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

Call Handling Tips for Maximising Risk Identification

Document Five of Five

Developed by Mary Kyle, Senior Sexual Health Advisor at PHE National Sexual Health Helpline, *in collaboration with the Faculty of Sexual and Reproductive Healthcare, the British Association for Sexual Health and HIV, Public Health England, and Brook*

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 five 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 focuses on call flow requirements to maximise opportunities to discern those at most risk, through safeguarding identification. Each service will have differing requirements dependent on skill mix and previous digital experience. For most SRH clinical staff, existing skills with a framework for escalation will require minimum changes to practice. This document is designed for clinical leads, GPs and nurse practitioners, SHAs and training staff unused to conducting telehealth consultations in SRH environment.

Setting

Taking a few minutes between calls to set yourself up makes all the difference to the way you enter a call. If you are trying to battle technology, answer e-mails or multitask, it quickly becomes apparent on the call, and you may miss subtle references.

Use a proper headset if possible. Often speaker phones can sound very concerning to callers, as they worry about being overheard. Headsets also allow you to be handsfree.

If an interpreter has been arranged, ensure that they are available and clear of their role before starting.

If using video, make sure you are lined up for proper eye contact and resist typing and looking away at your keyboard. If you are going to look away, then explain to the caller that you have to check something, so that they are included and not ignored.

Blur your background on video, particularly if working from home.

Try and have guidance documents already open, e.g. local guidance, BASHH, FSRH.

Make sure you know a support or senior escalation point for clinical advice or safeguarding, particularly for live incidents. When talking with callers in their own homes, you are much more likely to hear domestic incidents. You cannot deal with the caller and get emergency services at the same time.

Greetings and Checks

If you have an interpreter on the call, ask them to introduce themselves first and explain their role. If a family member is acting as interpreter, you must consider if this is appropriate for the type of consultation. If not, end the call explaining why and offer independent support.

The mode of entry into the conversation shapes your greeting. Begin pre booked appointments and direct calls by introducing yourself. If a direct call, you may prefer to introduce yourself with a title "*Good morning, you are through the city clinic. You are speaking with John and I am one of the nurses here. How can I help?"*. If the call is pre booked, use an alternative introduction "*Good morning, my name is John and I am one of the nurses here. Can I just check that I have the right person on the call? could you tell me your name and DOB or age?"*

Try to strike a conversational tone by adding precursor statements "*So before we continue, can I just check that you can hear me? And just in case, is there a number I can call you back on if the call drops?*

Confidentiality Statements must always be given before any discussion takes place, and you must document having done this. Each service has its own version of language but keep it simple and in plain English.

"We are always confidential here, whether on the phone or in person, except if we think there is a risk of you or someone else being hurt or put at risk, but we will always try to discuss these concerns with you and work with you before doing anything else."

Once the confidentiality statement is read again, a softening statement gets you back on flow.

"Great, the consultation can take a bit of time. Are you free to talk and able to answer questions without being overheard?"

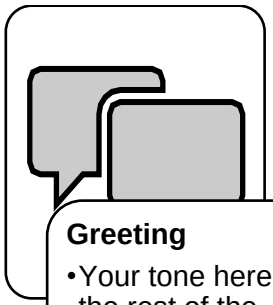
If you have your own local checklist for risk, have it to hand but make sure it is available on all consultations. This will ensure that the call remains on course, and that you do not miss anything.

Brook has a CORE form as an example, this can be found in Appendix One of this document.

Example Call Flow: Greetings and Checks

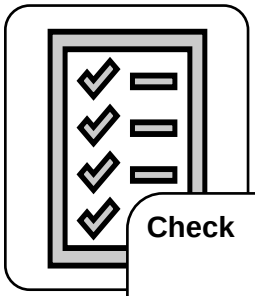
Setting

- Are you free and have you got privacy to carry out a consultation?
- If previously triaged, do you have notes?
- Is your technology prepared and stable? Do you have access to all documentation you may need?
- Do you know who is available in support if required?



