Teletriage for Sexual and Reproductive Healthcare Services in Response to COVID-19

Triage Integration Considerations to Prioritise Vulnerable Groups

Document One of Five

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Contents

Background

As a result of the COVID-19 outbreak, the provision of Sexual and Reproductive Healthcare (SRH) services has changed significantly. One of the most striking innovations that has taken place is the expansion of telehealth and telemedicine services. These changes have been regarded positively by service users and healthcare practitioners, and many elements are likely to be adopted in the long term. Going forward, it is important that these changes accommodate the needs of the population, particularly vulnerable individuals who may not have access to digital services.

This document is part one in a suite of five documents providing advice for teletriage for vulnerable groups. These documents provide tips for setting up or expanding telehealth / telemedicine SRH services, how best to mitigate risk, how to prioritise vulnerable groups, and when to escalate. In the context of these documents, telehealth refers to telephone contact, and telemedicine refers to end to end care, either via telephone or video conferencing.

These documents have been developed by Mary Kyle, Senior Sexual Health Advisor at PHE National Sexual Health Helpline, in collaboration with the Faculty of Sexual and Reproductive Healthcare (FSRH), the British Association for Sexual Health and HIV (BASHH), Public Health England (PHE), and Brook. They are not official guidance by these organisations, but rather aim to support services to deliver high-quality, safe SRH care remotely. They highlight lessons learned from the National Sexual Health Helpline and local service provision, which SRH services should consider to support the creation of a sustainable, resilient teletriage solution that can respond to local priorities.

This suite of documents is aimed at clinical leads, safeguarding leads and managers assessing the continued use of teletriage for SRH services. Their aim is to generate discussion among those responsible for managing workflow and staff training to consider issues such as designing algorithms for triage boundaries and skills gap analysis for their local service. This will ensure that vulnerable groups are prioritised, and will maximise opportunity to identify high risk and safeguarding issues. The final document in the series is aimed at healthcare practitioners, and provides tips for call flows.

Services may not be able to adapt every element of these documents into their own teletriage models. The suitability of the advice will depend on existing technology and patient need. These documents should thus be used to support the design of services as appropriate.

Aims

This document provides a list of considerations for services when setting up or expanding telehealth / telemedicine SRH services. It outlines considerations that should be taken before designing a model for teletriage. Examples of teletriage models, minimum skills requirements, essential checklists for remote support, and call handling skills are included.

First Considerations

Technology: Capacity for telehealth and telemedicine services will depend on technology services available for healthcare practitioners and service users. This includes amending online booking services to enable telephone appointments, deciding which services are suitable for automation, utilising online services for ordering tests, and enabling patients to prefill sexual health history electronically before their appointment. Whatever solution is adopted must be technologically stable and secure, sustainable, and have built-in contingency and resilience.

Medicine provision: Easy access to free emergency contraception and treatment is essential, particularly for those with increased vulnerabilities. Contingencies for postal delay should be considered, e.g. through the use of local pick up points in rural communities, and/or the use of hub spaces as pick up points.

Mental health support for distressed individuals: Services that previously offered mental health support should consider whether they have capacity to continue to provide this support, as those diagnosed without the normal explanations and reassurance are increasingly vulnerable. Mental health support services are particularly suitable for telephone consultation.

Outreach services: In the absence of full outreach capacity to vulnerable groups, there should be consideration of best practice examples from other areas, e.g. creating “Sexual Health Champions” within homelessness teams, drug and alcohol teams, accommodation support workers.

Training and support: The COVID-19 pandemic has resulted in significant changes to service provision. Training should be available for staff to support them in adapting to these changes.

Recognise limitations: Service users’ suitability and comfort with teleconsultations should be taken into consideration. Not all will be happy or able to participate in a remote consultation. Accommodating those for whom English is a second language (ESL) can be impossible if services do not have instant access to an independent interpreter. The National Sexual Health Helpline uses Language Line, but this requires some telephony access and there is a cost per contact. Teletriage will also not be suited to those with hearing difficulties.

