Triage Integration Considerations & Methods to prioritise Vulnerable Groups.

This document is aimed at Clinical Leads, Safeguarding Leads and Managers who are looking at the continued use of “tele” triage for SRH services.

The aim is to generate discussion amongst those responsible for managing workflow and staff training to consider issues such as designing algorithms for triage boundaries, skills gap analysis etc. For their local service.

Ensuring that our most vulnerable are prioritised and are not lost in the expected deluge as restrictions ease.

Maximising opportunity to identify high risk and safeguarding issues.

Background

This document forms part of a suite requested via the SRH Vulnerable Groups working Group and is designed to provide hints and tips for consideration when setting up or expanding tele health / tele medicine SRH services and how best to mitigate risk and prioritise the most vulnerable groups.

Many services already have protocols in place either emergent or for Business as Usual (BAU) tele health such as results services or PIN and will only require expanding on the existing training and processes. Two member of the group Lou Brack Head of Nursing at Brook and Mary Kyle Lead SHA National Sexual Health Information Line agreed to look at 3 strands that had been raised most frequently on the FRSH and BASHH service surveys.

Triage Limitations: As the National Helpline only offers information, advice and signposting they can share experience of using triage skills that maximise opportunity to "hear" risks and help staff accept the limitations of 'tele health and when to escalate.

Safe Working remotely: How to make this sustainable and part of BAU given it is expected that we could exit and re-enter restrictions for at least the medium term.

Tele-medicine: A whole new field for many there is little in the way of clinical guidelines, the lack of formal guidance from professional bodies is a source of concern. Research has identified many of these and signposting to these are included. Priority should be given by senior clinical staff into agreeing best practice guidelines. RCGP have been preparing for this for sometime and have produced a range of resources.

Tele -health tends to refer to telephone contact

Tele Medicine tends to refer to end to end care either via telephone or video conferencing

It is unrealistic to produce either intelligence trees or flows that will fit all services from GP with SRH to Specialist Centres

Aims

To provide a list of considerations each service can use to shape how to "open" their services. What protocols, processes and guidance will need to be designed or adapted to facilitate an "as safe as we can make it" approach to service. So that workstreams prioritise vulnerable.

What the new normal may look like

Identify Resources for staff development

Guide thoughts on what formal guidance will require to be written and sources of existing material.

Support to staff working remotely as Business as Usual

First Considerations

In order to create hints and tips that are useful for all service provision levels and the varied models commissioned, service will need to cherry pick from varied resources to shape their individual plan. This will depend on their access to:

- Online booking services many clinics have adapted their booking systems to allocate 10 min telephone appointments for rapid triage.

- Web based ordering of tests either central service or click and collect. If so what tests? Symptomatic or Non Symptomatic

- Access for patients to prefill sexual health history electronically pre appointment. (NHS Digital links below)

- Medicine provision: Given the financial constraints of this time easy access to free EC and treatment is essential particularly for those with increased vulnerabilities. Postal delay contingency should be seen as essential. Local pick up points in rural communities etc. Using hub spaces as pick up only points.

- Mental Health Support for distressed individuals, services who previously offered this should consider this as a first line restart as delayed diagnosis, treatment and those individual diagnosed “in a vacuum” without the normal explanations and reassurance are increasingly vulnerable. These services are particularly suitable for telephone consultation.

- In absence of full outreach capacity to vulnerable groups, consideration of best practice examples from other areas. Creating “Sexual Health Champions” within homeless teams, drug and alcohol teams, accommodation support workers etc. Using MECC (Link below) model.

- Staff confidence in providing service when they can’t see the patient. Many staff while willing to “muddle” through in the Covid crisis will be resistant or worried about more fundamental or sustained changes to provision. Training and support will be essential.

Triage is to Prioritise

Given many services were set up in a hurry, it was seen as a "better than nothing" approach that would last for a few weeks, going forward there will have to be a fundamental integration of this into service with agreed standards of practice. Each service will have to decide how many "routine" tasks can be automated. What their capacity is in each area, F2F, remote. When prioritising due consideration will also have to be given to "storing up" issues and how to manage this going forward, guidance on extended use of LARC's for e.g.: at some point we could go back into more restricted provision again, so things in may continue to be pushed out indefinitely.

