

Pandemic COVID 19

Contingency planning for out-patient Genitourinary Medicine, Contraception and Sexual Health Services (including online) and HIV services

(December 2021 Update)

Key Updates (December 2021)

Throughout 2021, much progress has been made in stabilising services across the UK and initiating the journey to recovering unmet need within the Sexual and Reproductive Health and HIV Sector, not least that documented within the BASHH Clinical Thermometer BASHH Survey series [British Association for Sexual Health and HIV - Covid-19 \(bashh.org\)](https://www.bashh.org/). Services have navigated the successive waves of the COVID-19 pandemic, however the unique and currently unfolding challenges of the Omicron variant pose perhaps our steepest and most acute stressor to date. We trust that this will be short-lived, that the benefits of vaccinations and booster programmes will blunt the impact and that the basic principles and spectrum of options laid out for services in the original documents remain extant for local adaption and implementation.

In recognition of the current situation, BASHH recommends:

1. **Open Communication:** form flexible communication networks with all your local partners within your service, within your organisation, within your locality, and your partnerships. Join BASHH Zooms, email your President john.mcsorley@nhs.net, communicate within your Trust, and local authority via email, WhatsApp, Teams & Zoom to support each other.
2. **Maximise all resources available** for the benefit of the population.
3. **Preserve expert workforce capacity and expertise** by temporarily deferring any non-urgent activity to prevent avoidable concurrent large-scale loss of workforce for the duration of this surge.
4. Services remind the wider healthcare system that many elements of sexual health, SRH & HIV are essential and high-priority so it is vital to **preserve these functions where possible**.
5. Where sexual health services also provide HIV care it is imperative that we **preserve sufficient workforce and face to face capacity** to address the updated COVID surge whilst also maintaining HIV care standards.
6. That **local services adopt an informed flexible approach**, adapting provision to preserve capacity that recognises the local prevalence of COVID-19 but especially the enhanced risk and speed of transmission with Omicron variant.
7. That **all online and telemedicine capacity and other modalities** to both safeguard the workforce and maintain or expand provision of care to the public **are optimised now** where available or introduced where not currently available.
8. In areas where online service provision is not as well developed as in London, for example, that **NHS COVID emergency and recovery funding is used to make resource available to support and expand access to sexual health, SRH and HIV services for all populations** by expanding the mechanisms to provide universal delivery of emergency hormonal contraception, progestogen-only pills and some STI treatments online, by every option available, including via local pharmacies.
9. That **any restrictions or limitations to STI testing on current digital pathways**, whether financial or based on clinical algorithms are **lifted for at least three months**
10. That, since most **contraception** access in England and the rest of UK is delivered through primary care, prioritising **online and remote capacity and access** can significantly reduce the burden on local GPs and should be an **urgent priority for commissioners**.

11. **Primary care commissioners should also now actively explore implementing access priorities** such as those within the Public Health England-developed [E-sexual and reproductive healthcare: national framework - GOV.UK \(www.gov.uk\)](#)
12. **Clinicians should review the relevant updated guidance from BASHH, FRSH & BHIVA and re-evaluate the spectrum of care they provide** to incorporate systemic or structural change adopted or adapted since the original Pandemic COVID-19 Response & Contingency Planning Documents were created.

Annex: Key Supporting Guidance

[Pandemic COVID-19 Sexual Health Services Priorities v0.8 BASHH \(November 2020\).pdf](#)

[COVID-19 Resources and Information for SRH Professionals - Faculty of Sexual and Reproductive Healthcare \(fsrh.org\)](#)

[Updated BHIVA guidance for HIV services during COVID surges](#)

THE ORIGINAL NOVEMBER 2020 GUIDANCE UPDATE IS AVAILABLE OVERLEAF

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 BASHH members across the UK. It represents a rapid review of COVID-19 contingency planning responses to seek a general consensus of the challenges faced by and the resultant priorities for services around the country. It is understood that these may change rapidly, or over a period of a few weeks or a few months as the situation develops. It is also understood that how COVID-19 affects individual regional areas and providers will not be uniform and local settings will need to react and adapt differently.

