Okay. And have you ever had jaundice or hepatitis?

Hannah:
No.

SP:
Do you have any allergies?

Hannah:
No.

SP:
Are you diabetic?

Hannah:
No.

SP:
Do you have asthma or any breathing problems?

Hannah:
No.

SP:
Do you take any steroid tablets?

Hannah:
No.

SP:

Have you ever had rheumatic fever?

Hannah:
No.

SP:
No. Do you have epilepsy?

Hannah:
No.

SP:
Any heart complaints?

Hannah:
No.

SP:
High blood pressure?

Hannah:
No.

SP:
Ever had thrombosis or a blood clot?

Hannah:
No.

SP:
No. And do you smoke or vape currently?

Hannah:
No, neither.

SP:
Okay. And have you ever had a blood transfusion?

Hannah:
No.

SP:
Have you ever been put to sleep with a general anesthetic?

Hannah:
No.

SP:

Have you ever had local anesthetic, where they numb part of your body, but you're awake? Sometimes used at the dentist, if you've ever had fillings or teeth out.

Hannah:
Yeah.

SP:
Yeah?

Hannah:
I mean, just for a filling, you mean, is it that sort of thing?

SP:
Yeah.

Hannah:
Yeah. I've had that.

SP:
Yeah. They've injected your gum?

Hannah:
Yeah, I've had that.

SP:
[crosstalk 00:05:41]. And any bad reactions at all to that, when you've had it?

Hannah:
No. That was fine.

SP:
Okay. Lovely. Could I then take your height and your weight, please?

Hannah:
Yeah, I'm five six and nine stone and two pounds.

SP:
Thank you. Have you ever been tested for sickle cell trait or disease?

Hannah:
No.

SP:
No. And have you ever taken a tablet called St. John's wart?

Hannah:
No.

SP:
Do you have any bleeding disorders or take any blood thinners?

Hannah:
No.

SP:
No. Do you have chronic adrenal problems? Sorry.

Hannah:
No.

SP:
Do you have inherited porphyria or systemic lupus sickle blood disorders?

Hannah:
No.

SP:
No. And you don't have a contraceptive coil in place at the moment?

Hannah:
No.

SP:
Okay. Have you been experiencing any ectopic pregnancy symptoms? That would be any lower abdominal pain or spotting or bleeding in the last five days.

Hannah:
No.

SP:
Have you ever been diagnosed with migraines?

Hannah:
No.

SP:
Have you ever had a blood test that showed low platelets?

Hannah:
No.

SP:
Low iron?

Hannah:
No.

SP:
No. Ever been treated with any iron tablets or iron infusions or injections?

Hannah:
No.

SP:
Okay. Lovely. So, is there anything in your medical history, Hannah, that we haven't discussed?

Hannah:
No. I don't think so.

SP:
No. Are you currently taking any medication at all?

Hannah:
No. Nothing.

SP:
Okay. Lovely. So, if anything does change, we would just ask that you make the nurse aware on the day.

Hannah:
Okay. Yeah.

SP:
All right. So, based on the information you've given me and your current gestation, we would offer you the medical abortion. Would it be safety to pass your pregnancy at home?

Hannah:
Yeah. Should be. Yeah.

SP:
Would you also be able to receive a small package to your home address that would include the abortion medication and the information leaflet?

Hannah:
Yeah. That's fine. Yeah.

SP:
Yeah. Okay. So, based on the information you've given me, we can offer you an appointment without an ultrasound scan. So, this involves taking a tablet that ends the pregnancy, and it's followed by a second set of tablets that will cause you to miscarry.

Hannah:
Right.

SP:
So, you may experience heavy bleeding with clots and cramping, and you will need to make sure that you have adequate pain relief and sanitary towels.

Hannah:
Okay. Yep.

SP:
Okay. So, an early medical abortion is between 95 to 99% effective and doesn't involve surgery or anesthetic, and after this call I'll send you a link containing information about your treatment, the consent form and the aftercare information.

Hannah:
Okay.

SP:
So, it's very important that you read these before your next appointment, which will be completed over the phone.

Hannah:
Okay. Yeah.

SP:
Are you able to access the internet to do that?

Hannah:
Yeah. That's fine. Yeah.

