BASHH British Association for Sexual Health and HIV

Pandemic COVID 19

Principles for Recovery for out-patient Genitourinary Medicine, Contraception and Sexual Health Services and outpatient HIV Services

Target Audience

Target audience includes all national and local decision-makers, commissioners, and providers in the statutory and voluntary sector.

Summary of Document & Purpose

This document has been developed through consultation with British Association for Sexual Health and HIV (BASHH) members, representing sexual health clinicians and services in every region of England and in Scotland, Wales and Northern Ireland. Contributions have also been received from national partner agencies including National AIDS Trust, The Terrence Higgins Trust, the BASHH Public and Patient Engagement Panel, the British HIV Association, and individuals with expertise in sexual health and HIV.[1]

It represents initial recommendations and guiding principles for the restoration of sexual health services as they adapt to the changing waveform of the COVID-19 pandemic affecting the UK, and specifically phase 2 emergence from the period of most pronounced national lockdown in April & May 2020.

It is designed to complement other local, specialty and national recovery plans and principles documents, including Academy of Medical Royal Colleges Principles for Reintroducing Healthcare Services[2] and Faculty of Sexual & Reproductive Health (FSRH) guidance[3], as well as wider system guidance. This document should be read in conjunction with the Contingency Planning for Outpatient Sexual Health Services[4] that described the BASHH strategy for maintaining essential services functions in anticipation of the first wave COVID-19 pandemic in March 2020.

BASHH & FSRH have communicated widely, continually and in-depth with services across the UK to understand the magnitude of the impact of COVID-19 across the population[5,6,7].

BASHH has also communicated extensively with system leaders within Public Health England (PHE), Department of Health & Social Care (DHSC), NHS England (NHSE), Association of Directors of Public Health (APDH), Local Government Association (LGA), English Commissioners, Voluntary Sector Organisations, and BASHH National Leads representing Scotland, Wales and Northern Ireland - where Health is a devolved matter - to ensure the national and UK responses are both flexible and optimally aligned. It is clear that there is a shared vision and shared principles that unite the sexual health system.

These principles are designed to be flexible to allow application at a locally determined footprint for effective governance, whether that be NHS Trusts, local authorities, Local Resilience Forums (LRFs), Integrated Care Systems (ICSs), or other bodies.

This document will be reviewed in 3 months following publication and updated as appropriate

Key Principles for Restoration of Sexual Health Services: Summary & Local Circumstances

Recovery plans should…

1. **be person centred, place based and take a whole system approach to maximise the sexual health and well-being of the population**
2. **address health inequalities and prioritise restoration of services to the most vulnerable and to those with the most complex needs**
3. **ensure swift action and ongoing evolution of interventions, while being flexible and adaptable for unpredictable circumstances**
4. **ensure patients are provided with virtual or remote care where safe and appropriate**
5. **ensure patients, staff and volunteers feel safe and all are protected during access to care**
6. **be fully resourced**
7. **meet, then exceed standards of access and care pre COVID-19**

CIRCUMSTANCES WILL DIFFER WITHIN AND BETWEEN SERVICES

BASHH recommends that services make locally informed decisions to prioritise restoring face to face capacity based on the following criteria:

- Prioritise vulnerable populations where there is evidence that lack of access is causing harm
- Prioritise complex clinical & non-clinical need, taking into account:
    - Capacity including estate and ability to provide safe services for staff and the public
    - Capability including staff skill mix appropriate to safely & effectively meet clinical need

Where these criteria are met appropriate activity should be restored without further delay.