Develop standards: To minimise risk to staff and service users, all processes that have evolved through the COVID-19 response must be reviewed and measured against minimum standards. It is important to recognise that ad hoc solutions can quickly become “accepted practice” and this has risk.

Health and safety: As social distancing continues it is important that staff physical and emotional wellbeing is considered, and that Health and Safety Executive (HSE) responsibilities are fulfilled. As homeworking becomes part of working life, ad hoc solutions will become less sustainable.

Tolerance: Staff and service users have been flexible and tolerant of technological glitches, but as services are restored expectations will rise. Managing expectations by professionalising services will be key to longevity. Services should not assume that all staff will be automatically suited to telephone triage.

Plan for worst case scenario: As we face the possibility of exiting and entering different levels of restrictions, plans should allow ease of switching. Lessons learned from audits can inform the building of frameworks.

Designing a Model

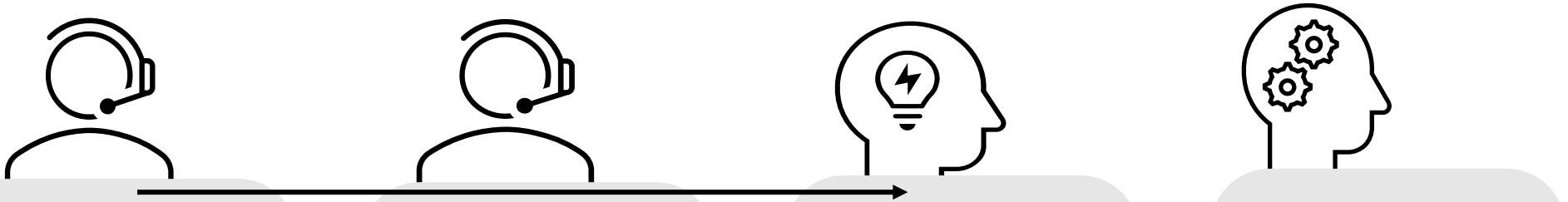
Proper use of triage can maximise service provision, but it requires a fully integrated approach. Triage boundaries require careful consideration to prevent long telehealth consultations followed by face-to-face (F2F). Services may design some call codes as auto F2F, e.g. complex contraception.

When designing a teletriage model, services should assess according to their service level, existing staff skills mix, and both physical and remote staff capacity. They must also consider whether they expect to triage all access via telephone, whether they will operate a tiered system, and if so, how many tiers. Finally, services should consider whether buildings not in use due to the increase in telehealth can be repurposed as pick up points for medication, or for alternative SRH services.

As most SRH staff are trained in motivational interviewing (MI) and brief intervention communication, and can adopt the same protocols for safeguarding, much of this decision making will be based on IT solution availability. In some services, all Tier 2 may work remotely, in which case the decision may be that all calls are routed to them routinely. As trained staff, they would need call handling skills to adapt and enhance their existing knowledge and to operate in a new environment.

Each service should design a triage model that maximises opportunity to have the most contact with vulnerable populations. Below is a possible triage flow. This example adopts a mixed model in which qualified staff conduct a ten-minute assessment and decide whether F2F is appropriate, or whether the call can be dealt with fully through remote consultation. An example of a call flow that builds in exploration of vulnerabilities and escalation is also provided.

Example Mixed Methods Triage Flow



T1 Reception

Staff provided with a triage algorithm

Signpost to online test ordering

Book appointments immediately for F2F if:

PEP

TOP

Under 16

EC

T2

- SHA/Nursing staff assessment.
- History taking
- All symptomatic: refer to F2 or provision of test and treat.
- Oral contraception renewal/ contraception discussion

T2 F2F

Available for booked appointments, either from reception algorithm or from T2 teletriage

Senior Clinical & Safeguarding

Escalations and procedures

Video consultations

Case Study from National Sexual Health Helpline

Female caller wanting to know where to get "the morning after pill". Her local clinic is closed because of COVID-19. "That's where I normally get it, but I had to buy it from pharmacy last week and it cost a fortune, I don't have enough money to buy it again." On discussion with the adviser, the caller reports that she can't go to her GP as she "has already got it once from there this week". "It's so embarrassing…and the nurse has to call you back, but you don't know when and you can't always answer in the house as my mum could hear and she will go nuts that I've been having sex outside and seeing my boyfriend as we are supposed to be in lockdown cause my brother has asthma."