Key Updates (November 2020):

Recent weeks have demonstrated that we are entering a new phase of the pandemic, with difficult challenges ahead of us as we head into winter. Whilst much of the good practice we have put in place since March remains relevant, there is a need for renewed focus on how essential sexual health service delivery can be maintained in the face of likely forthcoming national and local virus peaks and troughs, and the associated distancing measures and disruptions that will accompany these.

With this in mind, the following five principles have been identified to support local service planning and the adoption of measures that can help to ensure the continued delivery of the widest range of sexual health functions as possible in the coming months:

1. Prioritise measures that support the retention of a functional local sexual health service (supporting continued delivery of 'high-risk/high-priority' outlined in section 3)
2. Adopt a 'telephone and digital first' access policy where possible, to help manage in-service demand and to support the most efficient allocation of resource (digital services should be provided alongside the continued availability of face-to-face care, as part of a range of available options)
3. Deliver appropriate expertise where it is most effective, ensuring that sufficient levels of staffing remains in place to support continued delivery of core sexual health care
4. Close working with other parts of the pathway to help manage the accumulated backlog of patients requiring LARC
5. Support ongoing COVID-19 contact tracing efforts where possible, providing expertise and input in line with local resourcing needs and appropriateness

Background:

It is anticipated that there will be continued and varying levels of disruption to healthcare services during this new phase of the COVID 19 pandemic, which will last throughout winter and possibly into 2021.

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

The greatest ongoing pressure during the COVID 19 pandemic is anticipated to be felt with respect to staff sickness and the impact of caring responsibilities on the workforce (including isolation of family members), and within acute settings where significant numbers of ventilated patients will need to be cared.

In this context it is important to note that education and training represent key areas of service provision and that students are deemed essential workers. We are planning for examinations and recruitment to proceed

so trainees need the learning opportunities and study leave to be provided for them to undertake these successfully. The private sector has also agreed to make available staff and resources to help with the COVID 19 pandemic.

BASHH circulated a survey on 13th March 2020 to encourage the sharing of contingency planning across independently commissioned services. Detailed response and plans from across all 4 Nations in the UK were received. Service providers co-ordinating care for large populations and with a range of patient demographics and service provision arrangements as well as a large on-line service provider in the UK have been involved. Lead Clinicians and Clinical Leaders across Wales, Scotland and Northern Ireland have contributed to BASHH Survey and submitted contingency plans as well as comments on the development of this document

In addition to the BASHH survey a review of London providers' contingency plans (written documentation along with information communicated verbally and via email) was undertaken to help determine a commonality of clinical concerns and formulate a list of shared priorities whilst identifying where potential changes to care delivery methods could be most beneficial. 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 many GUM and CASH providers have already ceased to operate a walk-in model and instead moved to one of booked appointments – intended to ensure the maintenance of safe staffing levels whilst reducing the virus spread by preventing individuals with suspected or confirmed COVID-19 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 long term complex patients and HIV care. Where safe to do so routine contraception and long term non-urgent care have also been redirected or postponed.

The resultant information was considered alongside the Integrated Sexual Health Services Specification (Public Health England and Department of Health and Social Care, 2018), the Essential Services in Sexual and Reproductive Healthcare statement (The Faculty of Sexual and Reproductive Health, 2020), the Sexual Health and Blood Borne Virus Framework 2015-2020 Update (Scottish Government) and the Sexual Health Standards (Healthcare Improvement Scotland).

The most significant clinical concern was that whilst every effort should be made to provide cover to the acute settings during the COVID 19 emergency 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 as well as placing a future financial burden on the NHS and other associated care providers.

1. Shared Priorities – not listed in order of priority.

A local area's priorities position will be influenced by the presentation and needs of patients, the service specifications of individual providers and how COVID 19 is currently impacting a given service.

Government moves to increase levels of physical distancing aims to reduce the continued transmission of COVID 19 and if adhered to may help reduce the spread of sexually transmitted infections however for some it may conversely increase the risk of sexual contact and thus infection transmission or unplanned pregnancies.