SP:
Okay, lovely. So, a nurse from one of our centers will call you for that appointment and that'll be to conduct a full health assessment to check it is safe for you to have an abortion with us.

Hannah:
Okay.

SP:
And all of your risks and complications will also be explained to you. So, we'll make the appointment with that same call at the end of this consultation.

Hannah:
Okay.

SP:
So, the nurse will try calling you twice from a withheld number, and if you miss both of those calls, you will need to give us a call back to rebook the appointment, as you won't be able to collect the tablets or have them posted until that call has been completed.

Hannah:

Okay. Yeah.

SP:
All right. So, please be in a private and quiet place for the appointment, and you must not be driving or using hands-free.

Hannah:
Okay. Yeah.

SP:
Okay. For your safety and so that you can legally consent to your treatment, please don't use any recreational drugs or alcohol for 24 hours before your appointment. And if you did appear to be under the influence, it would be cancelled.

Hannah:
Okay. Yeah.

SP:
All right. So, you can choose to collect the medication from the center following your appointment, or we can post it to your home address.

Hannah:
Okay.

SP:
Which option do you think you might prefer?

Hannah:
The posting, please.

SP:
Yeah, no problem at all. So, if you're traveling anywhere, we advise that you read any small print related to any travel tickets, as it may mean that you need to declare that you've had medical treatment before you travel.

Hannah:
Right.

SP:
We also recommend that you don't participate in any strenuous activity until you've passed your pregnancy, and that includes physical activity and sports.

Hannah:
Okay. Yeah.

SP:
Okay. And all aftercare will be explained by the nurse.

Hannah:
Mm-hmm (affirmative). Okay.

SP:
Okay. Do you feel that you've understood everything so far?

Hannah:
Yeah. Yeah.

SP:
Lovely. Do you have any questions at all for me, Hannah?

Hannah:
No. Just when will the phone call from the nurse be?

SP:
Yes. So, as I said, we'll have to make that appointment at the end of the consultation, I just wanted to make sure that you are okay with the treatment and what to expect, before we move on.

Hannah:
Yeah. Yeah. Yeah, that's fine. Yeah.

SP:
Yeah. Okay. So, if you need more information at any point, have a look at mariestopes.org.uk.

Hannah:
Okay. Yeah.

SP:
But now that I've gathered everything, we can go ahead and make an appointment.

Hannah:
Okay.

SP:
So, you would like to have postage?

Hannah:
Yeah.

SP:
Let's have a look. So, I do have some appointments available tomorrow via phone call with postage. What sort of time is going to be best for you?

Hannah:
Okay. I mean, I'm work in the day. Are there any evening ones?

SP:

Unfortunately not. So, the latest would be 25 past two, and the earliest I've got is 8:50.

Hannah:
Could I do maybe the 8:50 one, I can go into work after then, so, yeah.

SP:
Yeah. Yeah, no problem. So, what I'll do for you now is just send you a text message to confirm this appointment at 8:50 tomorrow morning and that will also contain that link. So, the information for you to have a read of before your appointment tomorrow.

Hannah:
Okay. Great. Yeah.

SP:
So, once that phone call has been completed, the nurse will then put your medication in the post to you the same day. So, we just ask that you do allow up to five working days for it to arrive, as it is really difficult to estimate exactly how long it will take.

Hannah:
Okay.

SP:
But yeah, if you haven't received it after those five days, please do get in touch.

Hannah:
Okay. Great.

SP:
All right. So, due to the current situation with coronavirus, it may be that we need to cancel the appointment, but if we were to do that, we will contact you by phone and look for alternatives. So, just really to reassure you that you wouldn't be left without an appointment. If you do become unwell yourself prior to that ... No, I don't need to say that because you're not coming to us, are you? No.

Hannah:
No.

SP:
Yeah. You're staying very at home and receiving it in the post. So, yeah that's everything.

Hannah:
Okay. Great.

SP:
So, Hannah, I just sent those text messages across to you. Have you received those okay?

Hannah:
Yeah. I heard a little beep. I can't see it, but I think they came through. Yeah.

SP:
Okay, perfect. So, we'll speak to you at 8:50 tomorrow morning and then pop your medication in the post, once that phone call's complete. Okay?

Hannah:
Okay, great. Thank you.