Deciding A Model

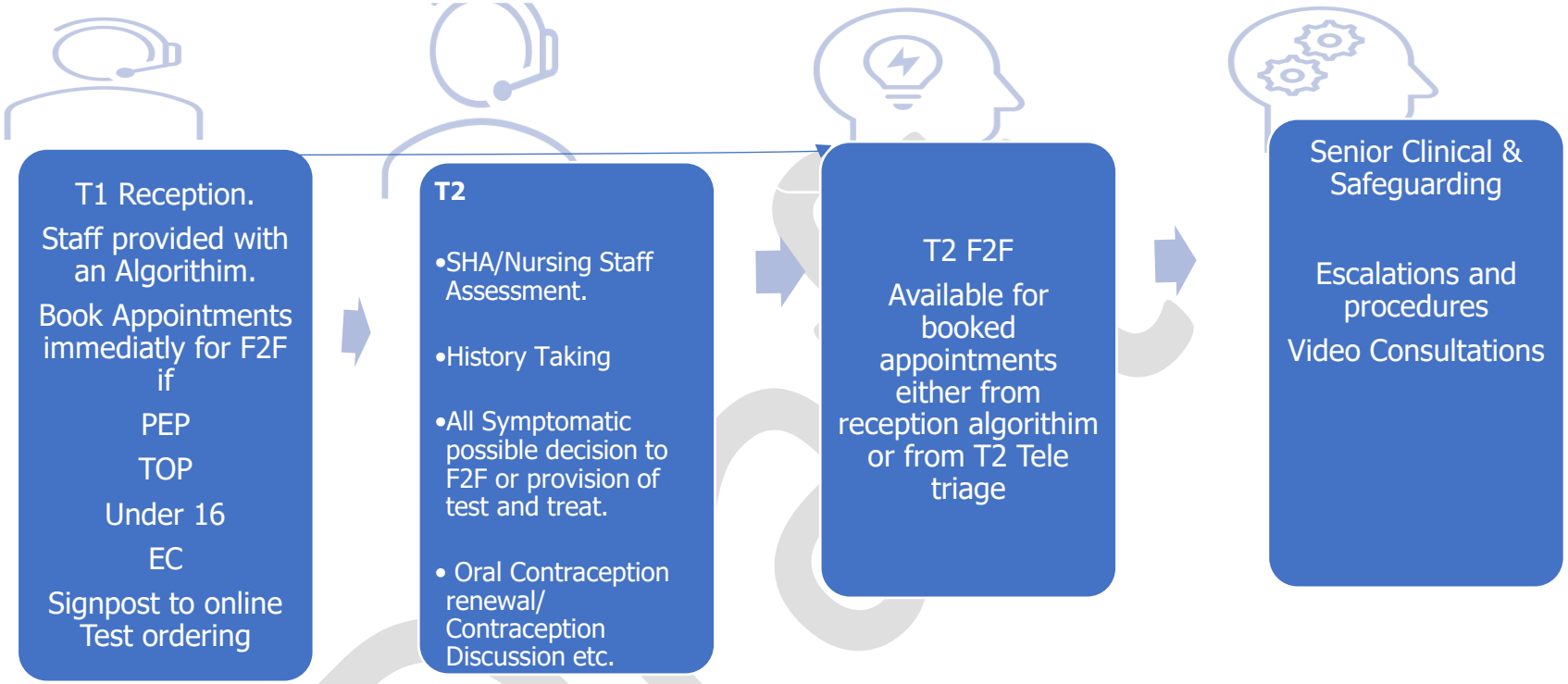
In order to decide a triage model a service would have to assess according to their service level, existing staff skills mix, capacity both physical and remote and whether they expect to triage all access via telephone and will they operate a tiered system and if so, how many tiers.

- Building footprint to allow for social distancing
- Can buildings not suitable for running clinics be re purposed as pick up only points or run as LARC only provision.
- Who can work remotely
- Can staff do F2F in another venue, GP surgery etc

Proper use of triage can maximise service provision but it requires a fully integrated approach. There is a risk that without careful planning of resource and boundaries for each patient interaction you could actually end up with a patient having 2 full consultations rather than quick assessment followed by appropriate consultation.