- A consistent desire to do the best for all patients with available resources within the current and rapidly changing pandemic situation.
- A continued undertaking to ensure the appropriate management of young and vulnerable individuals, sex workers and those experiencing domestic or sexual abuse.
- Appropriate testing of symptomatic individuals and those at high risk of infection.

- A TEMPORARY suspension of some ‘low priority’ activity to help manage capacity and priorities resources to ‘essential’ needs.
- Timely treatment of individuals diagnosed with an STI with specific regard for Gonorrhoea (increasing antibiotic resistance), Mycoplasma Genitalium (emerging STI also with antibiotic resistance), syphilis 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 (PEPSE, PrEP and post exposure vaccination).
- 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 easily accessible. To reduce provision barriers The Faculty have recommended POP becomes a pharmacy drug and pharmacies provide a 3 month, as opposed to 1 month, emergency supply of oral contraceptives. The Faculty are also undertaking to support the extended use of LARCs within effective window periods. Combined oral contraception (COC) should be available for those who have a blood pressure and BMI measurement documented within the past year. This may be achieved remotely, with self-reported BP and BMI (existing COC users with an accurate blood pressure and BMI measurement documented within the past year do not need these repeated during lockdown).¹
- Timely access to emergency contraception through sufficient triage to determine an individual’s risk coupled with easy access to emergency hormonal pills and continued access to emergency IUDs (as can be maintained safely with respect to staffing levels).
- Clear and up-to-date information (made available online and in local healthcare settings where appropriate) about where and how to access available services
- To consider how barriers can be removed to facilitate access to testing and treatment without increasing social contact and potentially COVID 19 transmission.

IN EXTREME CIRCUMSTANCES where a physical service cannot be provided

There is currently considerable uncertainty surrounding the impact of COVID 19 on the demands placed on the whole healthcare system and the capacity of the workforce to meet these demands. Where services are forced to reduce their capacity to the minimum level in order to support the NHS’s action on COVID, it would be recommended that the priority for STI care provision is a problem that is:

- **LIFE-THREATENING,**
- **POTENTIALLY LIFE-SHORTENING,**
- **CAUSING UNBEARABLE SYMPTOMS,**
- **PRESENTS A SIGNIFICANT PUBLIC HEALTH RISK** (e.g. acute symptomatic chlamydial infection, HIV sero-conversion illness or symptoms of gonorrhoea)

With respect to contraception provision in this scenario priority would be given to interventions aimed at reducing a significant risk of an unplanned pregnancy through the provision of:

- Emergency contraception

¹ The Faculty of Sexual and Reproductive Healthcare. FSRH Statement: Provision of contraception during the COVID-19 pandemic. October 2020. Available online at: <https://www.fsrh.org/documents/fsrh-update-provision-of-contraception-during-covid19/>

- Basic level of universal provision eg POP (OTC), condoms
- Abortion care

Service Leads may consider a presence in other service points e.g. URGENT CARE CENTRES, to provide and deliver Urgent Care and Advice there if they are unable to maintain their own physical service.

2. Shared Pressures – *not listed in order of impact*

Services providing GUM and CASH across the country differ significantly with respect to models of patient and staff management as well as having a varied access to, and uptake of, emerging virtual and remote care models. However common themes are hypothesised with respect to the pressures services are likely to experience during the current pandemic.

Triage -

To reduce the spread of COVID 19 healthcare services across specialities have reduced face to face consultations and GUM/CASH providers have widely implemented increased triage processes, by telephone or online pathways. Such triage will help assess the appropriate priority of a patient's concerns and if management can occur external to the clinic, allow services to manage their daily capacity with respect to staffing levels and also ensure patients with suspected or confirmed COVID 19 are seen, where appropriate, with appropriate levels of protection provided to staff. However the potential need to speak to and assess all individuals contacting a service will have a significant impact on staff availability to see patients.

Access –

All services are being asked to support the NHS's action on COVID therefore once triaged services may still lack the staff to see any but the most urgent cases due to redeployment or staff sickness. This situation may be partially mitigated by neighbouring services coordinating capacity and skill mix and thus signposting patients to the appropriate service however the resultant need to continually assess and manage capacity and demand is likely to place a further pressure on services' time and resources.

