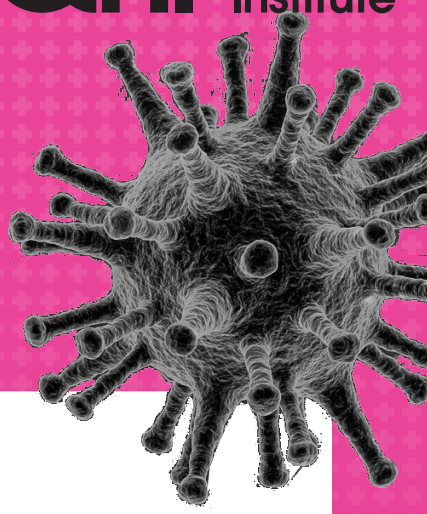
The Queen's Nursing Institute

Community Nursing Covid-19 Innovation/Best Practice

CASE STUDY

Adapting a Sexual Health Service during the Pandemic



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Personal details
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Please describe your practice innovation.

The provision of sexual health care in the UK has rapidly evolved since the beginning of the coronavirus pandemic, embedding the use of Personal Protective Equipment (PPE), social distancing and frequent cleaning into routine practice. Service capacity has been almost universally reduced, in some settings by more than 50%, due to staff isolation and illness, redeployment, changes in laboratory resources and the need to reduce footfall due to the limitations of the physical environment. Consequently, many clinics have been reduced to offering urgent care only for patients with the most distressing symptoms and emergency care needs, with other services being paused or discontinued.

Our service is the largest Level 3 integrated sexual health clinic in the North East and we have remained open, delivering sexual health care throughout the pandemic. Access is via same-day telephone consultation with a clinician, where needs are identified. Options for management include a face to face review for an urgent problem; a remote prescription; or remote self-sampling for asymptomatic sexual health screening. This model prioritises those with the most urgent concerns such as HIV exposure and need for emergency contraception, seeking to use available resources to prevent significant illness and unwanted pregnancy.

Whilst this way of working allowed demand to be met during the time of tightest social restrictions, when regulations were eased in June 2020, we were quickly overwhelmed. There was a huge backlog of routine care outstanding and we recognised that individuals requesting routine care continued to be disadvantaged, as they would always be superseded by patients with more urgent requests, and frequently not receive the care requested having to phone back another day.

This experience led us to develop our contraception call back (CCB) system. We developed a new triage protocol used by reception for patients requesting contraceptive care, enabling stable patients to be identified and given a booked telephone appointment with a clinician at a convenient time. We allocated a set member of staff to manage this activity, and designed the rota for urgent care to allow the two services to run concurrently. Identifying the general nature of the care requested at reception has allowed patients to be allocated appointments of appropriate length accounting for the complexity of their concerns. This has increased efficiency, facilitating an increased number of telephone contacts per clinical session.

The success of this service has been enhanced by a second aspect of service development: a new Health Care Assistant (HCA) led clinic where patients requesting oestrogen containing methods of contraception can be seen for blood pressure and Body Mass Index. Together these innovations allow us to offer the full range of contraceptive methods, with patients attending the building only once when unavoidable, either to collect medication or for a Long Acting Reversible Contraceptive (LARC) fitting. This has allowed us to review a large patient cohort in a COVID secure manner, prioritising patient convenience and choice, whilst minimising clinic footfall and retaining flexibility in the workforce as CCB services can be delivered by colleagues working from home.

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How has this enabled you to treat/support patients / residents/families/carers more effectively and safely?

Limited resources need to be used efficiently, and current capacity does not allow us to fully meet demand or to deliver care in the manner used pre-COVID with all patients coming to the building in person. Telephone triage alone disadvantages patients requesting routine contraception, which goes against the public health ethos of self-management and preventative medicine. Now, this innovation prioritises convenience (booked appointment), choice with all methods, and increases patient confidence in the service as demonstrates distancing at every step. The model used for our HCA clinic increases patient safety, protects clinicians and ensures safe prescribing.

4/

How has this enabled you to work more effectively with colleagues/partner organisations?

Within the team – up skilling of HCA has created an additional staffing resource, and removes the need for a highly trained clinician seeing a patient for BP/BMI when they could be seeing a patient with more complex needs. This also improves appointment capacity, which directly affects staff morale, as it is stressful to have to manage patients with complex needs who cannot be seen due to lack of appointments. It is equally stressful to have to tell a patient they need to change their contraceptive method, as there is no way to measure their BP and to be aware of patients who may have received no advice at all due to volume of patients seeking to access the service. Within the service, this innovation has improved work experience for staff – their feelings of ownership of a high quality service with less unhappy patients. It has provided an opportunity for training and development which has been mutually beneficial for nurses (as mentors / trainers) and HCAs through an increase in confidence, increase in a sense of utility in the service and a direct contribution to patient care, which was lost within their role when previous face to face asymptomatic screening stopped.

This has linked the work of clinician with the HCA contribution, thus increasing respect and valuing each other's roles and functions.

Regionally, we have disseminated our practice to colleagues in the region via the British Association of Sexual Health and HIV (BASHH) network discussing our experiences and patient feedback.

5/

Do you see this new way of working as a temporary adaptation to current conditions, or a permanent/evolving change?

This is a permanent evolving change as it is far more efficient than seeing all patients face to face as some requesting a Progesterone only pill (POP) may not need to see a clinician at all. As long as coronavirus continues, will need to minimise number of patients attending our service face to face for routine requests to ensure there is capacity (i.e. physical space) to review urgent presentations.

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Please describe any particular challenges you had to overcome.

We have had to further develop our system of patient triage and consider how we ensure safety netting – not missing urgent patients who need Emergency Contraception. Triage needs to be simple but also comprehensive enough to ensure patients are correctly allocated to appointment slots with the clinician available to meet their needs.

The clinical role development of HCAs has required us to liaise closely with our trust in terms of how the role has been developed; we have had to develop a bespoke process for formalising skills, teaching, training and to assess the development and achievement of competence.

7/

Please describe any continuing challenges you would like to address.

We host a number of junior medical trainees who attend our clinic for short rotations; our challenge will be to provide adequate training and experience in a short space of time to individuals who may never have prescribed contraception before. We need to ensure that we provide training and clarity on how these two parts of our system work together. We would like to continue to increase our in-house resources for staff by producing a telephone consultation guide and develop further a more detailed guide to red flag questions.

8/

Please list any websites, online platforms or apps that have helped you.

Use of Family Planning Association (FPA) leaflets and texting details of how to access them to patients – to provide information, to encourage informed decision-making and prevents the need to come to clinic for a leaflet. If the patient is uncertain, there is a guide to help personally recommend an option.

9/

What are the main pieces of IT or other equipment you need (e.g. digital camera, phone, laptop, iPad).

Computer and screen or laptop

10/

Please give any individual examples, quotes or other information.

A comment by one of the HCAs was that herself and her other colleagues who had ran the new HCAs clinic 'thoroughly enjoyed running the new HCA clinic, missed engaging with the patients'.

> "Together these innovations allow us to offer the full range of contraceptive methods, with patients attending the building only once when unavoidable, either to collect medication or for a Long Acting Reversible Contraceptive (LARC) fitting. This has allowed us to review a large patient cohort in a COVID secure manner, prioritising patient convenience and choice, whilst minimising clinic footfall and retaining flexibility in the workforce.
>
> Staff feedback