**Pandemic COVID 19**

**Contingency planning for out-patient Genitourinary Medicine,**

**Contraception and Sexual Health Services (including online) and HIV services**

**Summary of paper and actions:**

This paper has been compiled from responses received from clinical service leads across London and BASHH Officers. It represents a rapid review of COVID-19 contingency planning responses and findings, to seek a general consensus. It is understood that these may change rapidly, or over a period of a few weeks or a few months as the situation develops.

**THIS IS A LIVE DOCUMENT THAT WILL BE UPDATED IN THE COMING DAYS AS THE SITUATION DEVELOPS**

1. **Background:**

It is anticipated that major disruption to healthcare services during the peak of the current COVID 19 pandemic will last between 3 to 6 months with continued lower level disruption for a number of months after this.

All healthcare providers across England are being tasked to reduce capacity in out-patient clinics with respect to new and follow-up appointments, in order to reduce unnecessary F2F contacts and support NHS capacity in responding to the scale of the COVID 19 pandemic.

The greatest pressure during the COVID 19 pandemic is anticipated to be felt within acute settings where significant numbers of ventilated patients will need to be cared for.

Staff from all areas of healthcare will potentially be required to redeploy into an acute setting – to provide care for increased numbers of critical patients as well as to provide cover for significant staff shortages due to staff sickness or dependent care related issues. Further measures have been announced regarding trainee doctors, recently retired health professionals, nursing and other healthcare students nearing completion of their studies, and academic healthcare staff, all of which are designed to help further bolster the needs of the health service.

BASHH circulated a survey on 13th March to encourage the sharing of contingency planning across independently commissioned services. Concerns from respondents included; staff shortages, the ability to provide routine and urgent care to patients and the supply of medications to individuals requiring them.

In response to the pandemic GUM and CASH providers have ceased to operate a walk in model and have instead moved to one of booked appointments – intended to ensure the maintenance of safe staffing levels whilst reducing the virus spread by preventing COVID 19 positive individuals from attending services without appropriate precautions.

The majority of services have also suspended face to face consultations and moved to telephone appointments where possible for HIV care. Routine (LARC) and long term non-urgent care (complex) has also been postponed if safe to do so.

In addition to the BASHH survey 8 London providers provided their contingency plans as well as sharing information verbally and via email to help determine a commonality of clinical concerns and formulate a list of shared priorities whilst identifying where changes to care delivery methods are most likely to be beneficial. The 8 providers cover 16 authorities between them and 1 authority provides a sexual health e-service free to residents of participating boroughs. All the providers are acute trusts with some providing community based services, 4 services cater to a significant MSM population and all have a high share of SRH care. The resultant information was considered alongside the *Integrated Sexual Health Services: A suggested national service specification* (2018) produced by Public Health England and Department of Health and Social Care and the *Essential Services in Sexual and Reproductive Healthcare* (2020) statement from The Faculty of Sexual and Reproductive Health.

The most significant clinical concern was that whilst every effort should be made to provide cover to the acute settings as discussed a certain level of GUM and CASH provision must remain to provide ongoing care to individuals at risk of STIs, diagnosed with STIs and at risk of unplanned pregnancy. Reducing such services to too great an extent will result in a negative impact on the sexual health and reproductive health of large numbers of individuals, will lead to acute presentations in other emergency settings, and will also place a future financial burden on the NHS and other associated care providers.

1. **Shared Priorities:**

* Appropriate testing of high risk and symptomatic individuals.
* TEMPORARY suspension of some ‘low risk’ activity to help manage capacity and prioritise resources to ‘essential’ needs.
* Timely treatment of individuals diagnosed with an STI with specific regard for GC (increasing antibiotic resistance), MGen (emerging STI also with antibiotic resistance) and chlamydia (implicated in future chronic pain, ectopic pregnancies and subfertility).
* Further prevention of onward STI transmission by sufficient access to prophylaxis and preventative medications (specifically post exposure vaccinations, PEPSE and PrEP).
* Continued commitment to partner notification to further reduce the spread and negative impact of infections.
* Sufficient access to contraception – it was acknowledged that individuals may not be able to access their preferred method (specifically LARCs) at this time but that highly effective methods should continue to be readily available (Faculty recommends POP becomes a pharmacy drug and 3/12 emergency supply of oral contraceptives). The Faculty are also undertaking to support the extended use of LARCs within effective window periods.
* Timely access to emergency contraception through sufficient triage to determine an individual’s risk, easy access to hormonal methods (Faculty recommending extending emergency and as much access to emergency IUDs as can be maintained around likely staff sickness.
* A consistent desire to do the best for all patients within the current and rapidly changing pandemic situation (sexual assault management, young and vulnerable person safeguarding actions, provision of appropriate and good information and signposting).