Testing –

Many testing services currently serving physical providers are under increased pressure due to both the high levels of COVID 19 tests and the increased testing required for critically ill COVID 19 patients. Clinicians are therefore being asked to be mindful of the clinical significance of the testing that they request as well as considering how delayed resulting may impact the need for syndromic treatments. While syndromic treatment may be appropriate the need for specific tests, such as resistance tests, remains important to ensure the appropriate management of infections, the correct treatment of contacts and to guard against increasing levels of antibiotic resistance.

As clinic attendance has been restricted many services are diverting their asymptomatic patients to online testing platforms where available. Online testing is not however available in all areas and this may leave individuals with no asymptomatic testing offer.

Online testing platforms have therefore witnessed an increased demand for asymptomatic screens. This increase demand may also coincide with online providers being asked to extend their service offer to symptomatic patients that clinics have triaged and deemed to be at low risk of an STI or appropriate for online test of cure testing. However online provider capacity is not finite and they are also likely to be impacted with respect to staff shortages due to self-isolating and sickness.

Treatment / Contraception provision–

With physical services instructed to reduce the flow of patients to their service (many of which are on acute hospital sites) and the public being encouraged to reduce travel the traditional model, of attending a service to collect free contraception or medication following examination or diagnosis, is difficult to preserve. Individual services have differing existing processes, or have speedily implemented changes in response to the current situation, to provide patients with medication:

Links with online pharmacies – staffing levels and supply of the correct levels of medication within the community may impact the ability for these services to manage demand. Only certain treatments are currently available or may be appropriate via these services.

Provision of medication via post – staffing levels to manage the process, supply of medication within services and the potential impact of COVID 19 on mail services may impact the effectiveness of this strategy.

Provision of FP10 to local pharmacy or via post – staffing levels to manage the process, supply of medication within services and the potential impact of COVID 19 on mail services may impact the effectiveness of this strategy.

3. Categories of Risk & Care provision – NOT in order of priority.

Applicability to services will depend on service specification.

HIV care not covered in detail – see BHIVA for specific information

Abortion care not covered in detail – see NHEngland for specific information

All clinics should continue to manage 'unwell patients' that contact their service – consideration must be given to other illnesses that may be causing reported symptoms and if more urgent care is required. Enhanced triage should support additional signposting according to clinical need.

We are mindful that in a rapidly changing situation service providers may have very limited capacity to provide any service, and that the resource available may change on a daily or weekly basis. Lead Clinicians may have to set and review clinical priorities in cognisance of national public health priorities which endeavouring to provide the optimal service to individuals. BASHH will endeavour to monitor the situation and provide further advice and support as necessary. We recommend that all Service Providers set up robust communication networks locally and regionally to pool resources and intelligence to build maximal resilience across services.

High risk / High Priority

All pts will have undergone a method of triage before being directed to attend a clinic.

Consider the need for clinic attendance and examination vs testing without examination – will treatment / results management be significantly & positively impacted by clinic attendance?

Symptoms – where need to be seen to determine treatment, consider use of remote imaging (in line with nationally published 'key principles' guidance²):

Genital ulceration

Male purulent discharge

Rectal symptoms

Asymptomatic triaged as high risk of infection (consider any benefit of F2F vs online test)

Testicular symptoms

Syndromic treatment failure (potential STI, causing unbearable symptoms)

Recurrent / recalcitrant conditions (causing unbearable symptoms)

Vaginal discharge (not managed by syndromic treatment, likely STI)

Pelvic pain (likely PID)

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

Pregnant & symptoms (where ED not indicated)

High risk rash / seroconversion symptoms (consider COVID vs HIV/STS, consider any benefit of F2F vs online test)

TV contact (if able to abstain feeling more low risk in current climate...?)

