

Board of Directors Meeting 14th December 2016

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Board of Directors


***Meeting to be held 14th December 2016
at 1pm pm in Governors' Hall St Thomas Hospital***

A G E N D A

1. Apologies: Hannah Coffey, Robert Drummond
2. Declarations of Interest *oral*
3. Sexual Health and Reproduction Formal Consultation *attached (BoD/16/23)*
4. 2017/18 – 2018/19 Operational Plan sign off *attached (BoD/16/24)*

The next Board of Directors meeting will be held on 25th January 2017 at 3:45pm in the Robens Suite, Guy's Hospital

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Board of Directors Meeting	Guy's and St Thomas'  NHS Foundation Trust	
Sexual and Reproductive Health Formal Consultation Final Proposal	14th December 2016	BoD/16/23

This paper is for:		Sponsor:	Ian Abbs	
Decision	X	Author:	Robert Cook	
Discussion		Reviewed by:		
Noting		CEO*		
Information		ED*		
		Board Committee*		
		TME*	X	27 th October
		Other*		

* *Specify*

1. Summary

The Purpose of this document is to inform the Board of Directors of the outcomes from the formal consultations held with the public and staff in relation to the reconfiguration of Sexual Reproductive Services. It provides details on the proposed reduction in estates, headcount, the introduction of a standardised integrated service delivery model and harmonising hours with increased Sunday opening hours.

The consultations were developed in response to a 20% budget reduction applied by our lead commissioners, Lambeth and Southwark from October 2016, with a full year effect of £1.2M reduction. In addition the introduction in 2017 of a pan London offer for on-line provision for asymptomatic patients, and an integrated tariff will further reduce income available for service provision. As a result the service has developed a radical service redesign in an attempt to mitigate further changes in structure in the short term, and to provide a sustainable high quality service, treating as many patients as seen in business year 2015/16.

This proposal has been developed in partnership with Lambeth and Southwark councils, and has a number of co-dependencies relating to increased provision of services by primary care and pharmacy outlets within Lambeth and Southwark which the councils are leading on.

2. Request to the *Board of Directors*

To consider the views of the Sexual Reproductive Health Staff, Patient and Public Stakeholders and agree the response to the consultation document ratifying the preferred option, which entails:

1. Reduction of estate from 6 sites to 3, with the closure of Lloyd clinic on the Guys campus, and Vauxhall Riverside & Artesian within the community estate.
2. A new integrated staffing model
3. Online provision of services, and a commitment to the use of an online provider for asymptomatic patients pathways
4. Harmonisation of all clinic times and extended opening on a Sunday.

The Board of Directors is advised that acceptance of these proposals will result in redeployment and redundancy of staff in areas where jobs are at risk.

Figure 1. Establishment Change from preferred Option (Option 3)

Job title	Pre-consultation WTE budget	Consultation document proposed WTE	New WTE budget after consultation	Current WTE in post as of 20-10-16	Vacancies frozen	Redundancy/Redundancy
Senior doctor (Consultant, Staff Grade and Associate Specialist)	18.94	13.9	12	15.2	3.74	3.2
CNS	12.2	8.5	11	12.2	0	1.2
Band 6	13.84	8.1	11	12.32	1.52	1.32
Band 5	3.34	5.17	3.34	3.34	0	0
Health Care Assistant	17	11.7	11	10.68	6.32	0
Reception Staff	17.57	13	14	13.34	4.23	0
Health Advisor	11.47	11.7	11	8.5	2.97	0
Junior Dr	14	7.3	7.3	NA	N/A	NA
Sister & PDN	4	4	4	NA	N/A	NA
Total			84.64	75.58	18.78	5.72

The maximum redundancy risk associated with this option is £800K. We will mitigate this risk through vacancies within the Health Advisors which would give suitable alternative employment to the nursing staff at risk, we will be utilizing the Trust's redeployment register and other vacancies within the Specialist Ambulatory Services Directorate.

3. Detail/ Commentary

We provide an open access Sexual and Reproductive Health Services with a particular focus on the residents of South East London, treating an ethnically diverse patient population of over 2 million across a wide range of socio-economic groups. Sexual Health Services are funded by a public health grant managed by local councils.