Following the call flow below the adviser ascertained that the client was 15, as was her boyfriend. The caller reported that neither of them had any previous sexual contact, including oral sex. The adviser found the contact number of the local hub triage and explained the process. A discussion followed about condom use and the problems her boyfriend had using them. The adviser explained different fits were available and that the caller should discuss this with the clinic when she got through, which led onto a wider discussion on contraceptive choices. The adviser reassured the caller that it was safe to discuss contraception with the clinic, even if under 16, explaining the role of the clinic. In order to reinforce the safe sex message and understanding, the adviser walked the caller through the relevant sections of the Brook website and suggested she and her boyfriend explore it together. A discussion was also had about "sex outdoors and safety." This allowed the adviser to assess understanding and consent. The adviser also acknowledged the risks of any close contact outside the family group as a risk to her brother re COVID-19. The caller was invited to call back if she had any difficulty accessing services, or wanted to discuss anything further.

Take-aways:

- Take the time to do the complete discussion
- Don't respond to the question only
- Think Package: Pregnancy test, condoms, STI Testing Kit, progestogen-only pill (POP); further broader sexual health and wellbeing advice and safeguarding check

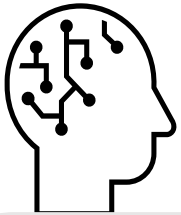
Example Call Flow

Soft Welcome

Provide a full salutation:

"Good Morning, you are through to the…how can we help?"

This gives the client time to collect their thoughts after a lengthy hold or sudden connection. Remember, we only have our voice to convey "a safe space".

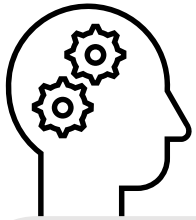


Ask

- *Is it alright to ask you some questions so I can make sure you get the right support?*
- *Can I ask your age?*
- *Are you able to answer without being overheard?*
- *When was the UPSI?*
- *Are you using any regular contraception?*
- *Is this a new sexual partner?*
- *Have either of you had previous sexual partners?*
- *Have you both had a recent STI test?*

Assist

- If not able to talk, ask if they can go somewhere more private and call back?
- **If under 16 escalate!**
- If the caller is unable to secure privacy, ask if they are safe?
- Consider time frames and best options available.
- Consider EC impact on existing contraception
- Discuss ongoing contraception options
- Suggest testing for STI / pregnancy if appropriate
- Test consent



Act

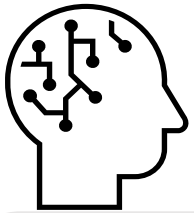
Has anything been said, or have you noticed hesitancy or reluctance?

You must consider whether a longer discussion, either with a senior or face to face, is required to ensure safeguarding responsibilities are fulfilled.

Minimum Skills Requirement at First Contact

Understanding the skills required to Make Every Contact Count MECC is critical to the triage process. There must be an opportunity at every stage to identify and escalate those belonging to vulnerable groups. Services usually use reception as a “gatekeeper”. If an inexperienced or untrained person answers the above call, the call flow could look like this:

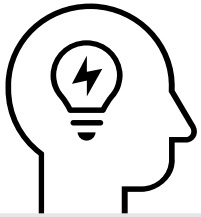
Hi, you are through to the clinic. How can I help?



How old are you?

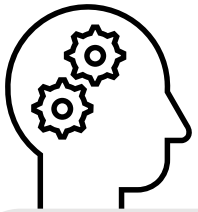
Can you come to the clinic to pick up medication?

Can you give us a mobile number so we can call if we need to?



We will text you a time to come and pick up your pill.

Do you need anything else?