Below is a possible triage flow but it may be local tech allows call queuing or reception staff become resource planners and have minimal service user interaction, each service will have to decide what maximises opportunity to have the most contact with their vulnerable populations.

In order to assess the usefulness of tele- triage it may be that using it as a mixed model where qualified staff do a quick 10 min assessment and decide F2F or can be dealt with fully on tele platform, this will by necessity be a local decision.



In some situations, it maybe that for environmental issues all T2 non F2F work remotely in which case the decision may be that all calls are routed to them routinely and as trained staff they would simply need call handling skills to adapt and enhance their existing knowledge to operate in a new environment. As most SRH staff are trained in MI & Brief Intervention communication and would adopt the same protocols for safeguarding etc. Much of this decision making will be based on the telephony IT solution availability. One example of a call flow that builds in exploration, of vulnerabilities & escalation options assumes entry at T2 remote Health adviser or nurse level is below it would be unrealistic to expect reception staff to conduct this level of assessment:

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."

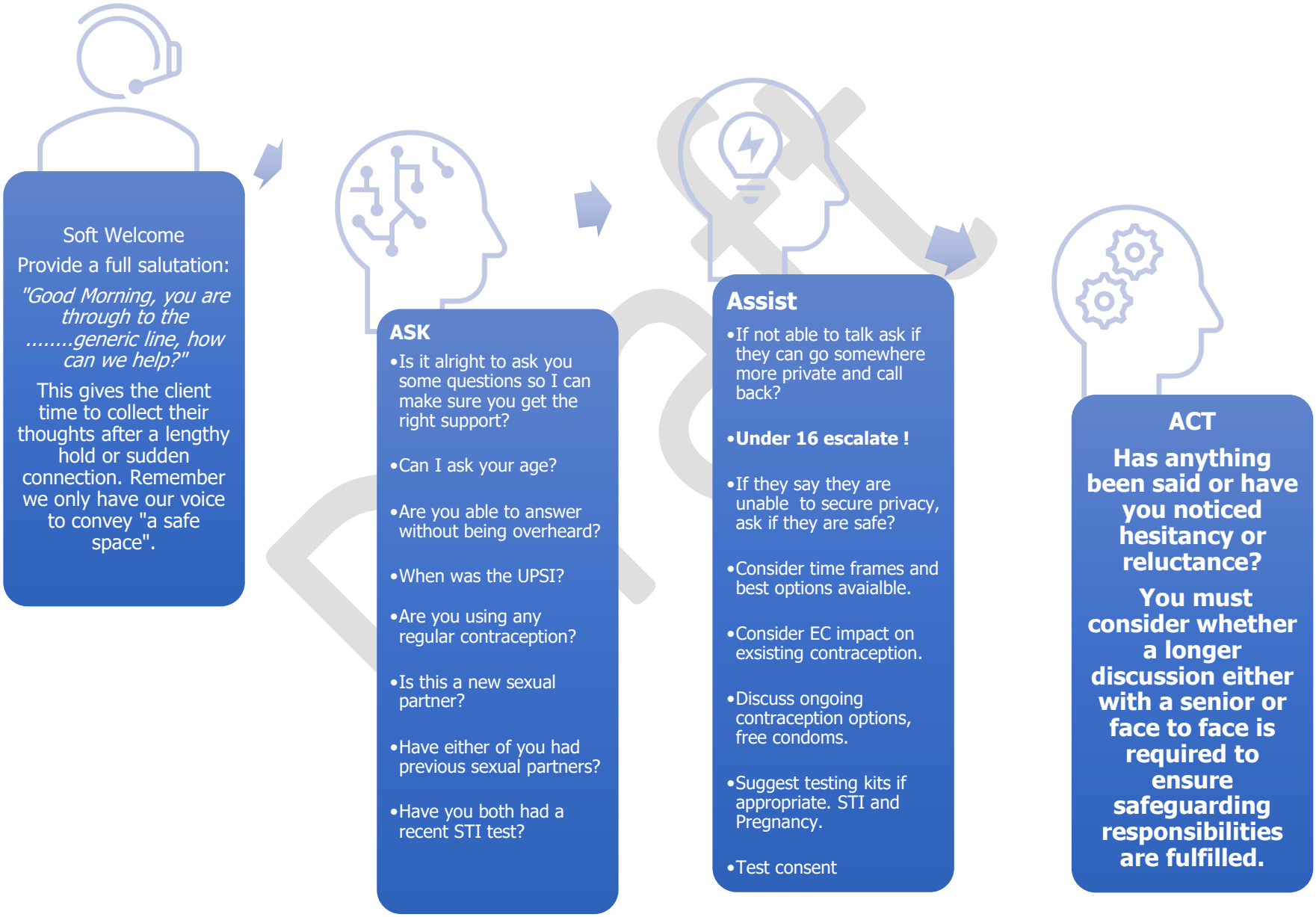
Following the call flow below the adviser ascertained that the client was 15, as was her boyfriend, it was reported that neither of them had any previous sexual contact including oral sex. Adviser found the contact number of the local hub triage and explained the process. A discussion was then had about 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