In December 2015 we were notified by Lambeth and Southwark Council commissioners of a 20% reduction in funding for the business year 2016/17. The full year effect of this level of funding reduction is a removal of £1.05million pounds and we have had an indication from the councils that further savings are likely to be required in future years. Against this financial backdrop our vision is to continue to be a forward thinking service in these times of uncertainty. It is also to ensure we deliver the best care to our patients and provide the best opportunities for our staff.

Options Considered

Option 1: Do nothing. This was rejected on the grounds of finance and sustainability

Option 2: Consolidate sites to 4 sites and an integrated staffing model.

Option 3: Consolidation of sites from 6 to 3 and an integrated staffing model

Figure 2. Level of saving achieved by options

	Sites	Net Saving	>90,000 appointment per year
Option 1	6	Zero	Yes
Option 2	4	£500K	Yes
Option 3	3	£1.1M	Yes

Based on the level of sustainability of savings achieved and the quality of the service we could deliver within this, the service's preferred model is Option 3.

The consolidation of sexual and reproductive health services across 3 non-acute community based sites with enhanced weekday and weekend opening times represents a unique opportunity for us to bring this vision to reality by developing patient-centered services we can all be proud of. The proposed model enables us to continue to provide care to as many patients as we do today, offering around 90,000 patient contacts per year. We will also be improving access to services by offering on-line services available 24 hours each day, 365 days per year; placing us at the forefront of accessible sexual and reproductive health services. In July 2016 GSTT subcontracted SH:24 as our online service to provide around 14000 asymptomatic patients online a year, meaning we can use our face to face clinics for those patients which higher need. It is envisaged that our multi-skilled multi-disciplinary teams will continue contributing to the health and well-being of our local communities and vulnerable and hard to reach patients.

Public and Key stakeholder Consultation

Between April and May Lambeth and Southwark councils undertook a public consultation on changes to public health services commissioning that outlined proposals which both commissioners and providers agreed would best mitigate the impact of funding reductions to these services for patients and service users in the longer term:-

- ☐ To have fewer clinics, but offer extended opening hours to support accessibility
- ☐ Extend home-testing for asymptomatic patients, as currently provided by the online service SH:24

Following the consultation, Lambeth and Southwark councils agreed to adopt the proposals. In order to meet its legal 'duty to involve', it was agreed that further patient and public engagement and wider public consultation would be undertaken by Guy's and St Thomas', to ensure the views of service users could inform the further development of the commissioning proposals. Between June and September, the Trust, with support from both councils, successfully sought the views of over 1200 patient and public stakeholders alongside The Sexual and Reproductive Health Department staff Consultation. EQIA were completed by both the trust and the local councils.

A full report on the public and patient consultation is provided in Appendix A.

Staff Consultation

The Sexual and Reproductive Health Staff Consultation ran from 22nd August until 10th October 2016. Responses to the proposals were gained through individual staff meetings and email, which have been collated into a formal response document. Staff side and Trust Unions were provided with the consultation document prior to formal consultation launch and their recommendations were reflected in the final document. Staff side have supported their members through the process and will continue to do so following an agreement of the outcome document.