SP:
No problem. If you need anything else from us, we are here from seven to 11 for any booking or appointment queries. And we do have nurses here 24 hours a days as well, if you need medical advice.

Hannah:
Okay. Great.

SP:
All right. Thanks so much for your time today, Hannah. I wish you all the best for your treatment.

Hannah:
Okay. Okay. Thanks very much.

SP:
All right. Take care. Bye-bye.

Hannah:
Okay. Thanks. Bye.

SP:
Bye.

Hannah:
That was a call with Marie Stopes International. The time now is 7:39 PM and it's the 29th of June, 2020.

CT6 - PO4 - 2020-06-19 - BPAS - Call1 – Audio

[KD redacted client surname and address, and service provider name ###]

Speaker 1:
So, today's date is the 19th of June, 2020, and it's 10:37 AM right now. And I'm making a call to BPAS.

Speaker 2:
Thank you for calling BPAS. If you have not been contacted by us, assume your appointment is going ahead as planned. You will be contacted by the clinic if this changes. This booking line is used for urgent queries and bookings. We thank you for your patience during this busy period. If in the last seven days, you have developed a new continuous cough or a high temperature, please inform the advisor when you are connected. If you already have an appointment booked in a clinic, please do not attend. If this affects you, and you have not already done so, please seek advice from NHS one, one, one online, and call us back to reschedule if necessary. We provide a confidential service and any information provided will be kept on a safe and secure system. Calls may be recorded for training and quality purposes. We advise that you have your GP details to hand. In order to provide your care, we may need to share some information with the NHS or other providers.

Speaker 2:
We would like to reassure you that information received will be kept confidential. We would generally advise that you don't bring children with you to your appointment. However, if that is difficult for you, please inform the advisor. We would like to send you communications about [inaudible 00:01:40] and ask you about your experience at BPAS. An advisor will ask your permission at the end of the call. You may withdraw permission at any time. Please press one for new booking, two for general information, three if you're an existing client, four if you have had treatments and would like to speak to our after care team, five if you are a GP or health care professional. Please press zero if you would like to hear these options again.

Speaker 2:
No digit has been selected. Please, we advise that you have your GP details and a pen and paper at hand. Please disclose all medical conditions. If we do not have the correct details, it may delay your treatment.

SP:
Good morning. This is SP. How can I help?

Anna:
Hi. I'm wondering if I can make an arrangement to have some home abortion pills sent to me. I'm pregnant, and I don't want it at the moment.

SP:
What we need to do first of all, is if you want them sent to your home, we'll have to do telephone consultation and set up a time for you with a nurse, and then she can discuss sending them out to you. So, I'll go ahead and take some details. So, can I take your first name?

Anna:
Anna.

SP:
Is that what the double N?

Anna:
Yes.

SP:
And what surname?

Anna:
###.

SP:
was that at the end?

Anna:
Yes.

SP:
And the date of birth?

Anna:
The 1st of February, 1998.

SP:
Okay. And your post code?

Anna:
It's ###.

SP:
And what was the first line of your address?

Anna:
###

SP:
So, your address didn't automatically come up on our system. Let me double check we've got everything right. So your first name Anna. That's A-N-N-A, your surname. That's ###.

Anna:
Yep.

SP:
And your date of birth is the 1st of February 1998.

Anna:
Yeah.

SP:
Yeah, I think that's fine. So what was the name of your GP practice?

Anna:
It's Links Road Surgery.

SP:
Links Road Surgery. [crosstalk 00:04:33].

Anna:
It's Portslade, but can they not be contacted? I don't really want anyone else to know.

SP:
Yes, that's fine. I just put no down to any contact with the GP. Did you just went and find us online, did you?

Anna:
Yeah, I just went online.

SP:
That's fine. That is all funded through the NHS for you at no cost to yourself, with us. So I will need to give you a booking reference number. So, you've got somewhere that you could jot this down?

Anna:
Yeah. I have.

SP:
The number is two, three

Anna:
Two, three

SP:
Five, two

Anna:
Five, two

SP:
Six double nine

Anna:
Six double nine

SP:
So, keep that number safe. If you ever need to contact us again in the future, or we contact you, we'd always ask for that reference number. We would also ask for a password. So could I take a memorable word as a password for you?