- **Example 1.** If there is local capacity and capability to provide non-emergency LARC then this should be progressively provided in a safe, sustainable fashion to address demand backlog, with priority given to clinical need and local vulnerability factors.
- **Example 2.** If there is local capacity and capability to provide safe & protected non-urgent immunisations or face to face evaluation of previously designated non-urgent conditions (e.g. genital rashes), then this can be activated to support the wider system address unmet need

Key Principles for Restoration of Sexual Health Services: Principles Detail

PRINCIPLE 1

Recovery plans should be person centred, place based and take a whole system approach to maximise the sexual health and well-being of the population

Further detail

- No entity, be that NHS / Local Authority / Voluntary Sector / Independent Sector / Commissioners of care etc. , has the resources, skills or expertise to maximise the response on their own. What exists and is currently functioning will vary, thus planning and detail of recovery should be based on local circumstances taking into account variance in estate, workforce capacity and capability, and resident population priorities.
- Planning should be developed in partnership and co-designed with service users, key populations, service users and the wider health system and should involve getting feedback from the service user population of their experience of the new models of care introduced since the COVID-19 pandemic started, and their views on how services are delivered going forward.
- Plans should include all community-based services, including those working across other issues that inter-relate with sexual health (e.g. drug services, alcohol and mental health services).

PRINCIPLE 2

Recovery plans should address health inequalities and prioritise restoration of services to the most vulnerable and to those with the most complex needs

Further detail

- Planning should be based on continued assessment of the needs of local key populations experiencing health inequalities and seek to redress these inequalities including how they are affected by COVID-19 and responses to the pandemic.
- Measures should prioritise support for people experiencing the most severe and urgent needs, rather than maximising volume of throughput. This includes an intent to provide the right service at the right time to every person and adoption of Make Every Contact Count methodology.
- Services should work with partners across the system to find innovative ways to support uptake of harm reduction and prevention strategies and work to maximise the value added by integrating non-clinical services (e.g. peer support, social care coordinators etc).

PRINCIPLE 2 ***SUPPORTING INFORMATION***

In the BASHH Clinical Thermometer Surveys in March and May 2020[5,6], and FSRH Survey[7], clinicians reported an immediate pattern of difficulty in maintaining access to and disconnection from a range of populations, despite service mitigations such as telephone-based services and instigation of digital access solutions. The impact was most pronounced in populations with recognised vulnerabilities or with the most complex needs.

The reasons are likely to be manifold and overlapping and remain to be understood fully, however, the observation is consistent with what is known about access to digital healthcare, namely the most vulnerable may be least likely to have their needs met this way.

The population most disconnected were young people who were twofold more likely to have gone missing from care access compared to pre COVID-19 and this is further evidenced by results from a recent BASHH Survey, where 76% of services identified young people requiring face to face care as their top priority.[6]

BASHH recommends that services make locally informed decisions to prioritise returning face to face capacity based on the following criteria:

- Vulnerable Populations where there is evidence lack of access is causing harm
- Complex clinical & non-clinical need

Taking into account

- Capacity (including estate and ability to provide safe services for staff and the public)
- Capability (including staff skill mix appropriate to safely & effectively meet clinical need)

The following table contains a list of vulnerable populations or clinical or other scenarios identified by lead clinicians as eligible for prioritisation for access to face to face care as capacity becomes available during restoration. The list is indicative, is not exhaustive, is not in any order of priority and individuals may be represented in more than one category. Some categories are already defined as 'essential functions' in the *COVID-19 Pandemic Contingency Planning* document.[4] Other individuals be may assessed and require face to face care prioritised on other locally decided criteria. This list is presented as a guide to inform local decision making.

Table (1) Populations or Scenarios identified as priorities for access to Face to Face Care

Young People	**People living with physical disabilities**
People with a history of domestic / sexual or other violence / or in coercive relationships	**Migrants or asylum seekers or people with no resource to public funds**
Children & adults registered vulnerable	**Looked after children & care leavers**
Men who have sex with men, trans or non-binary people, or other gender and sexual minorities where there is evidence of ongoing risk of STI acquisition	**People living with HIV with active sexual health needs (note HIV care per se is an essential function)**
Commercial Sex Workers and all people involved in transactional sex	**PEP & PrEP Users/seekers (Note already essential function)**
Women seeking LARC	**People with complex GUM issues**
Women with complex contraception needs	**Rural people with poor access to care**
People from BAME populations where there is evidence of ongoing risk of STI and HIV acquisition	**NEETs (Not in Education, Employment or Training)**
People with drug or alcohol problems	**Women with a risk of unwanted pregnancy**
People with no phone/internet access	**Local residents (reduce travel during COVID-19)**
Non-English speakers	**Pregnant (Note already essential function)**
People with ongoing Chemsex problems	**Travellers (Minceiri)**
People with mental health issues	**Women with a risk of unwanted pregnancy**
People with learning disabilities	**Women who want to attend our services (patient choice agenda)**
Homeless people	**People with specialised dermatology conditions e.g. lichen sclerosus and VIN**
People who are shielding for other health reasons but need sexual health or HIV services	**People over 65s as a needy population**