Final Proposals

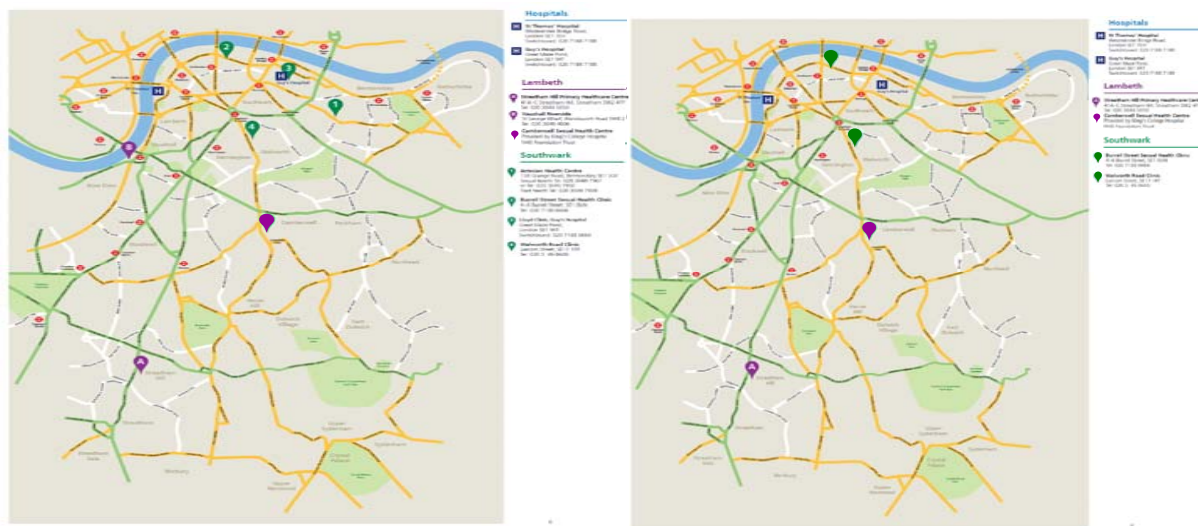
Estates

Sexual and Reproductive Health occupy space in Artesian Health Centre, Vauxhall Riverside Health Centre, Walworth Road Health Centre, Streatham Hill Health Centre, Lloyd Clinic at Guys Hospital and a standalone building at Burrell Street.

We propose to consolidate our estate and staffing resource through removal of our services in Artesian Health Centre, Vauxhall Riverside Health Centre and Lloyd Clinic at Guys Hospital. This will enable the Burrell Street, Walworth Road Health Centre and Streatham Hill Health Centre venues to deliver the level of service required to provide the 90,000 appointments per annum.

Figure 3. Current Estate Locations

Figure 4. Proposed Estate Locations



151 responses to the public consultation in regards to the closure of clinics of those they indicated:

- ❑ A larger number of patients who currently attend Lloyd Clinic might attend Burrell St in the future.
- ❑ Patients who currently attend Artesian Health Centre may prefer to travel to Walworth Road or Burrell Street in the future.
- ❑ Those who currently attend Vauxhall Riverside (a much smaller no. of respondents), responses note a preference towards Burrell Street or Streatham Hill

Staff raised concerns over the closure of Lloyd Clinic at Guys Hospital as this is the only in Hospital clinic and could pose access issues. Another issue raised was Lloyd Clinic is already a level 3 service provider with Walworth Road and Streatham Hill only providing level 2 services.

All sites have wheelchair access and will not pose any access issues. The Management Team alongside Essentia and NHS Property Services have agreed plans to convert space to provide microscopy facilities and provide the Level 3 service in all open service sites before the closure of Lloyd.

Estates would be closed over a staggered closure plan starting from January 16th until July 17. We are working with GSTT Community Services, Essentia and NHS Property Services to increase our current space at Walworth Road and Streatham Hill for additional clinical rooms and to ensure we provide Microscopy on all sites.

At the time of writing this paper floor plans have been agreed and quotations are being sought, as yet we do not have an indicative figure on the cost to capital.

Harmonisation and increase of Sunday hours

We sought the views of both public stakeholders and staff in regards to harmonising hours across the 3 remaining sites, the closure of the Streatham Hill clinic on a Saturday which currently operated for 2.5 hours and the extended opening hours on a Sunday at Burrell Street.

We had a positive response to the harmonisation of hours but some comments requested we closed later. There were also concerns over the provision of service available to Lambeth residents with the closure of Streatham Hill.

It is not financially possible to provide a service that runs later than 19:00 in the week and on two sites at the weekend, due to the additional budgetary requirements for unsocial hours payments and increased staffing numbers

Figure 5. Results of public stakeholder poll for opening hours

Opening time options	*Sum of responses rated 'very' or 'fairly' convenient			Weighted average score
	Patient-public stakeholders	Trust staff and primary care providers	All respondents	
8.30am – 3.00pm	69.79%	69.49%	69.63%	0.74
9.30am – 4.00pm	74.47%	82.14%	75.81%	0.97
10.30am – 5.00pm	81.79%	82.26%	81.97%	1.26

Figure 6. Results of Staff poll for opening hours

Working time options	Number respondents	%
8.00am – 4.00pm	16	32
9.00am – 5.00pm	28	56
10.00am – 6.00pm	10	20
None suitable	6	12
Total	50	100

There was not a significant different in preference and the Directorate Management Team have taken into consideration the risk of additional turn over at this critical time and the to ensure a positive work life balance have decided on the staff option of 09:00 – 17:00.

