Central and North West London NHS
NHS Foundation Trust

Healthcare professional experiences of the shift in integrated sexual health service delivery as a result of the SARS-CoV-2 pandemic: What can we learn and where do we go from here?

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Objectives:

In response to the SARS-CoV-2 pandemic, there has been an unprecedented shift in integrated sexual health (specialist sexual and reproductive healthcare) service delivery. From the 23rd March 2020, clinics at a large central London sexual health service were reduced and centralised, telephone assessments became the standard method of service provision and staff were deployed and/or saw their roles change.

A service evaluation was conducted using an online survey with the aim of capturing experiences of this new model of care in order to understand:

1. The acceptability and experience of the new model of care
2. What staff thought was working and what was not
3. How far phone or video assessments should be made mainstream and funded
4. Thoughts on how the service should be delivered during the transition from lockdown to post-COVID (recognising that some lockdown is likely to be in force for months to come, and that the level of this will vary)
5. What the post-COVID model of delivering care should look like, including could the current experience help us to modernise ISH services and focus on providing F2F services to the most vulnerable.

Methods:

Between 20/05/20-05/06/20, an online survey was advertised in the staff weekly bulletin email. Quantitative data was analysed in Excel and STATA v15 using descriptive statistics. Free text responses were thematically categorised using the Framework for a Systems Approach to Health Care Delivery[1].

Results:

Quantitative:

There were 60 responders, with 53 staff fully completing the survey. Seven responders were excluded because they only answered the first page of questions. Responders reflected those members of staff that were not deployed (see figure 1).

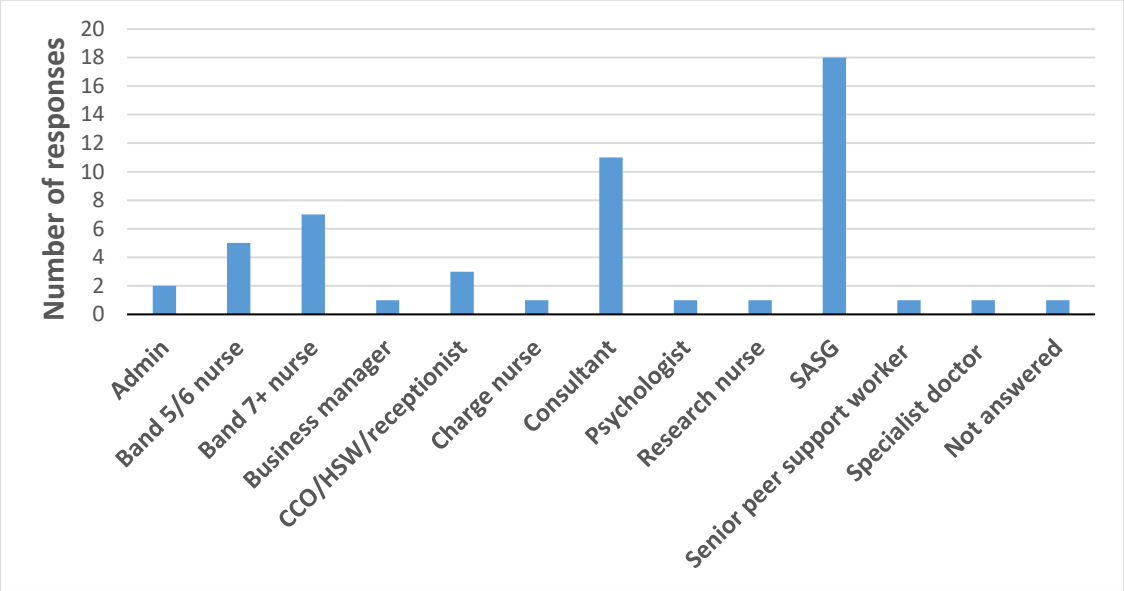

Figure 1: Responses to the question 'What is your role'? *CCO - Customer Care Officer; HSW – Healthcare support worker; SASG (Speciality and associate specialist grade doctor*

Four members of staff had been deployed at some point during the pandemic.