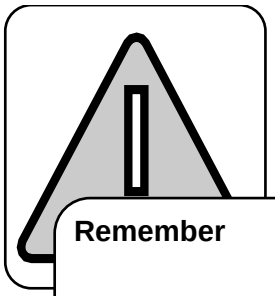
Greeting

- Your tone here sets the rest of the conversation.
- If responding to a linked appointment rather than direct transfer, begin with a greeting, e.g. *"Good morning, my name is John. I am one of the... before we start I just have to check a few things. Is that ok?"*



Check

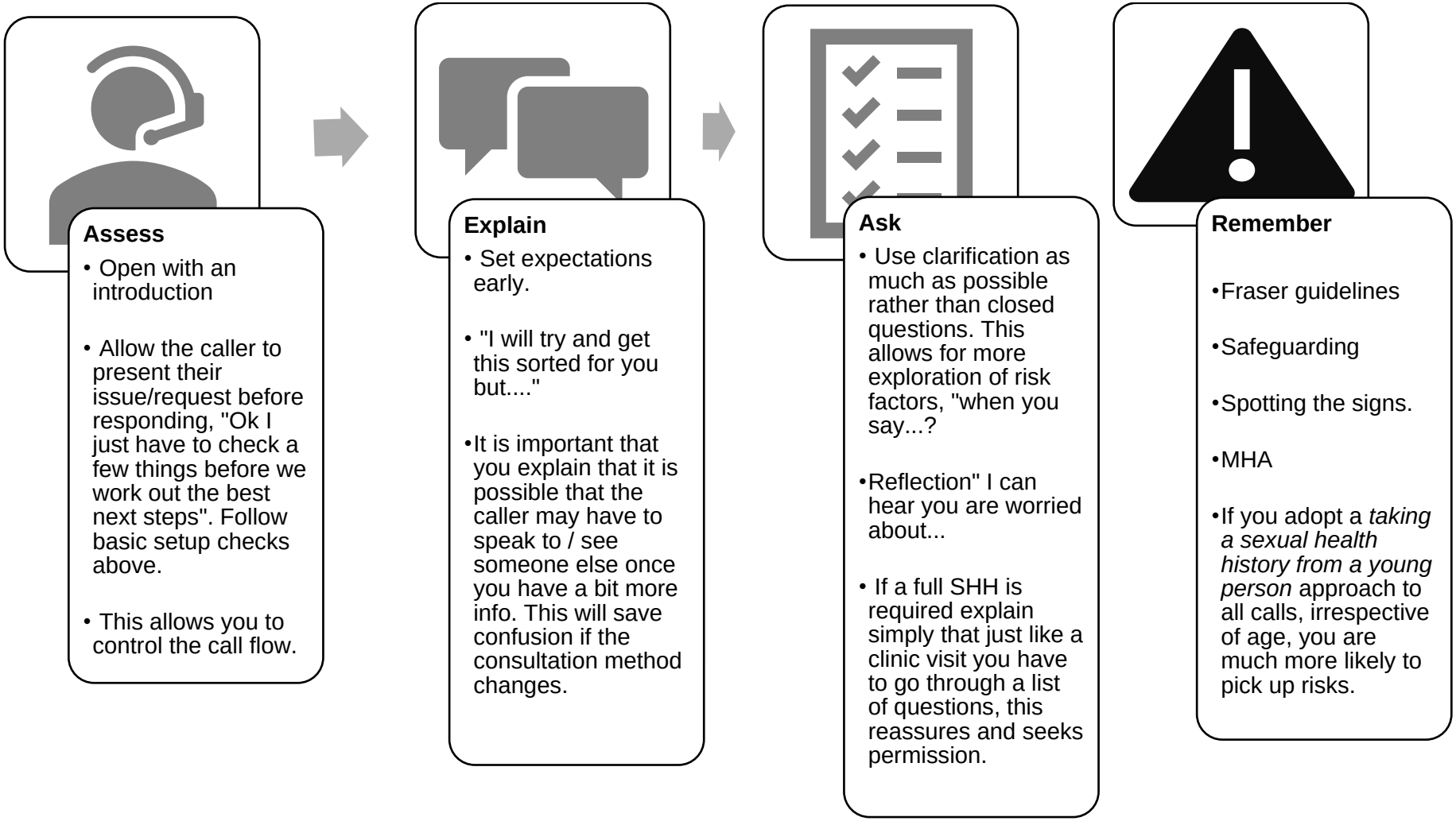
- If ESL, check whether the interpreter is on the call.
- Confirm that the caller can hear
- Confirm name and age / DOB
- Ask to record phone numer in case of technical difficulties
- Ensure that the caller has a privacy