No risk identification

Essential Checklist for Remote Consultations

Though many services adopted homeworking an emergency response to COVID-19, it is likely that homeworking will be adopted more widely beyond the pandemic. Full considerations for supporting staff working from home are explored in Document 2 of this suite. However, some issues must be considered as part of remote consultation preparation:

- A working space that prevents distraction, disruption or inadvertent disclosure of confidential information.
- Secure access to necessary records, library of protocol documents and guidance.
- Telephony solution that allows advisers to access support from colleagues during consultation.
- Rapid access to changing consultation method, if during the consultation something emerges that requires F2F consultation. Solutions will depend on service, but examples include ringfencing appointments, or a dedicated staff resource for emergent rota "duty drop in".
- A crisis escalation process. If during a call it becomes apparent that someone is in immediate danger, then no one adviser can deal with the caller and the escalation simultaneously. This is much more likely to happen during remote consultations, as the adviser is in the caller's environment.
- Contingency solutions for systems outages, telephony issues, IT issues etc.
- Sufficient time allocated for appointments
- A plan for supervision and support. This is particularly important for isolated staff dealing with emotive and often difficult subject matter in their own home.

Maximising Engagement in Remote Consultations

Fear of "missing something" in remote consultations is a common concern for healthcare practitioners. However, remote consultations have advantages if set up properly, and only require modest adaptations of existing protocols. Existing checklists for safeguarding should provide the template. Doing our job without non-verbal skills is the most difficult part of adapting our communication styles to maximise engagement. Consideration must be given to service users' and practitioners' comfort with communicating remotely:

- Service users cannot see providers smile as they are welcomed from reception. Tone and pace are thus important. If providers sound busy when they welcome service users, they are more likely to get brief incomplete information from questions and miss risk.
- Having a chat on the way into a consultation room to ease tension, and being able to see the person's demeanour, anxiety levels, distress or understanding of information is all part of the normal assessment. In telephone consultations, service users have not had time to come in, sit down and settle themselves with a little chat. For many practitioners, the loss of these guides will be intimidating and could shake self-confidence.
- Healthcare practitioners should be prepared for a slightly choppier start to remote conversations, and perhaps a flood of information. The anonymity some callers feel may make them more forthcoming.
- Before getting into the full discussion, set expectations on all calls and keep control. People can become angry if they go through a full consultation only to be told they must see someone else. If these expectations are set at the beginning of the call, service users are less likely to drop out.
- Healthcare practitioners can use verbal nods to show they are listening.
- Advisers should escalate to F2F if they feel it is necessary and should not feel pressure to "solve" everything.

FRAMES

The National Sexual Health Helpline uses an adaptation of the FRAMES model to keep control and flow of the call. For experienced SRH staff, going back to these basics will help ensure all that can be asked is asked. Six elements have been identified that were present in brief intervention clinical trials, and the acronym FRAMES was coined to summarize them (Miller and Sanchez, 1994). This has been adapted for call handling purposes.

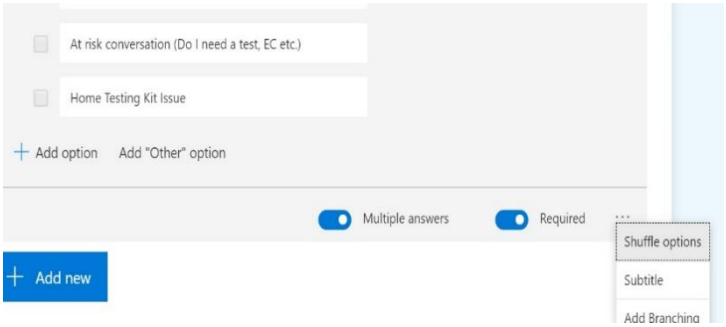
- Feedback – listening to how the service user is feeling to assess the areas of concern.
- Reason – using a balanced combination of open and closed questions to narrow down core areas of concern.
- Advice – using the information collected, and awareness of the service limitations, to understand primary concerns (can be addressed within tele environment) and secondary concerns (signposting, escalation safeguarding). Delivering tailored information.
- Menus – this is the most important area to concentrate effort, as this is where hidden concerns are most likely to be identified. Prior to giving recommended next steps, assess the following:
    - *Does the service user require further discussion to fully understand their needs or options?*
    - *Has the service user's emotional state become worse?*
    - *Does the service user require vulnerable person enhanced engagement / F2F?*
    - Offer appropriate national signpost for PIL alternatives, e.g. Brook, Sexwise
- Empathy – while advisers' information guides the service user towards next steps, advisers' tone and language guides the service user towards emotional stability
- Self-efficacy – check service user's understanding of next steps (i.e. understanding of local service, motivation to use signpost, buy in)