83% of responders had come into work all, or nearly all, of the time. There was a shift in tasks performed by staff from pre-COVID reflecting the new service delivery model (fewer face-to-face consultations, more remote assessments, minimising of face-to-face contact, reduction in staff numbers due to deployment to other services). Figure 1 summarises the services provided or performed before lockdown and from March to June 2020:

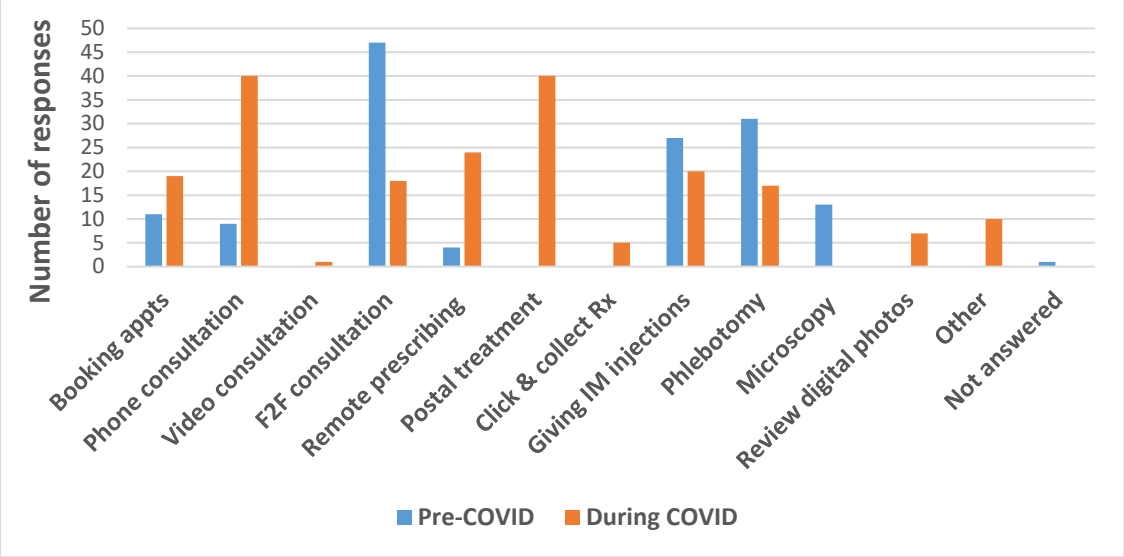

Figure 2: Responses to the questions 'Prior to the current coronavirus pandemic, which of the following services did you provide/perform (tick all that apply)?' and 'Since the start of the coronavirus pandemic, which of the following services have you performed/provided which you had not done before (tick all that apply)?'

When asked how confident they felt providing care in the new service model, 98% felt very confident (n=17) or confident (n=35) providing care in the new service model.
87% answered 'yes, definitely' (n=15) or 'yes, mostly' (n=31) in response to be asked if they had been provided with enough support to provide these new roles. Current job satisfaction differed between staff groups but remained similar to pre-pandemic. Mean current job satisfaction was 63 (on a scale of 0 to 100; poor to very good) with overall no change in satisfaction compared to the pre-COVID period. Satisfaction ratings by staff group are summarised in Table 1:

Role	Current job satisfaction (mean score)	Compared to Pre-COVID	Number of responses
Admin	75	No different	2
Band 5/6 nurse	42	Worse	5
Band 7+ nurse	65	No different	6
Business manager	83	Better	1
Consultant	66	No different	11
CCO/HSW/receptionist	43	Worse	3
Psychologist	75	Worse	1
Research nurse	50	Worse	1
SASG doctor	69	No different	18
Senior PSW	29	Worse	1
Specialist doctor	50	Worse	1
Not answered	75	No different	1
Overall	63	No different	51

Table 1: Satisfaction scores by staff role *(CCO - Customer Care Officer; HSW – Healthcare support worker;SASG (Speciality and associated speciality grade doctor; PSW – Peer support worker)*

Staff felt phone assessments worked well for: Contraception, recurrent herpes simplex virus, repeat pre-exposure prophylaxis prescription, triage, and mild symptoms. Staff felt phone assessments did not work well for: Young people, vulnerable patients, reviewing dermatological conditions, and more complex sexual health patients.