Remember

- Fraser guidelines
- Safeguarding
- Spotting the signs.
- MHA
- Much of this can be folded into your conversation but they **must be checked. This may involve direct questions.**

Example Call Flow: Greetings and Checks



Body of the Chat

Acknowledge that you have heard what the service user is calling about.

If you have set expectations of possible transfer early on, this prevents friction later. If the caller has spent time answering your questions and think they are finished, but then have to be re-routed, they may react negatively. Manage it before it happens.

Explain that there will need to be more questions as there is more than one possible outcome. This is “seeking permission”, something you have to do a lot more directly than when face to face without non-verbal communication. This is particularly important if, for example, the caller is just looking for POP / CHC, as they may not be expecting further conversation.

Use basic FRAMES behavioural change and MI techniques, using a mix of reflection and clarification language. Explore all possible issues and solutions:

- EC Options and Choices (Be aware of capacity issues. Don’t offer what you cannot provide, e.g. IUD.)
- Consent (Fraser, MHA and coercion)
- STI risk and assess (Offer testing in timeframes and by most appropriate method if required)
- Onward contraception or adjusting advice if Ulipristal and on COC (Quick start and script considerations)

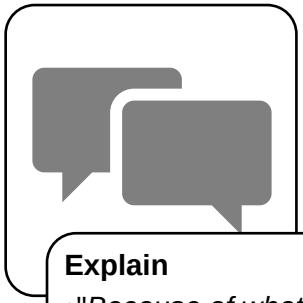
If you are taking a full sexual history, explain this to the caller “*In order to make sure we cover everything there is a list of questions we need to go through to make sure you get the right plan going forward. We do this with everyone so the questions are generic. Some may apply to you and others won’t, but we have to ask them all. Is that ok?”*

Again “seek permission” at every step, as this keeps the person-centred focus in the absence of non-verbal comms.

Example Call Flow: Keeping a Person-Centred Focus

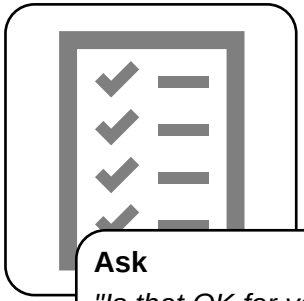
Ask Yourself

- Is there anything I have heard so far, in either content or demeanour, may mean that this person requires escalation (either clinical or risk).
- Do I need more information to progress this call.
- What is the gold standard for this type of presentation? Can I provide it, and if not, is it available via another route?



Explain

- *"Because of what we have discussed, I think the next steps that would help you would be..."*
- List next steps in detail, e.g.
- *"We can provide test kits that you can pick up from... and then do at home. You then return that to...We will have the results in by...So if we set up another call on...to discuss the steps after that, would that be ok?"*



Ask

"Is that OK for you"

"Are you able to do this?"

Explore understanding and barriers.

If there are barriers, explore alternatives.

Remember

Appropriate next steps list should always include, if relevant:

- Abstinence message if suspected STI
- Ongoing contraception safe sex message
- Full walk in to online PIL and expanded information if required
- PN discussion if diagnosed
- Clear next steps plan reiterated

Working in Partnership

Dependent on your role or things you have heard, you may at this point decide you require to move the appointment to F2F. Seek some senior support if unsure. *"I think because of your circumstances I might have to get you in to see someone, but can you give me a minute to check with one of my colleagues? I want to see if they agree and how we could make that work for you. Or do you want me to call you back in five minutes, would that be better?"*

Do not feel pushed beyond your competency or instinct. Some callers can be very rushed in their delivery and that can make you feel you have to match their pace. When faced with this you need to take control of the call. You can do this by simply saying *"I understand how frustrating all these questions are, but I can't be sure we have covered everything we need to help you unless I ask them."* And then reset the pace.