1. **Categories of Risk & Care – some aspects only applicable to certain responding providers:**

**High risk / High Priority / Ideally physical Clinic**

*All pts will have undergone a triage (either by online or physical provider) before attending a clinic.*

High risk / prophylactic vaccine

Male purulent / high risk discharge

Rectal symptoms

Testicular symptoms

Syndromic treatment failure

Pregnant & symptoms (ED not indicated)

Pelvic pain (likely PID)

IMB/PCB (likely STI / unlikely due to contraception)

High risk vaginal discharge

Genital ulceration

PrEP

PEP – triaged as recommended

Sexual assault management

Young and Vulnerable person assessment

High risk rash / seroconversion symptoms

+ve GC / HIV / STS management

TV contact

Asympto contacts unable to abstain until WP test

Symptomatic contacts

Symptomatic TOC

Mgen testing if symptomatic

Contraception if no FP10 / online provision

EHC if no FP10 / online provision

EC IUD All pts will have undergone a triage (either by online or physical provider) before attending a clinic.

HIV care – emergency / unstable patient

Abortion care provision

Psychological support

**Other areas of management**

|  |  |
| --- | --- |
| Results | *Reduced numbers as reduced attendance however these resources likely to be used on Triage* |
| PN |

**Low risk / Low priority / Ideally online / TEMPORARY suspension**

*Pts may initiate with an online provider and reach the following level of care before being directed to a clinic / pts contacting a clinic under COVID pressure with these issues would be signposted away (online if possible)*

Asympto (Reduce / Flex appropriate to available capacity, including potential for TEMPORARY suspension)

Dysuria

Low risk urethral discharge

Low risk rectal

Pharyngeal symptoms

Low risk testicular

Low risk syndromic failure

Low risk female discharge

Post PEP FU

CT treatment

Mgen test +/- treat (if available)

Asympto contact testing post WP

TOC

**Other areas of management**

Triage & book to physical clinic

Results

PN

The services which provided information are all GUM and CASH providers within London however each service has significantly differing methods of patient and staff management as well as varying access to emerging models of virtual and remote care. Additionally the recent government move to increasing levels of social isolation will have a significant impact on provision of care during this COVID 19 pandemic. If adhered to social isolation may help reduce the spread of infections across groups however it may increase the risk of unplanned pregnancies whilst reducing many individual’s access to testing and treatment. However it was possible to derive common themes for where pressures in services are likely to occur and ways in which issues may be mitigated.

1. **Pressures:**

Triage -

All physical services indicated that they had implemented triage processes for their patients which were to be undertaken via the telephone. Triage was needed to allow capacity management by ensuring only those with the highest priority concerns were attending and that the risk of COVID 19 transmission was reduced (ensuring patients were symptom free or that an isolation room was available). However the potential need to speak to and assess all individuals contacting a service will have a significant impact on staff availability to actually see patients.

Online providers are willing to expand their services to provide testing, diagnosis and treatment of patients previously routed away to physical clinics (due to high risk behaviours or the need for examination of symptoms). However their online portals and pathway processes will need to be adjusted and this will take time. These processes need to be sufficiently robust to ensure that users requiring an enhance level of interaction or care are still appropriately identified.

Access –

Once patients are triaged services may struggle to provide sufficient capacity for booked appointments or staff with the appropriate skills (for example for coil insertion). Many staff will be redeployed to acute areas as well as high levels of staff sickness due to COVID 19 being anticipated. Continually assessing and managing capacity and demand is likely to be an incessant pressure on services’ time and resources.