PRINCIPLE 3

Recovery plans should ensure swift action and ongoing evolution of interventions, while being flexible and adaptable for unpredictable circumstances

Further detail

- Plans and actions should evolve on the basis of continual assessment of impact and learning therof. They should therefore facilitate maintaining surveillance for robust and timely reporting of diagnoses and activity, include monitoring of progress against existing goals for sexual health and HIV, namely eradication of new transmissions of HIV, reduction in late and undiagnosed HIV, control of all STIs and high quality SRH care across the life course.
- Plans should build on existing capacity and implement investment and innovation to build long-term resilience. They should enable integration with clear pathways, systems and data sharing designed in collaboration with any partners, whilst ensuring appropriate levels of confidentiality and data protection.
- Data sharing should ensure the right to confidentiality is protected and that people understand how their data is used and shared.

PRINCIPLE 4

Recovery plans should ensure patients are provided with virtual or remote care where safe and appropriate

Further detail

- Services will need to prioritise digital care as part of their recovery plans to enable them to safely deliver capacity while accommodating an overall decrease in face to face contact. Wherever digital solutions are used, they need to be designed for optimal acceptability and reach and be mindful that some will be unwilling or unable to engage digitally.
- A menu of options will need to be provided to create a comprehensive and more holistic care model in which digital plays a large part, but not to the exclusion of all else. We have to think of this as a multi-layered offer of services where people self-manage where possible but are seen face to face whenever needed or desired. This should look like:
    - equity of access to digital healthcare for the population, irrespective of residence
    - online information, advice, signposting and support to maximise self-care, sexual health testing at home by default for those who are willing and able, whilst providing easily accessible alternatives for others.
    - online information should follow the *Accessible Information Standard*, providing information in people's preferred format, eg large print, British Sign Language (BSL) or image descriptions and can be read easily with standard user settings, magnifying software and screen readers.
    - appropriately supported access to telephone triage and or to telephone or video consultations (telemedicine) and/or face to face services where appropriate and/or where no procedure is necessary. Again, BSL and other interpreting services should also be available.

- face to face contacts for care by exception (during phase 2) unless clinical or patient need, with choice elements playing a greater part as capacity stabilises
- considering how digital solutions could support integrated care and reduce appointment burdens by providing joint appointments (i.e. more than one specialist, specialist and GP etc)

PRINCIPLE 5

Recovery plans should ensure Patients, staff and volunteers feel safe and all are protected during access to care

Further detail

- All services must have robust mechanisms in place to secure the wellbeing of all staff and patients accessing face to face services, compliant with all relevant recommendations. Service providers must also have systems in place to ensure telephone and video consultations are compliant with national guidelines and are updated as and when these change.

PRINCIPLE 6

Recovery plans should be fully resourced

Further detail

- Recovery plans must be fully resourced to ensure the response is run effectively and sustainably. This cannot be done with existing resources in view of the scale and complexity of what is needed. Significant, sustained, whole system investment is needed to implement new methods of healthcare provision at pace. Specific areas include:
  - Digital infrastructure, telephony and physical infrastructure investment, as much of the existing estate is not compatible with physical distancing and digital care support.
  - Training and support for staff that has been evaluated and proven to be effective to adapt to new ways of working[8] , and expansion of the sexual health workforce to align the overall skill-mix with the requirements of new processes. Early experience of the switch to telemedicine is that it requires more experienced decision makers and staff with prescribing capacity to be maximally effective, and that existent staff may require additional training to adapt to gain new skill sets. Many of the more experienced staff may not be available for face to face care due to shielding or distancing requirements.[5,6]
  - Solutions to enable new ways of working compatible with physical distancing, will have initial apparent “inefficiencies” and are incompatible with historic funding mechanisms. Transition to new funding systems that recognise the new complexities will require substantial initial and ongoing resource and support. These are pressing as emergency contingencies have relied on defer and delay for many non-urgent complexities that are now becoming urgent