Qualitative:

The thematic categorisation of free text responses to questions about confidence in providing care in the new service model, support providing these new roles, job satisfaction and experiences during the pandemic using the Framework for a Systems Approach to Healthcare Delivery (https://www.ncbi.nlm.nih.gov/books/NBK22878/):

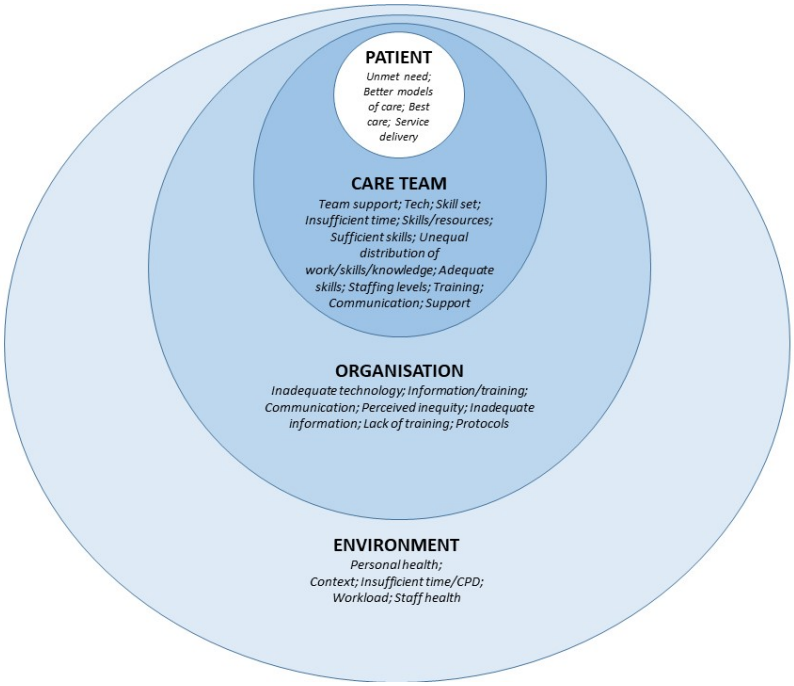

Figure 3: Thematic categorisation of free text responses to during the pandemic using the Framework for a Systems Approach to Healthcare Delivery

In response to the COVID-19 pandemic, our services were redesigned to move rapidly from established to new models of care with the aim of maintaining access to essential services for patients.

Implementing and delivering new models of care:

The delivery of new models of care were based on implicit assumptions (preconditions), for example:

1. Staff know how to deliver new models of care
2. Staff have the skills and capabilities to deliver new models of care
3. Staff have the support they require to deliver new models of care
4. IT and technology could support these models
5. Time assigned to appointment is sufficient to deliver care

Responses to the survey helped us to understand if these preconditions were met.

Staff know how to deliver new models of care
Staff have the skills and capabilities to deliver new models of care

- Staff groups highlighted the importance of communication and training.
    - Communication – mixed experiences from staff members. Whilst some colleagues felt there was frequent and good communication from the organisation and within the team, others a small number of staff expressed strongly that they did not feel this was the case. Although there was a general consensus that staff were well supported, in a minority of cases staff there was a sense of things being done to staff members without consideration of the impact this would have on their work-life balance, their job satisfaction or their ability to contribute significant skills to the delivery of excellent clinical care.
    - Training – Similarly, whilst most colleagues felt that there was adequate training, others felt strongly that they had not received adequate training to deliver new models of care effectively. For example, how to conduct new clinics and how to deliver IM injections. In some cases this seems to have contributed to some tension within the team, whereby some members feel others are not performing as well as they could and should be, thereby leading to inequity of workloads and variations in patient experiences and outcomes.
    - Whilst some people felt their personal circumstances had been taken into consideration and felt positively about this, there was also a sense of frustration from some that a proper consideration of individuals' personal and professional situations and skills were not taken into account when implementing changes. Rather, a hierarchical medical approach was taken with some staff members feeling that their considerable skills went unrecognised and unused with a knock-on effect for their job satisfaction and wellbeing.

Staff have the support they require to deliver new models of care]

- Training – Some staff expressed willingness to deliver new services/roles going forward as long as they received training to do this.

