Designing Triage with Focus on Prioritising Vulnerable Groups

This document may be useful for senior managers, clinical leads, commissioners and local health authorities.

It shows modelling on considerations of setting up resilient triage facilities dependent on existing infrastructure within local services.

It is designed to generate discussion on the model of triage that best facilitates “vulnerable first”, in local services as easing continues and build in contingency allowing for possible re-entry into further restrictions with minimal disruption.

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Decision Making on Line Set Up and Use.

When setting up systems or workflows in a tele setting some simple analysis is required to decide “what optimises output”. First step for example would be, taking into consideration all issues noted on discussion paper. Faculties can provide traffic light guidance only as resources locally will lead.

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

*Example only

Then dependent on those decisions plan on local analysis of Tech, Staff, Sites & Supplier so availability of testing labs, PPE etc.

	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 etc and priority routing. So many sites are already up and running with their systems but so many have virtually no web based Triage, that will need to be part of the solution for grabbing vulnerable as priority and will shape who does what and how at the entry point. As an example the Northern SRH main website does top line triage but there are many versions some more triage options some considerably less. https://www.thenorthernsexualhealth.co.uk/index.php

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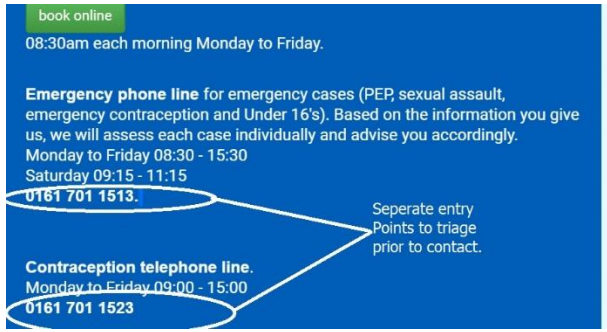
First Considerations post analysis

- How do we ensure our vulnerable identified local groups get priority access. Using the Northern example their front page has simple Triage built in

They have set things that are clearly online offering as active click areas on their page and provided an emergency button to direct callers. This takes you to this selection, which defines "an Emergency" these then give clear guidance to telephone Triage numbers



They have also provided specific inbound numbers, this allows calls to be directed more efficiently. Contraception line could be covered by T1 for clarification (Reception/HCA resource for e.g.) Where as the other number could be

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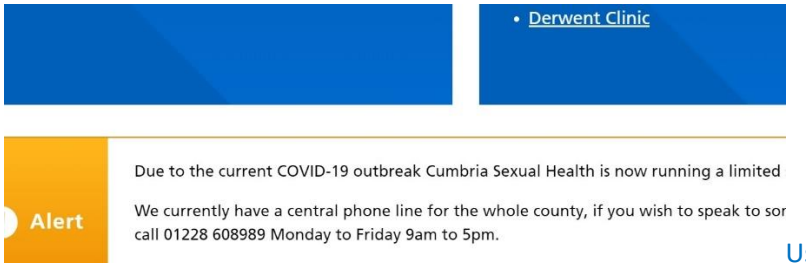
routed to T2 (Clinical staff, SHA) for assessment. They also have an online booking system available for all others, this may or may not cause lag or overload of non-essential tele triage but this will be a capacity decision.

How to decide in absence of Web Offer

In some areas there is little or no active web changes and just a centralised number, it is unclear in these situations how they have decided their triage process, who carries out the first point of contact or what decision making protocols are being adopted, but they may have developed useful decision trees.

Equally if they have just put all staff of mixed skilling on answering calls, which has been reported in some areas then it is unlikely they are getting the "optimum" workflow. Reception staff may well just be setting up call backs where, clinical staff are more likely just to try and provide solution, so it becomes a lottery on inbound calls, different lengths of engagement T2 advisers on and off the system dependent on complexity of presentation.

For a low web presence example, I used Cumbria, their Sexual Health Sites have had no adaptation apart from a COVID central response alert



Using these pages there was no filtering at all, no advice on PEP, their EC pages were linked to pre Covid pages.

This model was adopted in many areas, if you were to design a prioritisation method of triage for this model using lessons learned from emergency Helpline set up Breast Screening model for example. Then adapting the following flow would check efficiency of routing, appointments focused on local priority groups etc. In order to achieve this flow, you must first understand capacity as this allows a slide in provision dependent on available resource at any given time.