PRINCIPLE 7

Recovery plans should meet then exceed standards of access and care pre COVID-19

Further detail

- Recovery should recognise that current emergency pandemic contingencies temporarily authorise variations and restrictions on care. These do NOT meet pre-COVID-19 routine minimum standards and must be lifted at the earliest opportunity .
- Some contingencies have relied upon defer and delay for many initial non-urgent complexities that are now becoming urgent. Services must immediately and actively demonstrate continual review of quality of care provided across the whole system and ensure continual progress to achieving and exceeding required standards.
- Across the system all should work towards ensuring inequalities between services are also addressed and should include the ambition to meet and then move to exceed usual standards of access and care for their local population at the earliest possible time. This is important as the sexual healthcare system was not meeting the needs of the population prior to novel coronavirus pandemic in early 2020.[9]

Summary: COVID-19 & Restoration of Activity within Sexual Health Services - Genitourinary Medicine

Genitourinary Medicine (GUM) includes diagnosis and management of sexually transmitted infection (STI) and other genital conditions, contraception, sexual health outreach and promotion. HIV treatment and care are integral to most GUM services but is not specified here as is addressed via NHS Specialised Commissioning. It is essential that that both Sexual Health Services and HIV treatment and care provision are considered together.

Constraints to delivery

- **Premises** - existing estate may be partly or wholly unsuitable for physical distancing
- **Staffing reduction** - redeployment, sickness/self-isolation/shielding or service unable to adapt to risk
- **Limitation of PPE supply** to allow Face to Face (F2F) examinations and NHS limitations on procedures
- **Staff and public may not be able to access** services due to transport difficulties or lack of secure, safe facilities - particularly affects vulnerable groups including young people, those in controlling relationships or at risk of sexual/domestic violence, or those with communication limitations or inequalities
- **Laboratory capacity** may restrict STI testing due to competing Covid-19 testing demands
- **Online services** for STI testing and treatment and elements of contraception provision are not consistent across geographical areas. Equitable access to On-line and Telephone Care is a Must Do.

<table>
<tr><th>Available <25%</th><th>Available <50%</th><th>Available <75%</th><th>Available <90%</th></tr>
<tr><td>Care for:
• Life-threatening / life-shortening STIs
• Unbearable symptoms
• Significant public health risk
High risk/high priority defined in COVID-19 Pandemic Document *

Emergency contraception

Basic universal provision (POP) & condoms

Abortion care</td><td>Testing & management for symptomatic STIs
High risk/high priority COVID-19*

All Emergency contraception

Limited range of contraception,
LARC as soon as capacity

Abortion care –
onward referral</td><td>Testing & management for most STIs & genital infections

All Emergency contraception

Full range of contraception, including LARC

Abortion care - onward referral</td><td>Testing & management for all STIs, genital infections / conditions