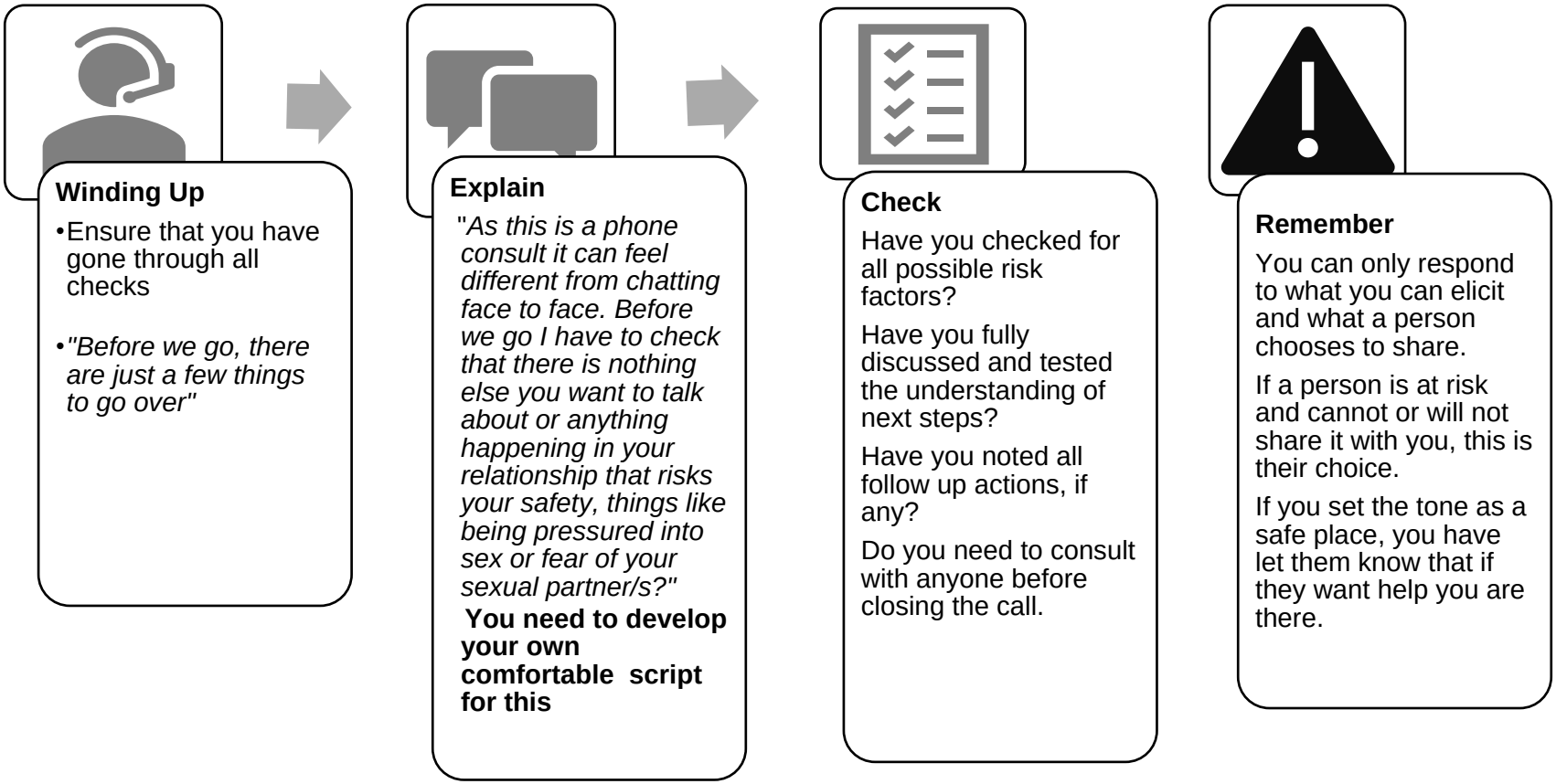
The anonymity of a call can work for you and against you. Some callers are much more forthcoming about details if they are not in front of you, but this can lead to over sharing. To manage this in the least abrupt way possible, use polite but relevant interruption to re-focus. Although you are stopping the caller, it sounds as if you are listening and responding. *"Sorry can I just ask, just so I don't lose track, did you have an STI check before staring a sexual relationship with the new partner?"*