- What is your maximum daily F2F appointments does that preclude anything other than "Must do" is it sufficient for your anticipated footfall.
- If not, what can be safely done end to end on Tele-Health. Decide your boundaries.
- How many "emergency appointments are on hold back and do you release these at a certain point or do you re task staff to outbound call back.
- If using Tele-Health what contingencies do you have for service outages either remote or onsite.

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- What is your maximum consultation time in order to maintain service provision and appointment system. Build in flex.
- What can you move to online only and how quickly
- Have you identified a “fallover” alternative agreement, local GP’s, other clinics etc.

Model Flow

The single most effective triage is setting up separate inbound line number so that it evens out the flow, but this depends on publicising this number to your target groups either through:

- Local outreach via Sexual Health Champions, in Drug and Alcohol, Homeless Teams, young peoples units etc.
- Quick Web page changes

Another simple method is to set up IVR: The press 1 for EC, press 2 for Symptoms etc.

However, in the absence of this and assuming single flow is all that is available. This model below assumes no web 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 general call-back on the day presents major problems both for service provision and service users, particularly some of the most vulnerable groups, homeless, young people, people working etc. who can be curtailed in discussions at various points in the day by location, etc.

Service user availability can seriously impact your tele triage capacity and should be considered, missed tele health appointments are no less disruptive than missed site. Consider:

- Can you allocate timed appointments
- If not, can you offer slots
- If first come first serve what is the emergency contingency if all slots gone.
- Can you allocate “procedures to certain days only and limit all other non-tele activity.

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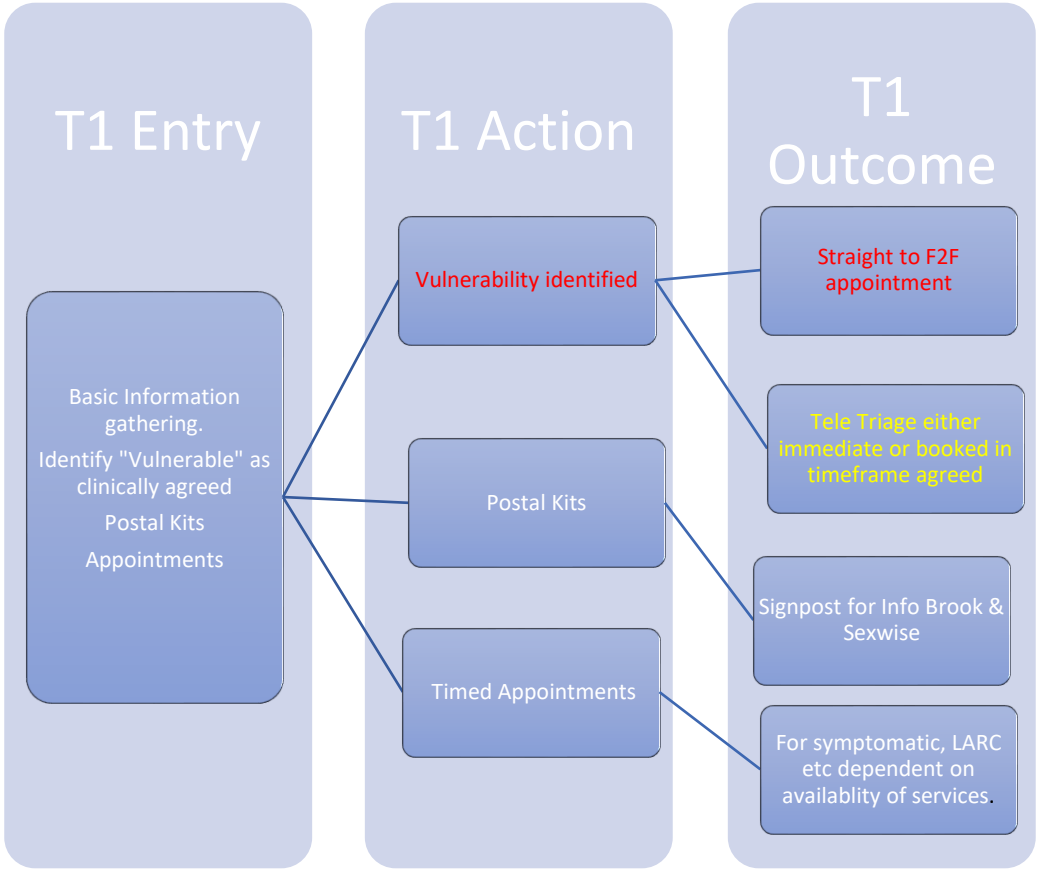

Using the 15yr old requiring EC on below, this would be an immediate “tele- or F2F” See Simple Microsoft forms in discussion paper, setting up easy triage questions for T1 with auto outcome for guidance.