Asymptomatic contacts (risk of transmission & unable to abstain until post window period online test)

Symptomatic contacts

² Key principles for intimate clinical assessments undertaken remotely in response to COVID-19. July 2020. Available online at: [https://www.gmc-uk.org/-/media/files/key_principles_for_intimate_clinical_assessments_undertaken_remotely_in_response_to_covid19_v1-\(1\).pdf?la=en&hash=0A7816F6A8DA9240D7FCF5BDF28D5D98F1E7B194](https://www.gmc-uk.org/-/media/files/key_principles_for_intimate_clinical_assessments_undertaken_remotely_in_response_to_covid19_v1-(1).pdf?la=en&hash=0A7816F6A8DA9240D7FCF5BDF28D5D98F1E7B194)

MGen testing if symptomatic

Treatment / Contraception provision – consider remote provision, reduced need for travel, greatest maintenance of physical distancing

PrEP (consider availability of medication, consider move to episodic if appropriate)

PEP (assessed as *Recommended*)

High risk / post exposure hepatitis B vaccine

Acute sexual assault management (awareness of local current SARC provision / suitability)

+ve GC / HIV / STS management

Contraception if no FP10 / online provision

EHC if no FP10 / online provision

EC IUD (triaged and patient desiring of IUD)

Other need for face to face –

HIV care – emergency / unstable patient

Young, Vulnerable, Sex Worker

Psychological support

Other areas of management

Results	}	<i>Potential reduced volume to manage due to reduced attendance however resources will likely be move to triage</i>
PN		

Low risk / Low priority - TEMPORARY suspense may be deemed necessary by local situation

- *Patients contacting a clinic with COVID pressures and triaged with an issue listed here can be signposted to:*

No treatment at present

Community based syndromic treatment

Remote treatment for positive infections

Online 'asymptomatic' testing service (advice may be given to bypass online triage questions)

- *Patients contacting online providers may be accepted to home testing if virtual service is able to triage and indicate an issue listed below.*

Symptoms – where **triage** indicates low risk / low priority yet screening via online is recommended if **available in local context**:

Asymptomatic

(Reduce / Flex as appropriate to available capacity, including TEMPORARY suspension)

Dysuria

Where after triage STI unlikely:

urethral discharge

rectal

testicular
female discharge
syndromic treatment failure

Pharyngeal symptoms

Post PEP post WP testing

Lumps, Bumps, Dermatological itch (suspected / recurrent / continuing - MC, HPV, scabies etc)

Mycoplasma Genitalium testing (online providers currently unable to provide such testing however may change over course for the pandemic and likely long term reduction in clinic capacity)

Contact testing (consideration of index infection, any symptoms of contact, window period status, potential for abstinence - flex as appropriate to local capacity)

Test of Cure (consideration of infection, results of resistance tests, adherence to medication, any current symptoms – flex as appropriate to local capacity)

Treatment

Management of positive diagnosis (online providers currently provide / link with postal / click & collect treatment, the medications available under remote prescribing or via OTC purchasing may change over the course of the pandemic and likely long term reduction in clinic capacity)

Other areas of management

Results	}	<i>Potential increase in volume as low risk patients with simple STIs are signposted to service</i>
PN		
Call back & referrals	}	<i>Potential increase in volume as increasing number of positive STIs need to be managed / referred on</i>

4. Potential changes to current models identified as being beneficial:

During the early stages of the pandemic, as contingency planning was initiated, many suggestions were made for areas where change could be affected to ease the provision of triage, testing, diagnosis, treatment and management have been suggested. The speed of the pandemic has now potentially reduced the ability for existing physical clinics to make such changes as the workforce is experiencing significant redeployment and the capacity of those remaining is increasingly stretched. We would therefore call on all non-NHS providers, policy makers and commissioners to consider how the sexual and reproductive health of the nation can continue to be protected during the pandemic and reduce the negative impact felt in the months and years to come.

An urgent request for sustained investment has been submitted to UK Government on 23/03/2020 from BASHH, FSRH & BHIVA

Central coordination of assessment and triage:

A central hub set up to act as a point of contact for all patients. The hub would provide 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 provider local to the patient.

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 between services regarding capacity / staffing skills to facilitate booking

A common remotely accessible portal to allow the transfer of clinical information

Commissioner agreement with regards to increased billing from such a service

Online provider to increase testing scope:

To allow testing of higher risk or symptomatic patients, provide additional tests (MGen / resistance tests), PrEP monitoring bloods, test of cure.

