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

Designing Triage to Prioritise Vulnerable Groups

Document Four 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 four 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 tele triage 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.

Aims

This document outlines considerations for setting up resilient triage facilities, dependent on existing infrastructure within local services. It explores set up, tips for triage in the absence of online services, and model flows. This document may be useful for senior managers, clinical leads, commissioners and local health authorities. It is designed to generate discussion on the model of triage that best facilitates the prioritisation of vulnerable groups in local services, and to build in contingency allowing for possible further restrictions with minimal disruption.

Decision Making Online - Set Up and Use

When setting up systems or workflows in a tele setting, some simple analysis is required to decide how to optimise output. The first step for is to take routinely provided services into consideration. A specific, local plan should then be developed, incorporating existing guidance from professional organisations, e.g. FSRH and BASHH. Logistics should also be taken into consideration, e.g. tech, staff, sites, suppliers, availability of testing labs, PPE etc.

Must Do Under 16 PEP Symptomatic	***Need To Do*** PREP Emergency LARC
Like to Do LARC Renewal Non Symptomatic	***Wait or Online*** Testing Repeat Scripts

***Example only**

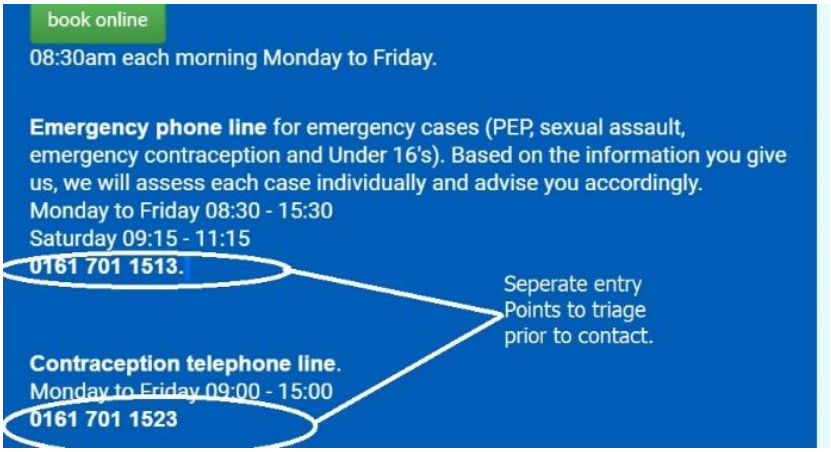
	SYSTEMS	SERVICES	STAFF	SUPPLIERS	SITES
ISSUES	5	3	1	8	0
GAPS	1. 2.	1. Power requirements have increased	1. Gap number one. 2. Gap number two	1. Supply backup for material F-Z	1. All sites covered
SOLUTIONS	1. Procure backup system 2. Replace backup system 3. Procure messaging backup	1. Backup power supply 2. Test all sites	1. Staff solution for mass absence	1. Massive contingency supply source required for all materials	1. No actions required.

Simple Gantt charting allows for a quick decision on issues such as site footprint and social distancing, staffing issues, and priority routing. Many sites are already up and running with their systems, but some have virtually no web-based triage. This will need to be part of the solution for prioritising vulnerable groups, and will shape who does what and how at the entry point. For example, the Northern SRH main website does top line triage.

First Considerations Post Analysis

Triage models must ensure that vulnerable groups get priority access. Northern SRH, for example, has simple triage built into their front page:

They have set active click areas on their page, and provided an emergency button to direct callers. This takes the user to this selection, which defines “an emergency”. These then give clear guidance to telephone triage numbers.



They have also provided specific inbound numbers, which allows calls to be directed more efficiently. The contraception line could be covered by T1 for clarification (e.g. reception/HCA resource), whereas the other number could be routed to T2 (clinical staff, SHA) for assessment. They also have an online booking system available.

How to Triage in the Absence of Online Triage

In some areas, services have not provided increased access to online services since the COVID-19 outbreak, and only a centralised number is provided. If these services have put all staff of mixed skilling on answering calls, which has been reported in some areas, then it is unlikely they are achieving the “optimum” workflow. Reception staff may well just be setting up call backs, whereas clinical staff are more likely to try and provide solutions. This becomes a lottery on inbound calls, with different lengths of engagement. T2 advisers are on and off the system dependent on complexity of presentation.