Anna:
Yep, just trying to think of one. I'm just going to say umbrella. I'll use that as a memorable word.

SP:
And we would also need a contract number, so is the one that you're calling on a good number for you?

Anna:
Yeah. This is a good number.

SP:
[redacted]?

Anna:
Yeah, that's right.

SP:
In the future, are we okay to contact you at any time and leave voicemails on that number?

Anna:
When will I get the call?

SP:
And so I'll put you in for a specific slot for the call, but this is just like in general, if we needed to contact you about any future appointments or anything, are we just okay to do it at anytime and leave voicemails, or would you prefer like daytime or evening?

Anna:
Yeah, you can call any time and leave a voicemail.

SP:
That's fine. So before [inaudible 00:06:56] just need to go through a few medical questions. So when was the first day of your last period?

Anna:
It was on the 17th of April.

SP:
Okay. And what was your height and your weight?

Anna:
My height is five foot six, and my weight is nine stone seven.

SP:
And have you got any medical conditions?

Anna:
No.

SP:
Do you take any prescribed medication?

Anna:
No.

SP:
Any asthma or allergies?

Anna:
No.

SP:
Any special needs or disabilities?

Anna:
No.

SP:
Have you ever had a baby born by C section before?

Anna:
No.

SP:
And have you taken a positive pregnancy test?

Anna:
Yeah, I have.

SP:
So, just have a look and see what sort of time we can get you an appointment. We can do an appointment today. We could do one o'clock or 3:15, or it would then be tomorrow.

Anna:
Can I do today at one o'clock?

SP:
Yeah. So, that's today at one o'clock [inaudible 00:08:34]. That's going to last up to 40 minutes with a nurse. She'll do a medical assessment with you, talk through all of your options, and talk about arranging some treatment. If you could try to be available about 30 minutes, either side at one o'clock. It's just in case they're a bit early or a bit late. And then, when they do call you, it's going to

come from a [inaudible 00:08:56] number, and they will be asking for that reference number and password from you as well.

Anna:
Okay. No problem.

SP:
All right, so did you want any appointment reminders by text or by email?

Anna:
You can send one by text. That will be fine.

SP:
Okay. And I do need to ask a few questions about feedback if that's okay. So in the future, can we contact you at all by telephone or by text about any feedback, [inaudible 00:09:32] or fund raising or would you prefer us not to?

Anna:
I prefer you not to.

SP:
That's fine. All right. That's all. So that's for today at one o'clock. Have you got any other questions at all?

Anna:
No, that's okay.

SP:
All booked. Take care.

Anna:
Okay, thank you.

SP:
Bye.

Anna:
Bye.

[KD redacted client surname and address, and service provider name ###]

SP:
Hello. Hi, my name's SP. I'm one of the nurses calling from BPAS. Can you talk?

Anna:
Yes, I can talk now.

SP:
Hello, hi.

Anna:
Hi.

SP:
I've just called to do your consultation over the phone. Is that all right?

Anna:
Yeah, that's fine, thanks.

SP:
Perfect. Lovely. Thank you. Would you like to just tell me what your safe word is?

Anna:
It's umbrella.

SP:
Lovely. Thank you. Just your full name and date of birth?

Anna:
It's Anna, and my date of birth is the 1st of February 1998.

SP:
Lovely. How are you feeling?

Anna:
Yeah, I'm good. I'm good, thank you.

SP:
Good. Lovely. So we'll just start by just doing some admin bits, so just how we can contact you, basically. So obviously your mobile, your voicemail's okay. Text is all right. Can we post to you?

Anna:
Yeah, you can post to me.

SP:
Okay. That's fine. So we've got ###, is that right?

Anna:
Yes. Are you going to put the organization name on the post?

SP:
No. The only thing we post to you potentially will be your treatment, if you hit that criteria, and it will come in just a plain cardboard box.

Anna:
Okay, thank you. That's good to know.

SP:
Can we email you?

Anna:
Yes, you can email me.

SP:
What is your email address?

Anna:
It's Anna, A-N-N-A, gc, letters G-C.

SP:
G-C, yeah.

Anna:
###.

SP:
So G-C, was that?

Anna:
Yes. Annagc###@gmail.com.