Proposed Service Delivery & Staff Models

THE CLINICAL SERVICE MODEL

In 2001 the UK government published a National Sexual Health Strategy that has served as the blueprint for all the changes that have been made in the specialty. This white paper grew out of an international call to integrate services, by the World Health Organisation one decade earlier, to address the lost opportunities in relation to contraception and HIV care in the face of the then untreatable pandemic. Historically we had two specialties, Reproductive & Sexual Health (RSH) and Genitourinary Medicine (GUM), which both managed patients with a predominant focus on contraception and sexually transmitted infections (STIs) respectively. It is recognised that the integration of RSH and GUM is better for patients, professional development and is more cost effective since there is an overlap between the two services.

The GUM service started to expand its contraception offer in 2008 with the introduction of all forms of long acting reversible contraception (LARC), the training of staff and ensuring all new staff were dual qualified. At the same time the RSH service in the Lambeth & Southwark community clinics provided more STI testing and over the last five years the offer of services for higher risk men who have sex with men (MSM) has improved with the introduction of triple site testing and hepatitis B vaccination. In addition to the improved MSM offer, the RSH service also started to provide psychosexual services too. Since the merger of the RSH and GUM services two years ago the new Sexual & Reproductive Health (SRH) Department has continued to develop the integrated services and with the provision of medical abortions at Burrell Street by MSI we now are able to offer all the services cited in the 2001 white paper.

In addition to the development of the integrated service we also developed nursing & medical staff through a number of different training programs to deliver a wider range of services, support autonomous practice and importantly for patients deliver a one-stop service in the majority of cases. During this integrated training, the junior nursing and medical staff were having difficulty accessing real-time support and thereby found it difficult to gain confidence and progress to independent practice. We then introduced a 'senior' model whereby one of the substantive doctors (consultant, associate specialists and staff grade doctors) would not see patients directly but make themselves available in clinic, logged onto the clinic software and support two clinics by answering clinical queries, supporting management plans, writing prescriptions, delivering teaching & recruiting for research. The GUM and then SRH service also developed triaging so that patients are seen by the most appropriate trained staff. We operate five streams in the service

and the majority of patients are seen by one member of staff on their outpatient visit. Over time these changes have resulted in a reduction in the number of follow up patients being seen in the service from 0.6 to 0.2 thus enabling us to see more new patients.

Finally, over the last five years the SRH department has introduced a number of digital solutions to support us to deliver an improved service for patients. We have used both off the shelf and bespoke digital tools with a focus on solving specific problems along the patient journey and these in chronological order include:

- Sign posting patients accurately to services (www.sxt.org.uk)
- Microsite for our flagship clinic (www.burrellstreet.org.uk) and a Twitter feed (@BurrellStreet)
- Appointments for specific services [<http://bit.ly/GSTT-SRH> delivered by Zesty (www.zesty.co.uk)]
- Management of patient waiting times using SMS & a web based tool (www.qudini.com)
- Home testing for patients who are asymptomatic (www.sh24.org.uk)
- Support for the delivery of partner notification (www.sxt.org.uk/pn/about)
- Support women to understand their pregnancy risk and options (www.sxt.org.uk/ec)

In summary, our services have changed significantly in the last decade and we are continually refining how we measure, monitor and modify our service to meet the needs of patients. In November all of our clinics will be moving to one electronic patient record (IMS Maxim) and this means that the three clinics proposed will be able to operate like Burrell Street & Lloyd do today with the real-time senior model as well as with improved data capture, result governance & provision and service reporting. The multidisciplinary team structure will be the same in all three clinics and this will enable all patients to receive the same high quality, one stop model regardless of their geographical location.

THE STAFFING MODEL TO SUPPORT THIS AND CHANGES

To reflect the changes in estates and weekend opening times we will iterate and roll out an integrated multi-disciplinary team model which has been successfully in operation at Burrell Street for 3 years. The model will provide a standard number of staff on each site each day, delivering care in an integrated manner to reduce the number of hand offs and repeat visits required by patients, such that sexual & reproductive health and genito-urinary medicine issues are addressed during the same visit by the same provider wherever practicable. This will require staff up-skilling.