If services were to design a prioritisation method of triage in the absence of online services, then adapting the model flow below would help to efficiently route appointments. In order to achieve this flow, services must first understand capacity, as this allows a slide in provision dependent on available resource at any given time. Services should consider:

- Maximum daily F2F appointments, and whether this precludes anything other than “Must do”
- If not, what can be safely done end to end on telehealth. Decide boundaries
- How many emergency appointments are on hold, and whether these should be released at a certain point or whether staff should provide outbound call back
- If using telehealth, what contingencies are in place for service outages, either remote or onsite
- Maximum consultation time in order to maintain service provision and appointment system. Build in flex
- What can be moved to online only, and how quickly
- Has a spillover alternative agreement been identified - local GP’s, other clinics etc.

Model Flow in the Absence of Online Triage

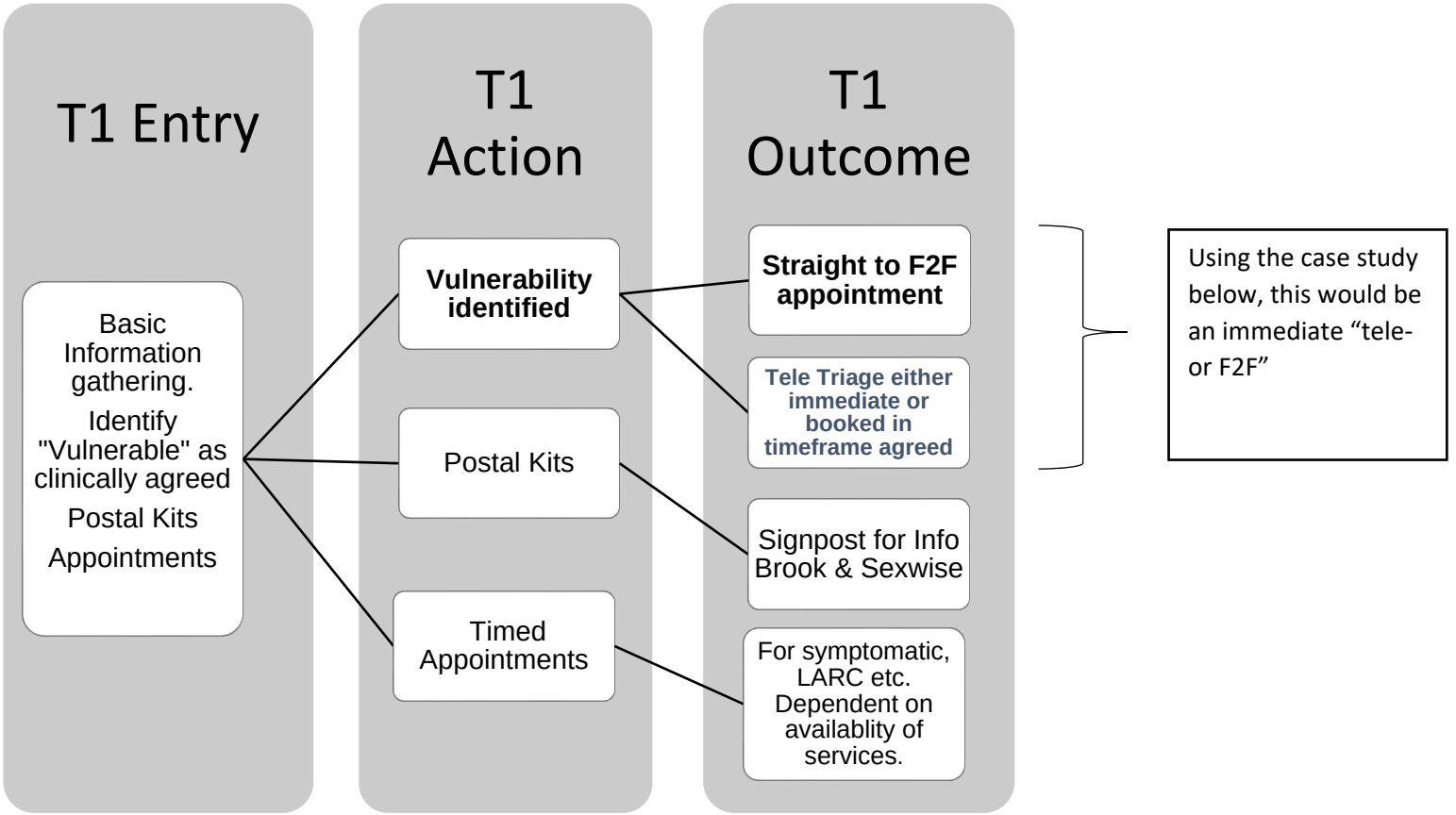
The single most effective triage is setting up a separate inbound line number so that it evens out call flow. However, this depends on publicising this number to your target groups through local outreach via Sexual Health Champions, in Drug and Alcohol, Homeless Teams, and young people’s units, or through web page updates. Another simple method is to set up IVR: Press 1 for EC, press 2 for Symptoms etc.