If you are recommending an action to someone, always explain why *"I would like to get a test kit to you because you have symptoms, but many STI's can produce similar symptoms so we have to test to make sure firstly it is an infection and if so which one it is so you get the right medication".* As people have often self-diagnosed, they will just want treatment. As you are not giving them what they might expect, then explaining why you are doing it diffuses possible breakdown in the consultation.

Make sure you have covered everything you want to in terms of next steps and have fully explained them and have the contacts agreement.

Provide post consultation resources so electronic PIL of choice or advice websites such as Sexwise and Brook.

Example Call flow: Closing Out



Closing Out

If there are no obvious risks, then clarify next steps, thank the caller, and end the call.

If you have not managed to either fold in the questions while taking a history, or had no opportunity, you must ask them at the end of the call. A simple statement will suffice "*As this is a phone consult it can feel different from chatting face to face. Before we go, I have to check that there is nothing else you want to talk about or anything happening in your relationship that risks your safety, things like being pressured into sex or fear of your sexual partner/s?"*

If no issues are raised, then close out with "*Great, so you will get your brother to run you to the local GP tomorrow and we will organise to have a test kit there for you, and if you post it tomorrow afternoon we should have the results on Thursday morning. I will call you at 2pm on Thursday afternoon, and will send you a text reminder. If your symptoms become worse in the meantime…."*

If issues are raised, follow your local procedure and escalate in accordance.

Immediately after call, do all action items immediately. Order kits, book appointments, send out reminders and complete documentation. At any point a consultation can go into crisis, so doing your post call work before starting another consultation prevents errors if subsequent plans go awry.

Be kind to yourself. You can only deal with what is presented to you. If you create a safe and comfortable environment for conversation, then you have done all you can to identify risks.

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: Closing Out

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.

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.

Appendix One – CORE Form Brook

Name	
Date of Birth	
Location Visited	
Date of Visit	
Client Number (if known)	

Form Filled In By:

Client Core Record

Client Information First Visit to Brook? If Yes, fill in Client Registration Form	Yes	No
Age Group If under 16, fill in Fraser Form	Under 13 16 – 17	13 – 15 18 and over
Brook confidentiality and privacy notice discussed Signpost to privacy notice	Yes	No
Does the client understand their visit is confidential unless there is a risk of harm to themselves or others	Yes	No
Gender identity	Male Not sure Other:	Female Prefer not to say Non-binary
Does the client identify as trans*?	Yes Not sure	No Prefer not to say

Family and Social Life Who does the client live with?	Parents Friends Other:	Other family Alone
Who is the client's legal guardian?		
Is the client a parent	Yes	No
Details/Notes		

Is the client a looked after child or care leaver?	Yes No
Name of social worker or key worker if applicable	
Is the client in education/employed/unemployed/volunteering? School College/FE University Apprenticeship Other education: Employed Unemployed Volunteering Other:	
School/College/University/Other details	
Are there any concerns about education or work attendance?	Yes No
Concerns about attendance	
Any other problems at school or college or employment status?	Yes No
Other problems at school or college detail	
Any other comments about support network available to client or family and social history	Yes No
Comments about support network or family and social history	
Another other agencies or workers involved in clients care	None Current Historic
Agency worker contact details and permission to contact	