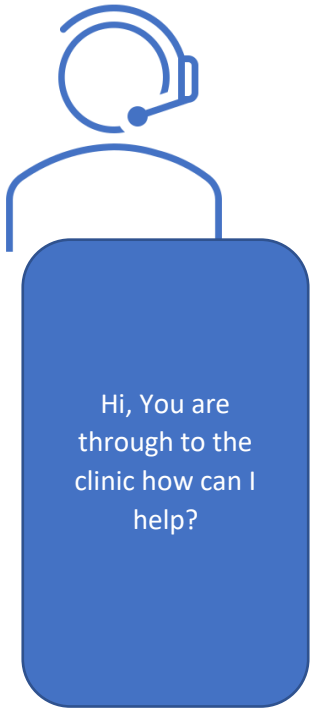
Don't just respond to the question.

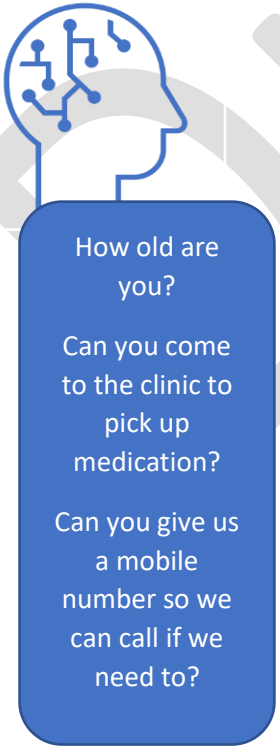
Think Package: Pregnancy test, condoms, STI Testing Kit, POP further broader sexual health and wellbeing advice and safeguarding check .

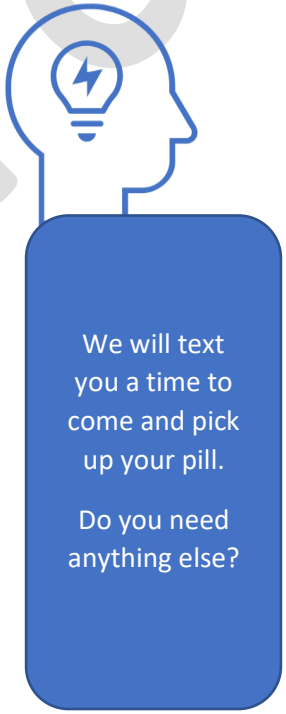

Soft Welcome
Provide a full salutation:
"Good Morning, you are through to the .....generic line, how can we help?"
This gives the client time to collect their thoughts after a lengthy hold or sudden connection. Remember we only have our voice to convey "a safe space".
ASK
•Is it alright to ask you some 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?
•Under 16 escalate !
•If they say they are unable to secure privacy, ask if they are safe?
•Consider time frames and best options avaialble.
•Consider EC impact on exsisting contraception.
•Discuss ongoing contraception options, free condoms.
•Suggest testing kits if appropriate. STI and Pregnancy.
•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

It is anticipated that telephone triage in some form or other will be with us for a considerable time. Understanding the skills required to in order to **M**ake **E**very **C**ontact **C**ount **MECC** and how critical this is to the triage process. There must be an opportunity at every stage to identify and escalate appropriately those groups considered most vulnerable as a priority. This will vary greatly per service but if as anticipated F2F services will remain constrained by social distancing and potential return to stricter measures then "must see" categories would have to target those groups. We usually use reception as a "Gatekeeper" this will require a shift in skill and clear algorithms. If an inexperienced or untrained person answers the above call the call flow could look like this.