If we haven't got the Feedback right, which demonstrates reflection of the callers concerns, or the Empathy, which is our tone and creates a "safe space", then we are unlikely to be able to provide complete tailored Advice or get buy in on Menus. The Self-efficacy section gives you an opportunity to recap and check understanding of next steps, as well as promote safer sex and behaviour change. Always provide a signpost for caller to look at after discussion to ensure the reinforcing of key messages.

Priorities for the Restoration of SRH Services

Respondents to the BASHH Clinical Thermometer Survey (see Resources), conducted in May 2020, were asked to identify their priority for restoring SRH services. 76% identified Young Peoples Service as their priority. Using the table of priority groups identified by respondents, services can model Triage Algorithms for receptions staff, ensuring focus is on local service "Priority F2F" or "must talk with". Individual services will of course be best placed to identify their priorities.

There are electronic algorithm tools available throughout the wider NHS estate, including Pathways for NHS 111 triage, which may be adapted for other clinical areas in time, but at a local level a simple Microsoft Forms with branching would be quick and effective to set up. This allows individual services to set their priority. In the example below, when 'at risk conversation' is clicked, a F2F appointment is automatically set up. This removes a potential "fall through" of vulnerable clients at the reception point.



Results from BASHH Clinical Thermometer

Who are your local populations of concern or areas of priority?

Order of frequency cited as Top Priorities for Access as Services Re-open Safely (372 Responses)

76% of Services intend to restore Young People Services as their Top Priority Need

Young People Services
People with a history of domestic/other violence
Children & Adults registered vulnerable
MSM
Commercial Sex Workers
Women seeking LARC
Women with complex contraception needs
Homeless
People with Drug or Alcohol problems
People with no phone/internet access
Non- English speakers
People with Chemsex problems
People with Mental Health issues
People with learning disabilities
People with learning disabilities
People with a history of sexual assault

People with high risk symptoms needing examination
Care Leavers
PrEP Users/seekers
People living with physical disabilities
Migrants or Asylum seekers
Looked after children
People living with HIV
People with known untreated STIs
Women who want to attend our services
People with complex GUM issues
Rural people
NEETs
Locals
BAME

Resources:

Learning

https://www.rcn.org.uk/clinical-topics/supporting-behaviour-change/motivational-interviewing basic MI concepts

https://portal.e-lfh.org.uk/Catalogue/Index?HierarchyId=0_13_401&programmeId=13 communicating with young people (ELfH login required)

https://portal.e-lfh.org.uk/Catalogue/Index?HierarchyId=0_13_401&programmeId=13 Sexual Health & Young People (ELfH login required)

https://www.youtube.com/watch?v=urUMWbQR62o EC Telephone consultation training session

https://www.scie.org.uk/e-learning/communication-skills Communication Skills General for new start or non-healthcare trained staff

Guidance

https://www.adph.org.uk/2020/04/covid-19-prioritisation-of-sexual-reproductive-health-services/

https://www.fsrh.org/fsrh-and-covid-19-resources-and-information-for-srh/

https://www.bashh.org/covid-19-resources/

https://www.bhiva.org/Coronavirus-COVID-19

https://www.fsrh.org/standards-and-guidance/documents/fsrhbashh-standards-for-online-and-remote-providers-of-sexual/

https://www.fsrh.org/standards-and-guidance/documents/fsrh-service-standards-for-consultations-june-2020/

Additional

https://www.sps.nhs.uk/articles/reproductive-health-patient-group-direction-pgd-templates/ PGD Templates