SP:
Lovely. Thank you. That over. Then, can we let your GP know if we need to?

Anna:
I'd rather you didn't let my GP know.

SP:
Yeah, that's fine.

Anna:
Thank you.

SP:
Good. Lovely. Then we just need an immediate contact from you, so someone we would be able to get in contact with if we can't get hold of you. Who would that be?

Anna:
I don't really want anyone else to know. Is it okay for you to just contact me?

SP:
It would literally just be for an emergency, that's all, so if anything went wrong and we needed to contact someone. It's very unlikely we would have that, and we would never tell anybody anything unless we absolutely had to, if there was a real emergency. So it could just be anybody, a friend is fine.

Anna:
Can I get back to you on that one because I haven't really told anyone at the moment.

SP:
Yeah, that's fine. That's okay.

Anna:
Thank you.

SP:
Do you have any allergies?

Anna:
No.

SP:
No. That's fine. Okay. All right. Lovely. Then just some demographic information as well. So have you got a partner?

Anna:
No.

SP:
Which country were you born in?

Anna:
The U.K.

SP:
England, was it?

Anna:
Yes.

SP:
Yeah. What would you describe your ethnic origin as?

Anna:
White British.

SP:
Lovely. And sexual orientation?

Anna:
Heterosexual.

SP:
Do you have any religious beliefs?

Anna:
No.

SP:
Do you have any disabilities?

Anna:
No.

SP:
Lovely. Thank you. Okay. So we'll just move onto the first bit then. So it's just about your decision-making process. So have you made a decision regarding your pregnancy yet?

Anna:
Yeah, I don't want it.

SP:
Okay. What are some of the reasons that you wanted to have a termination?

Anna:
I'm still studying right now and I'm just not ready. It's not going to help me start my career. I just don't feel ready right now.

SP:
Okay, yeah. Education and career. So I've put continuing with this pregnancy would have a negative impact on your mental health. Would you say that's true?

Anna:
Yeah.

SP:
Who do you live with?

Anna:
I'm living with my family, my parents.

SP:
Lives with parents. And you've not told anybody?

Anna:
No.

SP:
[inaudible 00:04:00] It's completely up to you obviously but we always recommend that you do tell someone just in case anything goes wrong or you need to go to hospital for any reason. Of course, that's completely up to you, but just in case anything does go wrong. So just consider that if you want to.

Anna:
Okay.

SP:
Would you say you have a good support network from friends and family, that kind of thing?

Anna:
Yeah, I do.

SP:
Has a good support network. Then the person concerned, so obviously you've not told them, is there any reason you haven't told them, do you feel safe with them, that kind of thing?

Anna:
Yeah. I feel fine. Everything's fine. I'm just not ready right now.

SP:
That's fine. Okay. Do you feel safe at home?

Anna:
Yeah, I do.

SP:
You're sure of your decision are you?

Anna:
Pardon? Sorry?

SP:
Are you sure of your decision, would you say?

Anna:
Yeah, I'm definitely sure.

SP:
Yeah, lovely. Do you think you'd want to have any counseling at all?

Anna:
No. I think... no.

SP:
That's fine. If you change your mind then it's all over the phone, you could just let me know and we can book you in for something. So that's afterwards on the form. That's fine.

Anna:
Okay.

SP:
Okay, lovely. So we'll move onto your medical history now. So you've said you're not allergic to anything, is that right?

Anna:
Yeah, that's right. I'm not allergic.

SP:
Lovely. Cool. And then what was the first day of your last period?

Anna:
It was the 1st of May. Yesterday I gave a different date but actually I've looked at my app and actually I made a mistake and it was the 1st of May.

SP:
That's okay. I'll change that in just a second. So one, two, three, four, five ... Okay. How was that period? Was it normal? Would you say it was shorter or lighter than usual?

Anna:
I think it was normal.

SP:
Okay. Normal period, and came at the time it was expected, was it?

Anna:
Yeah.

SP:
Okay. As expected. Okay, lovely. You're sure of that date because you've got a period tracker app. How long does your period usually last for? How many days do you bleed for usually?

Anna:
Between 28 and 30 days usually.

SP:
Okay. But how many days do you bleed for when you have a period?

Anna:
Oh. For about five days.