Essential Checklist for Remote Support

Homeworking for many has been to this point an emergent solution, however this has been by necessity "*a make it work*" response, which going forward if it is to be adopted as Business as Usual has HR, legal and staff safety issues that require a robust, sustainable agreed process for support. The national Sexual Health Helpline has operated a remote working model for 2 years and lessons learned and considerations are on a separate document. However, some issues have to be considered as part of consultation prep and are included on this list.

- A working space that prevents distraction or disruption or inadvertent disclosure of confidential information.
- Secure access to necessary records, library of protocol documents and guidance.
- Telephony solution that allows adviser to access support from colleagues during consultation
- A "rapid" access to changing consultation method, if during the course of the consultation something emerges that makes F2F a requirement. Solutions will depend on service but ring fencing appointments or a dedicate staff resource for emergent rota "duty drop in".
- An emergent "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 you are in the callers environment. Use of SKYPE or Teams work if monitored continuously. Most services will not have a process for this but it is a common issue on Helpline.
- Contingency appointment solutions for systems outages, telephony issues.
- Sufficient time allocated for appointments, recognising different model of contact, IT issues etc.
- 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. Think duty of care.

Call Handling Skills Training to Maximise Opportunity to Identify Risk.

Remote consultations only require very modest adaptations of our existing skills using existing protocols, however consideration must be given to individual comfort with communicating without our "usual tools". Having a bit of chat on the way into a consultation room to ease tension, being able to see the persons demeanour, anxiety levels, distress or understanding of information is all part of the normal assessment, for many practitioners the loss of these guides will be intimidating and could shake self-confidence. For any triage of vulnerable groups to work the emphasis on "usability" for the service user must be the focus.

Fear of "missing something" is a common concern for staff , however 'phone consultations have advantages if set up properly.

- The "anonymity" some callers feel may make them more forth coming.
- You can easily change this to a F2F if you feel it is necessary, so you don't feel pressure to "solve" everything.

Scripts were considered to aid in this, however the sheer variety of possible presentations makes this impossible, instead ways of communicating that let you "hear" certain alerts and guide you to explore were seen as the way forward, use of existing checklists for safeguarding should provide the template. Doing our job without the non-verbal skills we all use is the most difficult part of adapting our communication styles to maximise engagement.

The key differences are:

- They can't see you smile as you welcome them from reception. But they can hear it! Your tone is everything as is pace, if you sound harassed and busy when you "welcome" someone, you are more likely to get brief incomplete information from questions and miss risk.

  "Good morning…My name is Jo, I am one of the health advisers. .how can I help you today."

- You have to be prepared for a slightly choppier start to the conversation, perhaps a flood of information. People haven't had time to come in sit down and settle themselves with a little chat about the weather, lots of verbal nods to show you are listening "*u-huh*, *I see, mm-hh.*

- The National Helpline uses an adaptation of **FRAMES** (Miller, 1994) model to keep control and flow of the call and the grids system to ensure certain questions are "folded" in to explore consent, coercion etc. For experienced SRH staff going back to these basics will help ensure all that can be asked is asked. Using the Brook taking a sexual health history from a young person model on all calls irrespective of age, focuses our minds on risk.

FRAMES

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 internal call handling purposes.

Explanation of (adapted) FRAMES Approach

Feedback – listening to how service user's present – what is their story and how are they feeling?* *Advisers start 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, advisers will understand what concerns are primary (can be addressed within tele environment) and what are secondary concerns (signposting, escalation safeguarding.). Deliver tailored information.

Menus – prior to giving recommended next steps, assess the following:

Does the service user require further discussion to fully understand their needs or options , F2F or emergency response

Has the service user's emotional state become worse – F2F, or emergency response

Does the service user require vulnerable person enhanced engagement/ F2F

Offer appropriate national signpost for PIL alternatives https://www.brook.org.uk/ or https://www.sexwise.fpa.org.uk/

Empathy – where advisers' information and support guides service user towards next steps, advisers' tone, and language guides service user towards emotional stability

Self-efficacy – check service user's understanding of next steps (i.e. understanding of local service, are they motivated to use signpost '(buy in')

summarise the call

Before getting into the full discussion, set expectations on all Calls & Keep Control

"I can hear how worried you are, I will try to help you but once we have had a chat it maybe that you have to come in and see someone to get the right help."