IT and technology could support these models
Time assigned to appointment is sufficient to deliver care

- Many raised concerns about how IT and telephone services were not sufficiently robust to deliver the models of care in the way they were envisaged. For example, poor phone connections, a lack of video conferencing and ability to see the patient (and rashes) made it challenging to take adequate histories and safely deliver care.
- Back to back 20-minute appointments were generally seen as insufficient time to deliver care and to address all the care needs of patients.

Underpinning factors:

- More broadly, there was a feeling that not all staff groups had been considered equally and fairly throughout the process. This was particularly true for non-consultant grade doctors, more junior nursing bands and admin staff.
- This had a knock-on effect on job satisfaction and personal wellbeing.
- From many, there was broad and consistent recognition of support within the team and organisation. However, some felt that there was insufficient support and communication or that colleagues and managers had been irritable, difficult to approach and actively unsupportive.

These factors are summarised in Figure 3:

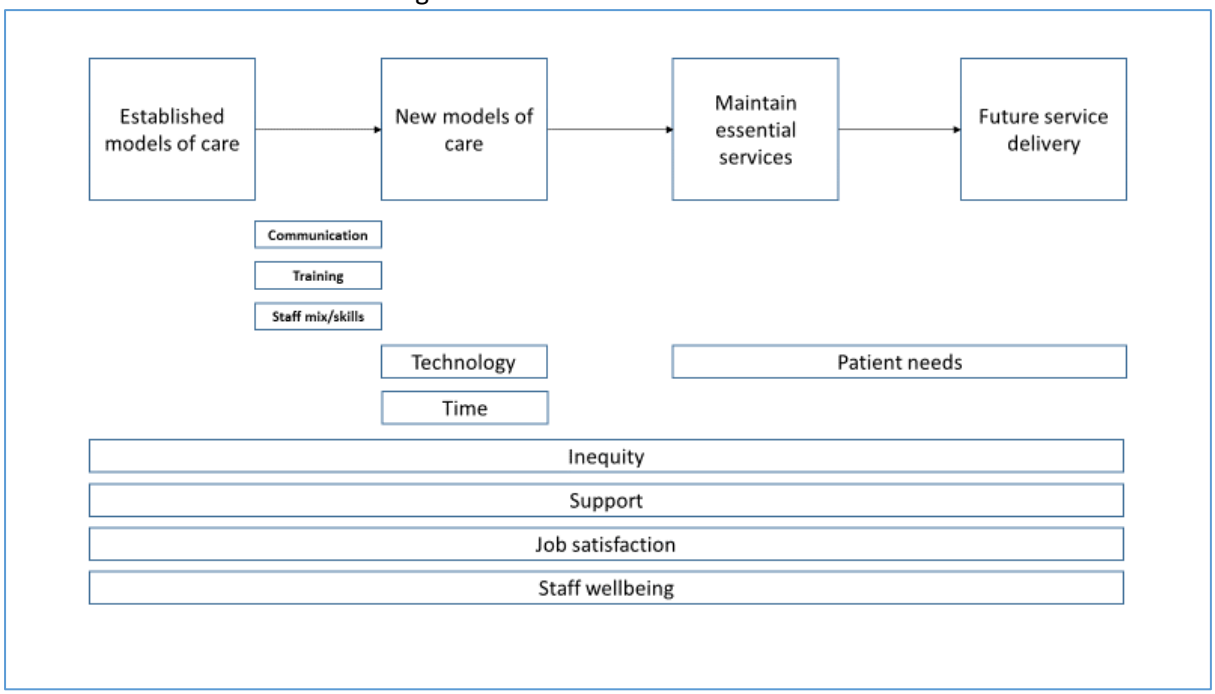

Figure 3

Conclusions:

Despite the tremendous amount of change, the majority of staff providing ISH services felt confident and supported during this time. Feedback has been used to make changes to service provision, and to staff support and roles, where issues have been identified. In response to the feedback we have enhanced support for staff in their new roles through increased one to one and group supervision, daily clinic 'huddle' meetings to keep staff updated of changes in service provision. Summaries of the 'Huddle' meetings are circulated daily to all staff via email to support staff working from home. Regular updates of changes in Treatment guide are circulated in our weekly service bulletin and an online staff quiz at the start of our monthly service Educational meeting serves to enhance learning. Finally, a broader range of roles has been introduced to increase variability for staff.