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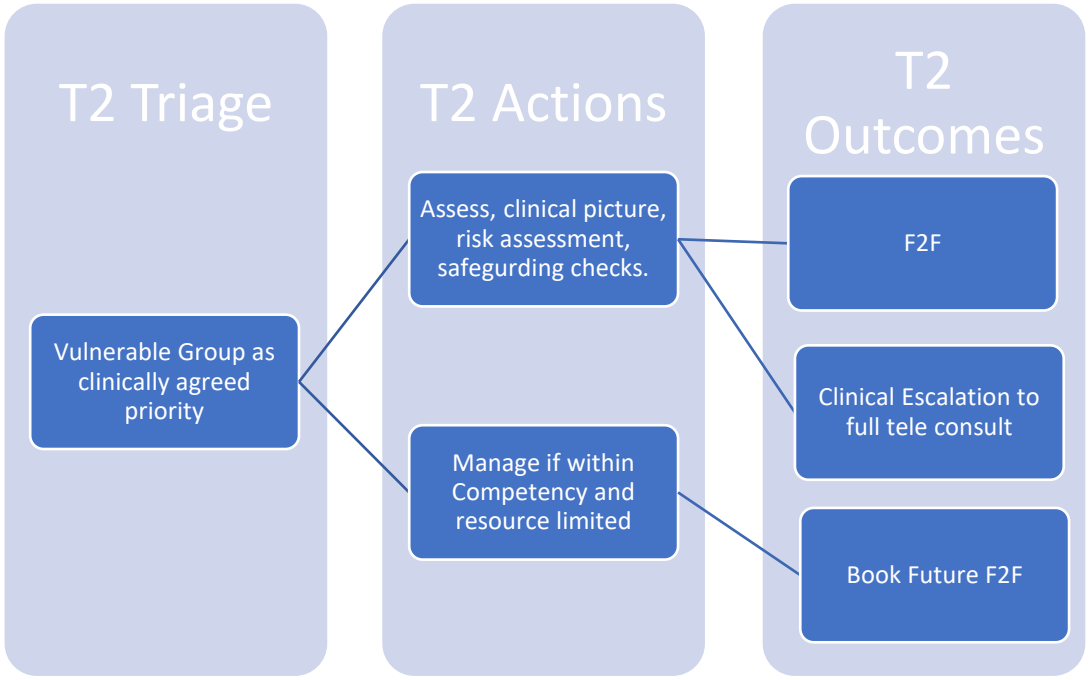

Again, using the sample from below, 15 yr old requiring EC ideally this would be F2F.

However, it may be that an experienced clinician could having had a full discussion decide to respond to the emergent situation, EC and recognising limitations booked early follow up F2F as a next steps.

- Triage Guidance will have to be decided at a local level to suit capacity.
- Variables are huge, for e.g. a clinic with a high BAEM senior staff may simultaneously have a high capacity of experience working remotely and able to conduct tele health and low capacity for procedures.

♦ It may be that if services were available at GP surgery reception staff may simply triage directly into local SRH hub triage system.

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Case Study: From National Helpline purely onward signpost.

- *Female caller wanting to know where to get "the morning after pill". Her local clinic is closed because of COVID. "That's where I normally get it, but I had to buy it from Asda pharmacy last week and it cost a fortune, I don't have enough money to buy it again." On discussion with the adviser the client 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, it was reported that neither of them had any previous sexual contact including oral sex. Adviser found the contact number of the local hub triage and explained the process. A discussion was then had about condom use and the problems her boyfriend had using them. Adviser explained different fits were available and she should discuss this with the clinic when she got through, this led onto a wider discussion on contraceptive choices, the adviser reassured the client that it was "safe" to discuss contraception with the clinic, even under 16, explaining the role of the clinic. In order to reinforce the safe sex message and understanding she walked the client into 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 adviser to assess understanding and consent, adviser also acknowledged the risks of any close contact outside the family group as a risk to her brother re covid-19. The young woman was invited to call back if she had any difficulty accessing service or wanted to discuss anything further.

Take Aways:

Time to do the complete discussion

Don't just respond to the question.

Think Package: Pregnancy test, condoms, STI Testing Kit, POP further broader sexual health and wellbeing advice and safeguarding check .

*Full call flow on document 1 of suite

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