Figure 7. Staffing the integrated model

Sites of operation

Burrell Street (weekday)	Streatham Hill	Walworth Road	Burrell Street (weekend)
Senior covering the service >>			Senior covering the service
Senior Doctor	Senior Doctor	Senior Doctor	Senior Doctor
Junior Doctor*	Junior Doctor*	Junior Doctor*	Clinical Nurse Specialist
Junior Doctor*	Clinical Nurse Specialist	Clinical Nurse Specialist	Clinical Nurse Specialist
Clinical Nurse Specialist	Band 7 or 8 nurse	Band 7 or 8 nurse	Band 6 Nurse
Clinical Nurse Specialist	Band 6 Nurse	Band 6 Nurse	Band 6 Nurse
Band 6 Nurse	Health Advisor	Health Advisor	Band 5 Nurse or Band 7/8
Band 6 Nurse	Health Care Assistant	Health Care Assistant	Health Advisor
Band 5 Nurse or Band 7/8	Receptionist	Receptionist	Health Advisor
Health Advisor	Receptionist	Receptionist	Health Care Assistant
Health Advisor			Health Care Assistant
Health Care Assistant			Receptionist
Health Care Assistant			Receptionist
Receptionist			Receptionist
Receptionist			

* Subject to availability
Dependent upon their training rotation

Hours of operation

Session	Monday	Tuesday	Wednesday	Thursday	Friday
8:00 – 12:00			Training		
12:00 – 16:00			Note 1pm start		
16:00 – 19:00					

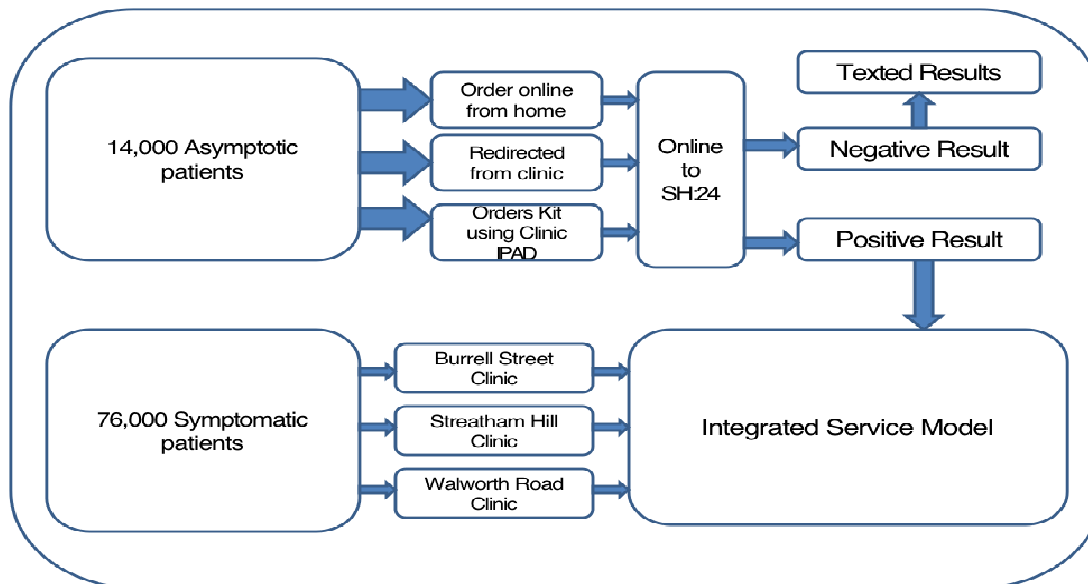
Session	Saturday
8:00 – 12:00	
12:00 – 16:00	
Session	Sunday
9:00 – 13:00	
13:00 – 17:00	

This model will allow the service to provide 90,000 appointments per year and ensure:

- The service will provide governance and support primary care, specialist services, training and research in keeping with the level 3 service
- Each component of the multidisciplinary team will need to be able to fully serve the SRH core service. Staff will be provided with relevant training and support to achieve the required levels of competency
- Patients requiring a face to face consultation will be managed in an integrated manner with the fewest number of handovers between professionals, and repeat visits/appointments as possible.

Please see Annex B for WTE Staffing and financial requirement

Figure 8. Model utilising online services and the integrated staffing model



Part of being able to produce this staffing model is by redirecting more asymptomatic patients to our online testing partner SH:24 and freeing up our clinical time for patients who require face to face appointments for complex needs.

The response from public was very positive with 65% of respondents advising they would use this service.

Of those who responded that they would be reluctant to use this service was due to ability to use Information Technology and concerns over accuracy of results.