All Emergency contraception

Full range of contraception, including LARC & Complex contraception care

Teaching & Training

Abortion care -
onward referral</td></tr>
<tr><td>Syphilis & HIV contact testing only
Syndromic & Epidemiological treatment for other STIs</td><td>Testing All STI contacts</td><td>Testing All at risk</td><td>Testing All</td></tr>
<tr><td>Sexual assault care</td><td>✓</td><td>✓</td><td>✓</td></tr>
<tr><td>PEP provision</td><td colspan="3">PEP & PrEP provision</td></tr>
<tr><td>Modified STI treatments
TOC only if symptomatic</td><td colspan="3">Optimum treatment & tests of cure (TOC) for STIs</td></tr>
<tr><td colspan="2">Vaccination - Hep B for high risk e.g. post sexual assault</td><td colspan="2">Vaccinations – Hep A & B & HPV4 for those eligible</td></tr>
<tr><td>Partner notification for STIs & HIV</td><td>✓</td><td>✓</td><td>✓</td></tr>
<tr><td colspan="2">Remote consultations (telephone/video) for symptomatic STIs, emergency or basic contraception, abortion care</td><td colspan="2">Remote consultations (telephone/video) for all requesting GUM/Contraception consultation</td></tr>
<tr><td colspan="3">No F2F consultation without telephone triage: teleconsultation: F2F by exception *</td><td>F2F consultation patient choice</td></tr>
<tr><td colspan="2">* F2F examination for symptomatic STIs, emergency contraception, basic contraception, abortion care. Injectable LARC if >25% All LARC when capacity</td><td>F2F examination including genital lumps by exception *</td><td>F2F examination including genital lumps and rashes</td></tr>
<tr><td colspan="3">No choice of clinic : On-Line and Telephone Triage/Telephone/Video Consultation first by capacity and risk assessment: F2F by complexity or vulnerability</td><td>Restore choice of clinic – safe walk in, booked, outreach</td></tr>
<tr><td>No psychosexual service</td><td>Only if mental health concerns</td><td colspan="2">Psychosexual service restored</td></tr>
<tr><td colspan="2">No outreach. Health promotion electronic/telephone</td><td colspan="2">Outreach and health promotion – safely restore service</td></tr>
</table>

Reduced activity compared to 90% available	Restore & rebuild to equivalent 90% available	All restoration with new ways of working

* **Pandemic COVID 19 : Contingency planning for out-patient Genitourinary Medicine, Contraception and Sexual Health Services and HIV services**
https://members.bashh.org/Documents/COVID-19/Pandemic%20COVID%2019%20Sexual%20Health%20Services%20Priorities%20v0.5%20BASHH.pdf

Annex - Medical Royal Colleges Principles for reintroducing healthcare services[2]

Principle 1 – There should be clear messaging to the public stressing the need to seek medical help for serious conditions whilst encouraging appropriate self-care

Principle 2 – Patients should be offered virtual or remote care where safe and appropriate ensuring those who are unwilling / unable to engage with remote care models are offered high quality, accessible face-to-face alternatives.

Principle 3 – Patients should be offered alternative management options using shared decision and ensuring patients have clear accessible information on the options available to them

Principle 4 – Patients should feel safe and be protected when they need to access face to face healthcare in all settings

Principle 5 – Staff should feel enabled, safe and protected to deliver equitable and clinically prioritised care

Principle 6 – Staff should be supported and provided with training and education that will ensure adequate preparation of current and future staff to deliver services that meet the needs of the population

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[2] Principles for reintroducing healthcare services: Academy of Medical Royal Colleges..https://www.aomrc.org.uk/wp-content/uploads/2020/05/COVID-19_Principles_for_reintroducing_healthcare_services_0520.pdf

[3] FSRH guidance for contraceptive provision after changes to Covid-19 lockdown May 2020. https://www.fsrh.org/documents/fsrh-guidance-contraceptive-provision-changes-covid-lockdown

[4] Contingency planning for outpatient Genitourinary Medicine, Contraception and Sexual Health Services (including online) and HIV services. https://members.bashh.org/Documents/COVID-19/Pandemic%20COVID%2019%20Sexual%20Health%20Services%20Priorities%20v0.5%20BASHH.pdf

[5] British Association for Sexual Health & HIV (BASHH) "Clinical Thermometer Survey" 1 April 2020. https://members.bashh.org/Documents/COVID-19/Immediate%20Response%20to%20COVID19%20in%20Sexual%20Health%20and%20HIV%20Services%20-%20Comments%20Summary%20for%20website%20upload%20.pdf

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[8] Health Education England. The Topol Review. February 2019. https://topol.hee.nhs.uk/

[9] Terrence Higgins Trust, British Association for Sexual Health and HIV. "The State of the Nation". February 2020 https://www.tht.org.uk/sites/default/files/2020-02/State%20of%20the%20nation%20report%20v2.pdf