Digital Life

Does the client have any concerns about their online life and activity?	Yes No
Is there a risk of harm from digital activity? Conversation may include whether client knows the age of all their digital friends, that sharing images is illegal, cyber bullying is 24/7, dangers of meeting people from online, checking privacy settings etc.?	Yes No
Does the client know how to protect themselves online? Conversation may include digital footprint lasting forever, keeping evidence, blocking offenders, reporting to CEOP, parents, police or teachers	Yes No
Notes about risk of harm for client and how to protect themselves	

Physical, Mental and Emotional Health

Is the client generally well?	Yes No
Not generally well notes	
Does the client suffer from any chronic conditions	Yes No
Chronic conditions details	

Any history of depression	None Current Historic
Actions taken	
Any history of anxiety	None Current Historic
Actions taken	
Any history of suicidal intentions	None Current Historic
Actions taken	
Any history of bullying	None Current Historic
Actions taken	
Any history of self-harm	None Current Historic
Actions taken	
Any history of eating disorders	None Current Historic

Actions taken		
Any other mental and emotional health issues?	None	Current Historic
Actions taken		
Any domestic violence including honour based violence and/or forced marriage?	None	Current Historic
Domestic violence further details		
Any female piercing, tattooing or removal of genital skin or risk of for client or family	Yes	No
FGM details – Mandatory Reporting		
Any other risk factors?	Yes	No
Other risk factors details		

Sexual History

Have you ever had sex?	Yes	No	
Are you currently sexually active?	Yes	No	
Number of partners/contacts in the last 6 months			
Age group and gender of contacts			
Type of sex engaged in	Oral	Anal	Vaginal
Does the client use condoms?	Yes	No	Sometimes
Does the client have a current method of contraception (not condoms)	Yes	No	
Is the client in a relationship?	Yes	No	
How long for?			
Partner age			
Age difference or power imbalance concerns?	Yes	No	
Sex and the law discussed?	Yes	No	
Is the partner known to any external agencies?	Yes	No	
What external agencies?			
Is the client in an abusive relationship?	Yes	No	
Abusive relationship notes			

Does the client feel safe with their partner	Yes No
Feel Safe notes	
Have you ever had sex without your consent?	Yes No
Sex without Consent Notes	
Any grooming behaviour described by client?	Yes No
Grooming behaviour notes	
Other than the partner has anyone else been present at the time of sex?	Yes No
Other people notes	
Where is the client having sex?	
Have any attempts to secure secrecy been made by the partner?	Yes No
Secrecy Notes	

Any historic sexual abuse, coercion, exploitation, or power imbalances between client and partners?	Yes No
Historic notes	
Any risk to others identified	Yes No
Risks to others	
Does the client's own behaviour place them at risk of harm?	Yes No
Client's behaviour notes	
Any other comments about sexual history and risk factors?	Yes No
Other Comments about Sexual History	

Lifestyle Factors

Does client smoke cigarettes?	Yes	No
How many per day		
Does client drink?	Yes	No
Number of units per week approximately		
Does client use recreational drugs	Yes	No
Does client smoke cannabis?	Yes	No
How many spliffs per day		
Is the client an IV drugs users?	Yes	No
Does the client use a needle exchange program?	Yes	No
Does the client use cocaine?	Yes	No
If yes do they share papers for use?		
Does the client use chems?	Yes	No
Recreational drugs notes		
Misuse of substances as a disinhibitor so that client is unable to make an informed choice relating to sexual activity or behaviour	Yes	No

Practitioner Observations

Disinhibitor notes		
Any concerns about neglect or emotional abuse	Yes	No
Neglect or abuse concerns		

Any concerns about physical violence? Obvious signs, verbal disclosure, current or historic	Yes No
Physical violence concerns	
Other concerns identified (e.g. radicalisation)	Yes No
Other Concerns	
Is there a need to refer the client to further support within Brook? For example to education team or clinical team	Yes No
Further support notes	
Is there an ongoing support plan for the client?	Yes No

Ongoing support plan Include dated updates to the plan within this episode of care	
Are there any safeguarding concerns? If yes a safeguarding proforma must be completed	Yes No
Any other concerns not documented elsewhere?	Yes No
Other Concerns	