SP:
Five days. That's fine. Lovely. Would you describe them as regular?

Anna:
Yeah.

SP:
Yeah. Lovely. Is this the first time you've been pregnant?

Anna:
Yeah, it is.

SP:
Have you had a scan at all for this pregnancy?

Anna:
No.

SP:
No. Have you had any pain or bleeding?

Anna:
No. I haven't had any bleeding, no. I haven't had anything.

SP:
No pain either?

Anna:
No. I've been a little bit nauseous at times, but no pain.

SP:
Okay. Good. Okay, lovely. Have you ever had any surgeries before, where you've been put to sleep?

Anna:
No.

SP:
No. Lovely. Do you know of anybody in your family's had any problems with any anesthetic before?

Anna:
No.

SP:
Lovely. Do you use any prescription medicines?

Anna:
No, I don't.

SP:
Do you have any herbal or homeopathic remedies that you use?

Anna:
No.

SP:
No, that's fine. Do you have any health problems you can think of off the top of your head?

Anna:
No, I haven't.

SP:
No, okay. Lovely. So what I'm going to do is, I'm going to go through a really long list of health problems. If you've ever had any of these things, or currently do, then just stop me and we'll talk about them. Okay?

Anna:
Mm-hmm (affirmative).

SP:
So, asthma, diabetes, other breathing problems, high blood pressure, heart disease, heart valve problems, heart attack or stroke, migraine headaches, blood clots in your legs, arms or lungs, so DVT, bleeding disorders like hemophilia, clotting disorders like factor V Leiden, anemia, sickle cell disease, thalassemia, seizures, fits or epilepsy brain tumors, mental health problems, adrenal problems, liver problems, gallbladder problems, any other gastrointestinal problems or thyroid problems. Any of those?

Anna:
No.

SP:
Lovely. Have you ever had cancer of any kind?

Anna:
No.

SP:
No. That's fine. Have you had a smear test? I think you're a bit too young for a smear test.

Anna:
Yeah, I haven't.

SP:
Have you ever had any treatment to your cervix before for any reason?

Anna:
No.

SP:
No. Have you been told you've got fibroids or an abnormally shaped uterus?

Anna:
No.

SP:
No. That's fine. Have you ever been told you've got a pelvic infection or sexually transmitted infection?

Anna:
No.

SP:
Have you ever been told you've got hepatitis or HIV or AIDS?

Anna:
No.

SP:
Right, lovely. Anything else you can think of that we've not mentioned?

Anna:
Yeah, I haven't got anything else.

SP:
Lovely. Do you smoke?

Anna:
No.

SP:
Do you drink?

Anna:
No. I mean, like-

SP:
Do-

Anna:

No, I don't drink, no.

SP:
No, that's fine. Do you currently, or have you in the past, used recreational drugs?

Anna:
No.

SP:
Lovely. When you got pregnant, were you using contraception?

Anna:
I was using condoms.

SP:
Condoms. But you've not got a coil in place or anything like that?

Anna:
No.

SP:
No. Perfect. That's all good. Cool. Okay. So have you done any research on our website to see about the sort of treatments? Do you know anything about it?

Anna:
I've had a look at the videos online.

SP:
Perfect. Okay. So what it would be, because we're quite sure of your dates, it's about seven weeks-ish, so that would mean that you would have the early medical abortion, which is using the tablets. So we'd be able to post that to you as well, if you're comfortable, otherwise you can come into a clinic to pick it up. It's up to you as to what you want to do.

SP:
But either way, what would happen is, you would have two boxes of tablets, one of which you just take on the first day that you want to start your abortion. So we prefer you start that on the day that you receive your package. You just swallow that one. What that does is it just stops the hormones going to the pregnancy and it just softens up your cervix ever so slightly. Most people don't get any side-effects at all from that but some people do get a little bit of cramping and bleeding. Others do feel a little bit nauseous, but we'd still want you to continue with the termination even if you did have that cramping and bleeding. But, like I said, most people don't get anything at all.

SP:
Then you need to wait between 24 and 48 hours, and then you will need to open the second box of tablets. In that box there are six tablets. Four of those you need to insert as high as possible inside of your vagina, and then two hours later, the following two. There's six in total. They're very small tablets, they're only about the size of the top of your finger and they're quite easy to insert as well. [crosstalk 00:10:51]

Anna:
Okay. Is it only that way you can use them?