In the absence of this, and assuming single flow is all that is available, the model below assumes no online triage, no online booking tools and one inbound number. It also assumes limited or no call queuing ability. Focus has been put on booking timed appointments, as in general a ‘call-back on the day’ approach can present problems for service provision and service users, particularly some of the most vulnerable groups, e.g. homeless, young people, as well as people working, who can be curtailed in discussions at various points in the day.

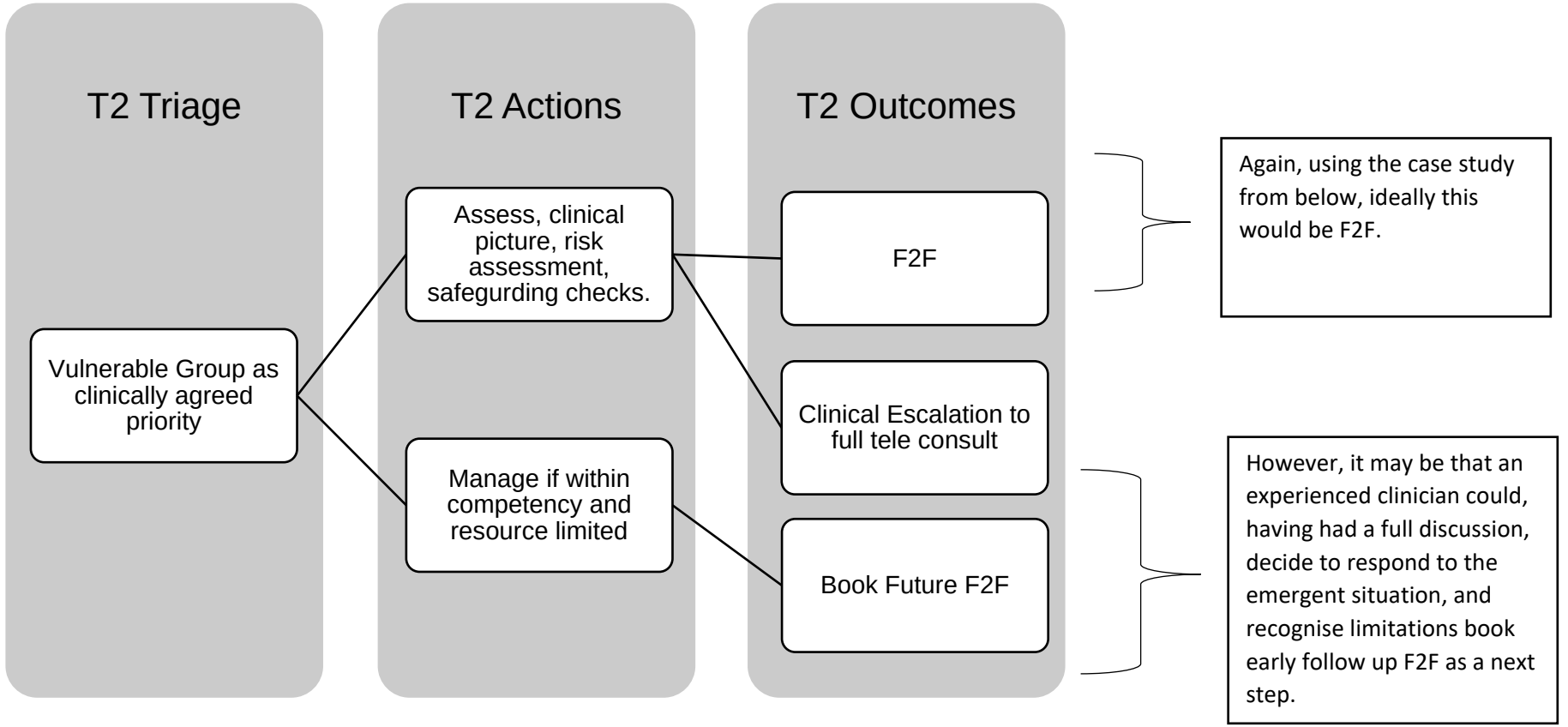
Service user availability can seriously impact teletriage capacity and should be considered. Missed telehealth appointments are no less disruptive than missed site appointments. Consider:

- Whether timed appointments be allocated
- If not, slots be offered
- If appointments are offered on a first come first serve basis, what is the emergency contingency if all slots are gone
- Can procedures be allocated to certain days only and all other non-tele activity be limited

Model Flow in the Absence of Online Triage: T1 Triage



Model Flow in the Absence of Online Triage: T2 Triage



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