Testing –

The current testing services for physical providers are under increased pressure due to managing COVID 19 tests and the increased sample testing required for critically ill COVID 19 patients. For this reason many services have diverted their asymptomatic patients to online testing platforms and reduced the level of exploratory testing undertaken.

Online testing platforms therefore have witnessed an increased demand for asymptomatic screens whilst they may also be asked to consider increasing the variety of tests that they can undertake, MGen, as well undertaking TOC which may impact on the results communication process to patients as well as reducing their capacity to undertake testing of more complex patients if this was to be agreed.

Treatment / Contraception provision–

Physical services have been instructed to reduce the flow of patients to their service (many of which are on acute hospital sights) whilst the public are being encouraged to reduce travel. This makes the traditional model of attending a service to collect free medication difficult to preserve.

Some services are posting prescriptions to patients which require patients to attend a pharmacy. Others are posting medication directly to the patient yet capacity, demand and supply may prove a struggle for these services whilst those not already operating such a model will need to approach their pharmacy leads to gain permission which is likely to further delay the process.

Some services have remote provision in place for medication; for pharmacy collection or by posting medication or FP10s to an address as facilitated by online providers or physical services posting out individually. However demand may outstrip capacity (as such services are also likely to suffer staff shortage and medications may not in sufficient supply at the differing settings). Additionally many areas have not yet signed up to one of these models and patients may not be able to access the correct medication or may be expected to pay an online provider which they may choose not to do.

1. **Potential changes to current models identified as being beneficial:**

Central coordination of assessment and triage:

One provider to act as a central point of contact for all patients. Such a provider would undertake a standardised triage and determine what level of service is required. Online testing could be initiated at this point or if an examination / intervention were required an appropriate appointment could be booked with a suitable provided local to the patient.

To work this would require -

Sufficient staffing capacity to undertake the triage / potential sharing of staff between trusts / increased remote access for home working when self-isolating

Sufficient media / website information to direct patients to this provider

Effective liaison with services regarding capacity and staffing skills to facilitate booking of patients

A commonly accessible portal to allow the transfer of clinical information

Commissioner agreement with regards to increased billing from such a service

Online provider to increase their testing scope:

To consider testing higher risk or symptomatic patients, provide additional tests such as MGen and PrEP bloods and undertake routine test of cure.

To work this would require –

Additional testing capacity – potentially by reducing asymptotic and repeat testing. Consideration needs to be to the equitability of this across the country / which areas have the greatest need

Potentially an adjustment to testing kits to include additional samples

Adjustment to current online triage of protocols as allowed by IT staffing levels

Sufficient staffing to undertake additional results management

Effective liaison with physical providers to quickly refer patients for treatment

Commissioner agreement with regards to increased billing from such a service

Increased access to online pharmacies for contraception and treatment:

To consider all services being able to facilitate the dispensing of free treatment via an online pharmacy or service postal model as well as online pharmacies looking to increase which medication they can provide with regards to sexual health.

To work this would require –

Legal considerations with respect to prescribing

Online links between pharmacies and individual providers or pharmacies a single portal accessible to many providers

Commissioner agreement with regards to increased billing from such a service and consequences for current providers of progressive shift of workload

**Appendix.**

**Indication of symptoms / management, when call back triage should be undertaken and which service type should provide the care as indicated by review of separate provider’s business plans / SOPS produced in specific response to the current COVID 19 pandemic.**

*Patient Management:*

|  |  |  |
| --- | --- | --- |
| T | Triage | * Online - *no human contact* |
| CB | Call Back | * Telephone– full consultation undertaken on phone thus reducing F2F time if needs to attend a service * Health Advisor or Clinician (Dr/Nurse) as indicated by scenario or staff availability |
| NCT | No Contact Tests | * Online / postal provider test - *no human contact* |
| NCTreat | No Contact Treatment | * Online / postal / ‘click&collect’ – *no human contact* |
| MCT | Minimal Contact Tests | * Needs to attend service, full history taken prior to attendance, examination +/- tests as indicated |
| MCTreat | Minimal Contact Treatment | * Needs to attend service, full history taken prior to attendance |
| RI | Remote Imaging | * Pt sends image via secure service |
| ADL | Activities of Daily Living | * If issues / symptoms not managed will significantly negatively impact pt |
| Ref | Referral | * Referral / Sign Post to appropriate non GU services (that remain available) |
| IP | Information Provision | * About infection / risks / contraception – during consult or online |
| C&C | Click & Collect | * Provision of medication at a service / pharmacy – pt needs to attend but doesn’t need consultation |