People can become angry if they go through a full consultation only to be told they have to "see" someone else. If you set that out right at the beginning you are less likely to get "drop out".

Menu's Section: Is the most important area to concentrate effort on as this is where you are most likely in a telephone consultation to pick up hidden concerns, there are limitations but this is the best chance to pick up vulnerabilities "When you say you are having sex outside…..?"

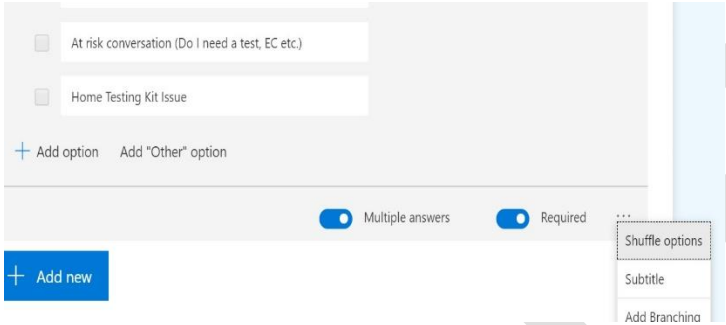
However, if we haven't got the Feedback right which demonstrates reflection of the callers concerns or the Empathy which is our tone and creates a "safe space" then we are unlikely to be able to provide complete tailored Advice or get buy in on Menus. Self-efficacy section gives you an opportunity to 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.

Opening Up Priorities:

Respondents to the BASHH Clinical Thermometer Survey (2) (See Resources) conducted in Week 1&2 of May 2020 were asked to identify their priority for re instating services, there were obvious geographical and service type differences however 76% identified Young Peoples Service as their priority, using that table of respondents identified priority groups it would be easy to model Triage Algorithms for receptions staff to follow ensuring focus was on local service **"Priority F2F"** or **"must talk with".**

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 if branching was "At risk conversation ticked auto- was set to "Go to appointment tele" because that was the clinical agreed outcome then it removes a potential "fall through" of vulnerable client at the reception point, usually provided by the least clinically qualified staff.



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

INDIVIDUAL SERVICES WILL OF COURSE BE BEST PLACED TO IDENTIFY THEIR PRIORITIES.

Key Take Aways

Triage boundaries require careful consideration to prevent long “tele health” consultations followed by F2F, it may be that you define call codes that are auto F2F “Complex contraception for e.g.

Don’t assume all staff will be automatically suited to telephone triage.

People have evolved the way they practice and although they can adapt in an emergent situation it does not mean they either feel equipped or expect this to continue, going forward. The difference between tolerating and embracing.

Recognise the Limitations.

Service users suitability and comfort with tele consults, not all will be happy or able to participate in a remote consultation, ESL can be impossible if you don’t have instant access to an independent interpreter phone service, the National Helpline use Language Line but this requires some telephony access and there is a cost per contact. Those with hearing difficulties etc. Equality Acts Access.

Develop Standards

In order to minimise risk to staff and service users all processes that have “evolved” through the Covid 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 & Safety

As social distancing continues it is important that the physical and emotional wellbeing is considered as well as all HSE responsibilities fulfilled, as homeworking becomes either the whole or part of a staff members working life ad hoc solutions will become less sustainable.

Whatever solution is adopted

It requires to be technologically stable and secure, sustainable and with built in contingency and resilience.

Tolerance

Accept that our “all pull together” attitude has a shelf life. Staff and service users have been flexible and tolerant of glitches but as easing happens expectations will rise, manging these out by professionalising the services you can now offer, will be key to longevity.

Plan for worst case Scenario

As we face the possibility of exiting and entering different levels of restrictions having plans that allow ease of switching . Lessons learned audits can help inform building of frameworks.

Resources:

Each of these have hints and tips on alternative communication strategies, that may be helpful even to experienced staff having to adapt how the communicate.

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

Additional

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