SP:
You can put them in your mouth as well but they don't taste very nice and obviously they don't absorb as well as being in your vagina.

Anna:
Oh, okay.

SP:
So we always recommend that you put them inside, but if you're uncomfortable with that, then you can let them dissolve in your mouth. But obviously, if you are feeling sick already and you do vomit, then you can't really put them back inside your mouth again. So it's a little bit difficult and less likely to be completely successful. But, like I said, if you're uncomfortable with doing that, then of course you can put them in your mouth, and it comes with instructions as well so you'll be able to look at that as well. Okay?

Anna:
Okay. Yeah, okay.

SP:
So once those are in, generally people start to bleed within a couple of hours. Obviously everybody's different, so it can take longer or shorter for each person. Then when you do start to bleed, it will be quite heavy and painful for at least a few hours. We do want you bleeding fairly heavily because we obviously want you to be passing the pregnancy, but we don't want you to be bleeding too heavily. So if you're ever completely soaking two or more really thick sanitary towels in an hour, and you do that for two hours consecutively, that's when you need to be going to hospital. Otherwise, we do have an aftercare line, and that's open 24 hours a day, seven days a week, and they'll be able to help you. So they're all nurses and midwives and they'll be able to give you support if you do need that as well.

Anna:
So how long does the bleeding last for?

SP:
Generally between six to eight hours but, like I said, everybody is different. So you'll notice when you pass the pregnancy it will be quite clotty and then once you've passed the pregnancy, generally your bleeding does get lighter as well, but it does need to carry on for at least four days and is likely to go on for a couple of weeks afterwards.

Anna:
Okay.

SP:
We also give you some codeine as well which is a really strong painkiller. Have you ever had codeine before?

Anna:
No, I haven't.

SP:
No. No, that's fine. So what I usually say to people who've not had codeine before, just try one. It says on the packet you can have one to two every four to six hours but codeine can make you feel a little bit sick and it can also make your head feel a bit spinny, that kind of thing. So if you've not had it before, maybe just have one, and you can have paracetamol and ibuprofen with that as well. Obviously if you're still in pain, have another codeine, that's absolutely fine. Then things like hot water bottles and baths really do help as well. But if you ever feel out of control with the pain or the bleeding or anything like that, you need to get yourself to hospital because they'll be able to help you there as well. Okay?

Anna:
Okay.

SP:
All right? So, like I said, once you've passed the pregnancy, you need to bleed for at least four days, and then that's likely to go on for a few weeks. We'll also provide you with a pregnancy test to do three weeks later as well. It's one of our ones. If you test positive, then you need to contact us: negative, you don't need to. Make sure that you just don't use any shop bought pregnancy tests because they're a lot stronger than the ones we use, so they're likely to pick up on the old pregnancy hormones which means you might get a false positive. Okay?

Anna:
Okay. Yeah, okay.

SP:
All right? Does that make sense?

Anna:
Yeah, it makes sense. Okay.

SP:
Have you got any questions about that at all?

Anna:
So you were saying that I can take ibuprofen, paracetamol and the codeine at the same time?

SP:
And codeine, that's it, yeah.

Anna:
Okay.

SP:
Okay?

Anna:
Yeah, okay.

SP:
Lovely. All right. So we need to go through a consent form, and it just goes through the risks of the procedure.

Anna:
Okay.

SP:
Okay?

Anna:
Mm-hmm (affirmative).

SP:
I'm just going to get that on my computer. Two seconds. All right. So one of the first risks is an inaccurate period estimation. Obviously we're quite sure of yours. So that shouldn't be a problem but obviously if your period was wrong, then things might be slightly more developed and the treatment might not be appropriate for you. But as long as you're sure, you know it was a normal period and it came at the right time, then things should be okay.

SP:
Unpredictable: time to complete the procedure is variable. That means we don't know when you're going to start bleeding or finish, unfortunately.

SP:
Side-effects of the drug. So commonly nausea, vomiting, diarrhea, headache, dizziness, fever or chills.

SP:
Retained products of conception. That's when the pregnancy's ended, there's tissue left behind inside of the uterus. You'll know that because your pregnancy test can come back as positive. So it's really important you do call us if that is positive.