This would require –

Additional testing capacity – potential reduction asymptomatic & repeat testing, sampling resources, testing resources, staffing numbers

Adjustment to testing kits to include additional samples

Adjustment to triage protocols – template design & implementation staffing

Increase capacity to manage additional results

Effective liaison with physical & virtual providers to facilitate treatment management

Commissioner agreement with regards to increased billing from such a service

Increased access to online pharmacies for contraception and treatment:

To consider *all services* becoming able to facilitate free treatment via an online pharmacy or service postal model

AND / OR

To consider alterations to medication available via online pharmacies / OTC medications

To work this would require –

Legal considerations with respect to prescribing

Online links between pharmacies and individual providers

Commissioner agreement with regards to increased billing from such a service

Appendix.

The following is an indication of suggests for management of specific symptoms / treatments / scenarios.

It was informed by the review of business contingency plans and SOPs from 8 London providers as described in the main body of this document.

It is not an exhaustive list of every possible situation – the exact management of each specific patient will depend on a wide number of fluctuating factors and services must consider how best they can manage with the priority to provide the most good for the most number of patients.

NB – Symptoms, treatments and services are listed briefly – the full episode of care required is not documented and would remain the responsibility of individual services to manage the full episode with regards to their local policies and current abilities.

Patient Contact & Management: Suggested contact mediums and ways to manage scenarios to ensure full clinical consideration of patients’ needs whilst maintaining the highest possible level of social isolation for each patient.

T	Triage	<ul style="list-style-type: none">• Online - <i>no human contact</i>
CB	Call Back	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• Online / postal provider test - <i>no human contact</i>
NCTreat	No Contact Treatment	<ul style="list-style-type: none">• Online / postal / ‘click&collect’ – <i>no human contact</i>
CT	Contact Tests	<ul style="list-style-type: none">• Needs to attend service, full history taken prior to attendance, examination +/- tests as indicated, contact to be maintained at a minimum. COVID symptoms to be managed as per local policy.
CTreat	Contact Treatment	<ul style="list-style-type: none">• Needs to attend service, full history taken prior to attendance, contact to be maintained at a minimum. COVID symptoms to be managed as per local policy.
RI	Remote Imaging	<ul style="list-style-type: none">• Pt sends image via secure service
ADL	Activities of Daily Living	<ul style="list-style-type: none">• If issues / symptoms not managed will significantly negatively impact pt
ExRef	External Referral	<ul style="list-style-type: none">• Referral / Sign Post to appropriate non GU services (that remain available)
IP	Information Provision	<ul style="list-style-type: none">• About infection / risks / contraception – during consult or online
C&C	Click & Collect	<ul style="list-style-type: none">• Provision of medication at a service / pharmacy – pt needs to attend service but doesn’t need significant contact

Required provider interaction required: based on the above definitions of suggested contact and management this would be the minimum / maximum contact a patient should receive to ensure diagnostic and treatment safety whilst reducing the risk of COVID 19 transmission to patient or service.

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

OCB – Verbal triage then online provision of testing and or medication – VERBAL CONTACT & NO ATTENDANCE