*Highest provider interaction required:* reflects current changes to practice as dictated by need to increase social isolation aimed at reducing COVID 19 viral transmission

OP - Online portal only for triage / Online portal only for medication – NO ATTENDANCE

OCB – Human triage then online provision of testing and or medication – HUMAN CONTACT & NO ATTENDANCE

Clinic – Issue requires clinic attendance for testing and or medication – HUMAN CONTACT & ATTENDANCE

**NB** – Symptoms, treatments and services are listed briefly – the full episode of care required is not documented. ie PEP provision = baseline bloods, POCT, risk reduction counselling, dispensing of medication etc

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  | Provider |
| **Documentation / Risk assessment / History Taking** | | |  |
| Sexual history taking and risk assessment | T / CB |  | OP / OCB |
| Safeguarding assess under 18s & vulnerable adults | CB | Ref | OCB |
| Under 16 | CB | low threshold for F2F | OCB |
| Sexual Assault - Acute | CB | Ref  MCT & MCTreat | OCB |
| Sexual Assault - Follow up (post WP) | CB | Ref – Mental health  NCT | OCB |
|  | | |  |
| **Prevention** | | |  |
| Vaccination | | |  |
| Low risk | T / CB | Defer | OP / OCB |
| High risk | T / CB | MCTreat | Clinic |
| Prophylaxis | T / CB | MCTreat | Clinic |
| Condom provision | Media | Increase access |  |
|  |  |  |  |
| **Screening (& treatment if indicated)** | | |  |
| Asymptomatic Screening inc MSM  (? cap numbers /frequency to free up testing capacity for higher risk patients) | T | NCT | OP |
| Male Dysuria | T / CB | NCT / MCT  Ref | OP / OCB / Clinic |
| Male Urethral Discharge | | |  |
| Low risk STI | T / CB | NCT | OP / OCB |
| High risk STI / purulent | CB | MCT +/- MGen test +/- MCTreat  OR  (NCT +/- MGen test – online available?) | Clinic  (OCB) |
| Rectal symptoms | | |  |
| Low risk STI | T | NCT, Ref | OP |
| High risk STI | CB | MCT +/- MCTreat | Clinic |
| Pharyngeal symptoms | T | NCT | OP |
| Testicular symptoms | | |  |
| Low risk | CB | NCT / MCT | OCB / Clinic |
| High risk | CB | MCT +/- MCTreat | Clinic |
| Balanitis | T / CB | Ref | OP / OCB |
| Syndromic treatment failure | | |  |
| Low risk | CB | NCT, Ref | OCB |
| High risk | CB | MCT +/- MCTreat | Clinic |
| Female - ? Pregnant - Asymptomatic | T | Buy pregnancy test  NCT | OP |
| Female – Pregnant - Symptoms | CB | MCT +/- MCTreat  Ref (bleeding ED) | Clinic |
| Pelvic Pain | CB | MCT +/- MCTreat | Clinic |
| Vaginal discharge / smell | | |  |
| No risk | T / CB | Ref (pharmacy) | OP / OCB |
| Low risk | T / CB | NCT & Ref | OP / OCB |
| High risk | T / CB | MCT +/- MCTreat | Clinic |
| Lumps/Bumps symptoms – suspected MC / HPV | CB | NCT  Defer | OP / OCB |
| Genital ulceration | CB | RI  MCT +/- MCTreat | Clinic |
| Tropical STIs | CB | MCT +/-MCTreat | Clinic |
| PrEP - Consider risk reduction & discontinuation / move to event based during pandemic where appropriate | CB | NCT, MCTreat  (NCTreat - any no contact provision?) | Clinic |
| PEP - FU | T | NCT | OP |
| Itching | T / CB | Ref (pharmacy) | OP / OCB |
| Rash / Seroconversion symptoms |  |  |  |
| Low risk | CB | NCT | OCB |
| High risk | CB | MCT +/- MCTreat (STS) | Clinic |
|  |  |  |  |
| **Treatment (& further testing if indicated)** | | | |
| Positive GC | Recall | MCTreat (+ culture if NCT diagnosis) | OCB / Clinic |