Anna:
Okay.

SP:
Infection is about two in 1,000. We don't give out antibiotics anymore because of antibiotic resistance. It's just up to you to watch out for signs. So that's if you get any smelly discharge and just feeling really under the weather or you've got abdominal pain that goes on for a few days afterwards, that kind of thing, then please do get in contact with your doctor to see if they think you need any antibiotics.

Anna:

Okay.

SP:
Unpredictable: irregular or prolonged bleeding is variable, as is pain. We've spoken about that.

SP:
Continuing pregnancy is rare: It's less than one in 100 people but it can happen obviously. So you need to call us if your pregnancy test is positive and also if you feel like your treatment hasn't gone how you would have expected it to go. So if you have lighter bleeding than expected, or no bleeding, then please do call us, and also if you have less than four days of bleeding. Hemorrhage is very heavy bleeding, and we've talked about that as well, what to do there.

SP:
Undiagnosed ectopic pregnancy is one in 7,000 people, and that's when a pregnancy's outside of the uterus, but you've not got any signs of that. So you've not had any pain or bleeding, so I'm not worried about that.

SP:
Psychological problems are variable. We've mentioned counseling.

SP:
And something which is on every consent form is death, which is less than one in 100,000 people. Okay?

Anna:
Okay.

SP:
Then extra procedures that may become necessary is a surgical abortion or uterine aspiration if you had retained products of conception or a continuing pregnancy; A blood transfusion if you were to lose too much blood; A laparoscopy, which is exploratory surgery into your abdomen; and then only in the case to save your life would they do a hysterectomy. That's when they take your womb away. That's two in 100,000 people, so really, really rare. Okay?

Anna:
Okay.

SP:
Then just a couple of extra bits. So the second part of the treatment, the Misoprostol, is not licensed for abortion but doctors are allowed to prescribe it for this purpose, and it's been used worldwide safely and effectively for several years.

SP:
I'll email over this consent form to you. You don't need to do anything with it, it's just for your records. Then anything else that may be done in hospital will only be done in order to save your life or in your best interests. Okay?

Anna:

Yeah, okay.

SP:
All right? Do you have any questions about that one at all?

Anna:
No. I think I understand it.

SP:
Okay. Perfect. Then what's your plan for contraception?

Anna:
What, after continuing-

SP:
Yeah.

Anna:
I haven't really thought about it too much. I think I'm just going to still use condoms. I don't think I'm going to use pills or anything.

SP:
Okay. Have you been on the pill before?

Anna:
No. I don't really want to use the pill.

SP:
No, that's fine. What are some of the reasons that you don't want to, just out of interest?

Anna:
I'm just a bit worried about it messing with my hormones a bit. I'm a bit more wary of using the pill. I know it works but I'm more comfortable just using condoms.

SP:
Yeah, that's fine. Okay. If you do change your mind, just have a little chat with your GP and they'll be able to prescribe something or see what your options for other things. There's things like coils and things that are non-hormonal, but that's fine, you can have a think about that in the future if you want to.

Anna:
Okay.

SP:
Okay. So do you have any questions about anything at all before I process this?

Anna:
I think I'm okay. I think that's good. I think you answered most of my questions.

SP:
Perfect. Okay. So I'll email over your consent form and I'll also give you the Brighton clinic number as well, so if you do have any questions or anything like that, then call those. They are open today until about 1:00 P.M.-ish, I would say, and then open again on Tuesday. If there's anything in between that you need to ask any questions, just call the booking line that you booked this consultation in.

SP:
Your box should arrive in the next one to three days-ish. I've put your mobile number as there's tracking a thing as well, so you'll be able to see what the status is there as well.

Anna:
Okay, brilliant. Thank you.

SP:
Okay? All right then. It was nice to speak to you, and good luck with everything.

Anna:
Thank you. For the consent form, do I need to sign it before-

SP:
No, no. It's just for your record. I don't have to send it if you don't want me to.

Anna:
Okay. Yeah, you can send it to me, yeah.

SP:
Okay. It's just have a little look at. All right?

Anna:
All right. Thank you.

SP:
Okay. Thank you very much. Bye.

Anna:
Thank you. Bye.