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

	Patient Contact	Patient Management	Required Provider
Documentation / Risk assessment / History Taking			
Sexual history taking and risk assessment	T / CB		OP / OCB
Safeguarding assess under 18s & vulnerable adults including sex workers	CB	Ref	OCB
Under 16	CB	low threshold for F2F	OCB
Sexual Assault	CB	ExRef - SARC capacity	OCB
Acute – requiring prophylaxis +/- symptoms		CT & CTreat	Clinic
Non Acute – no prophylaxis / asymptomatic		NCT & NCTreat	OP
Follow up (post WP)		ExRef – Mental health NCT	OCB
Prevention			
Vaccination			
Low risk	T / CB	Defer	OP / OCB
High risk		CTreat	Clinic
Post exposure Prophylaxis		CTreat	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 / CT Ref	OP / OCB / Clinic
Male Urethral Discharge			
Low risk STI	T / CB	NCT	OP / OCB
High risk STI / purulent	CB	CT +/- MGen test +/- CTreat OR (NCT +/- MGen test – if online available?)	Clinic (OCB)
Rectal symptoms			
Low risk STI	T	NCT, Ref	OP
High risk STI	CB	CT +/- CTreat	Clinic
Pharyngeal symptoms	T	NCT	OP
Testicular symptoms			
Low risk	CB	NCT / CT	OCB / Clinic
High risk	CB	CT +/- CTreat	Clinic
Balanitis	T / CB	Ref	OP / OCB
Syndromic treatment failure			
Low risk	CB	NCT, Ref	OCB
High risk	CB	CT +/- CTreat	Clinic
Pregnant - Asymptomatic	T	Buy pregnancy test NCT	OP
Pregnant - Symptoms	CB	CT +/- CTreat ExRef(bleeding ED)	Clinic
Pelvic Pain	CB	CT +/- CTreat	Clinic
Vaginal discharge / smell			
No risk	T / CB	ExRef(pharmacy)	OP / OCB
Low risk		NCT & Ref	OP / OCB
High risk		CT +/- CTreat	Clinic
Lumps/Bumps symptoms – suspected MC / HPV	CB	NCT Defer	OP / OCB

Genital ulceration	CB	RI CT +/- CTreat	Clinic
Tropical STIs	CB	CT +/-CTreat	Clinic
PrEP - Consider risk reduction & discontinuation / move to event based during pandemic where appropriate	CB	NCT, CTreat (NCTreat - any no contact provision?)	Clinic
PEP - FU	T	NCT	OP
Itching	T / CB	ExRef(pharmacy)	OP / OCB
Rash / Seroconversion symptoms			
	Low risk	CB	NCT
	High risk	CB	CT +/- CTreat (STS)
Treatment (& further testing if indicated)			
Positive GC	Recall	CTreat (+ culture if NCT diagnosis)	OCB / Clinic
New HIV positive diagnosis	Recall	CT + CTreat	OCB / Clinic
STS & Non HIV BBV – likely diagnosed via asympto screen	Recall	CTreat + ?FU CT	Clinic
Positive CT	Recall	NCTreat	OCB
PEP - indicated	CB	CT + CTreat (dispense 28/7)	Clinic
Recurrent or Recalcitrant STIs or Conditions – candida / HSV / vaginismus / HPV			
	New	Defer	-
	FU	Defer	-
	ADL impact	CB	ExRef(pharmacy) CTreat
Complicated STI – Treatment failure / unusual history	CB	RI CT +/- CTreat	Clinic
HPV	T / CB	Defer	OP / OCB
Contact of STI			
	TV	Recall	NCTreat / CTreat
	Asympto post WP & can abstain	Recall	NCT
	Asympto in WP & can abstain	Recall	NCT post WP
	Asympt & can't abstain	Recall	NCTreat / CTreat
Sympto – management dependant on index infection	Recall	NCTreat (CT), CT, CT +/- CTreat (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	CT (MGen) (NCT ? MGen)
	Remain symptomatic	Recall	CT +/- CTreat
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	Clinic

	Escalate to F2F as necessary		
Psychosexual – New / FU with mental health concerns	CB	ExRef(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 / CTreat	OP / OCB / Clinic
Depo – unwilling to switch method / supply issues (Sayana Press)	CB	CTreat (?Staffing)	Clinic
LARC – Implant/IUD/IUS – able to abstain/condoms/bridge	CB	Defer	-
LARC – Implant/IUD/IUS – high risk of pregnancy	CB	CTreat (?Staffing)	Clinic
Emergency Contraception – IUD unsuitable / declined	CB	ExRef(pharmacy)	OP / OCB
Emergency Contraception – IUD accepted	CB	CTreat (?staffing)	Clinic
Complex Contraception routine (missing threads / deep imp)	Defer		-
Complex Contraception high risk / symptomatic	CB	CTreat (?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 <ul style="list-style-type: none"> Initially provided by individual partners Local lead designated to coordinate resources in event of significant closures 		