| New HIV positive diagnosis | Recall | MCT + MCTreat | OCB / Clinic |
| STS & Non HIV BBV – likely diagnosed via asympto screen | Recall | MCTreat + ?FU MCT | Clinic |
| Positive CT | Recall | NCTreat | OCB |
| PEP - indicated | CB | MCT + MCTreat (dispense 28/7) | Clinic |
| Recurrent or Recalcitrant STIs or Conditions – candida / HSV / vaginismus / HPV | | |  |
| New | Defer |  | - |
| FU | Defer |  | - |
| ADL impact | CB | Ref (pharmacy) MCTreat | Clinic |
| Complicated STI – Treatment failure / unusual history | CB | RI  MCT +/- MCTreat | Clinic |
| HPV | T / CB | Defer | OP / OCB |
| Contact of STI | | |  |
| TV | Recall | NCTreat / MCTreat | OCB / Clinic |
| Asympto post WP & can abstain | Recall | NCT | OCB |
| Asympto in WP & can abstain | Recall | NCT post WP | OCB |
| Asympt & can’t abstain | Recall | NCTreat / MCTreat | OCB / Clinic |
| Sympto – management dependant on index infection | Recall | NCTreat (CT),  MCT,  MCT +/- MCTreat (GC culture) | OCB / Clinic |
| TOC | | |  |
| Asympto, correct treatment taken in full | Recall |  | OCB |
| Asympto, correct treatment taken in full, increased failure risk (GC/MGen) OR Pregnant | Recall | MCT (MGen) (NCT ? MGen) | OCB / Clinic |
| Remain symptomatic | Recall | MCT +/- MCTreat | Clinic |
| Results management | Recall | Health Advisor or Clinician (Dr/Nurse) as indicated by scenario & staff availability | OCB |
| Partner notification – consider speed of need for treatment based on WP and ongoing risk of SI with infected partners | Recall | Health Advisor or Clinician (Dr/Nurse) as indicated by scenario & staff availability | OCB |
| Specialist HIV care – ongoing care of previously diagnosed patients | Move to virtual where possible  Defer bloods if appropriate  Ensure medication supply  Escalate to F2F as necessary | | Clinic |
| Psychosexual – New / FU with mental health concerns | CB | Ref (Mental health)  Defer | Clinic |
| Psychosexual – FU with no mental health concerns | Defer |  | - |
| Abortion care | Protection of services to ensure timely access to procedure.  Move to medical where possible due to likely reduced staffing available for surgical | | Clinic |
|  |  |  |  |
| **Contraception** | | | |
| Routine Oral/Patch/Ring – 6&12/12 supply, no BP required for POP  Increased demand due to bridging LARCs? | T / CB | NCTreat / MCTreat | OP / OCB / Clinic |
| Depo – unwilling to switch method / supply issues (Sayana Press) | CB | MCTreat (?Staffing) | Clinic |
| LARC – Implant/IUD/IUS – able to abstain/condoms/bridge | CB | Defer | - |
| LARC – Implant/IUD/IUS – high risk of pregnancy | CB | MCTreat (?Staffing) | Clinic |
| Emergency Contraception – IUD unsuitable / declined | CB | Ref (pharmacy) | OP / OCB |
| Emergency Contraception – IUD accepted | CB | MCTreat (?staffing) | Clinic |
| Complex Contraception routine (missing threads / deep imp) | Defer |  | - |
| Complex Contraception high risk / symptomatic | CB | MCTreat (?staffing) | Clinic |
| **Non Patient Facing** | | | |
| Clinical Leadership & Governance – Regional model via networking across sites. Continue to provide telephone support to non-GU services – manage inward referrals as appropriate to current pandemic situation. | Undertaken by All   * Initially provided by individual partners * London lead designated to coordinate resources in event of significant closures | | |