Patients who are tested positive are requested to visit their local sexual health clinic and notification from SH:24 is provided to our results team who book an appointment for the patient to ensure treatment is provided quickly. This offers the trust targeted appropriate referral volumes for local residents.

We will also pilot a 'Click and collect' service in each sexual health clinic that will allow a patient to arrive at one of our sites and order a test kit for home use, they will be able to leave the clinic with a home testing kit, to provide a range of options for patients who are unwilling/unable to use online services

All services models ensure that patients in vulnerable groups such as under 18 are directly to a sexual health clinic and not provided with a test kit for home use.

Finance Assessment

The preferred option will provide a cost release/opportunity in the following two areas:

1. Staff Saving

Current staff structure WTE	New staff structure WTE	Saving WTE
130	109	21

Current staff structure £'000	New staff structure £'000	Saving £'000
£6,567	£5,530	£1,105

Rationalisation from 6 to 3 sites will result in a headcount reduction of approximately 21wte releasing recurrently c£1.1m. Staff groups covered can be seen in the previous section.

In preparation for implementing of the proposal, subject to full approval, the Directorate has scrutinised the need to replace posts that have become vacant through turnover. To date, this has resulted in a £300k saving (2016/17 to Mth 6).

Staff exist costs have been modelled by HR and would amount to, in the region of £800k.

2. Space Saving

The reduction of 6 to 3 venues will provide a notional space saving benefit of £370-426K, in the two community sites, of £100k - £150k, as well as £270k of additional space release on the Guy's site. This community saving will probably not be cash releasing to Essentia due to the lease arrangements, though will provide a Trust opportunity for repurposing the space for other Community services.

Range of cost bases £'000

Site Name	2016/17 % SRH site use of total	% SRH site use post transformation	Annual spend based on Financial Planning cost/sqm of £320.00	Annual spend based on 2011/12 cost/sqm	Saving Range £'000
Riverside Medical Centre	17%	0%	£45	£74	£45 - £74
Artesian Health Centre	22%	0%	£55	£82	£55 - £82
					£100 - £156

The key to facilitating a reduction in foot print will be the pathway re-design for asymptomatic patients, where such patients will be directed, in the first instance, to an online provider SH:24. There will be a cost associated with delivering this new asymptomatic patient pathway, some of this will be mitigated through a reduction in trust pathology and other non pay items spend.

Savings target

Against a savings target of £1.05m, the preferred model would release approximately £1.47-1.53m, with the balance put forward as mitigation to the minimum 8.5% tariff deflator expected with the introduction of the integrated tariff.

Next Steps

Indicative timeline of implementation

Timeline	Activity
27 October to 31 st March 2017	<input type="checkbox"/> Outcome of staff consultation, staff interviews and redeployment for new service model
By 15 December	<input type="checkbox"/> Public consultation report published online (summary version to be made available)
December– 31 st March 2017	<input type="checkbox"/> Phased implementation of agreed staffing changes
January to July 2017	<input type="checkbox"/> Phased implementation of site changes

Recommendations and Actions

The Board of Directors is asked to

- a) **CONSIDER** the views of patient-public stakeholders outlined in the findings of the consultation and;
- b) **APPROVE** the service preferred; Reduction of estate from 6 sites to 3, with the closure of Lloyd clinic on the Guys campus, and Vauxhall Riverside & Artesian within the community estate. A new integrated staffing model. Online provision of services, and a commitment to the use of an online provider for asymptomatic patients pathways. Harmonisation of all clinic times and extended opening on a Sunday
- c) **AGREE** the Trust's responses to the consultation and the recommendations for change / implementation and the approach to funding of redundancy payments.

Annex A

Consultation on proposed changes to sexual and reproductive health services in Lambeth and Southwark: Report on the findings of the consultation and patient and public engagement activities undertaken between June and September 2016

1.0 Executive Summary

- 1.1 This report describes the findings of the recent consultation and highlights earlier patient and public engagement activities on proposed changes to sexual and reproductive health services in Lambeth and Southwark. The public consultation between 25 August and 30 September was undertaken in response to a reduction in funding for services provided by Guy's and St Thomas' NHS Foundation Trust and commissioned by Lambeth and Southwark council.
- 1.2 Between June and September, Guy's and St Thomas NHS Foundation Trust, supported by both Councils, completed various patient and public engagement activities including the recent consultation. During this time, the views of over 1200 patient-public stakeholders have been collected.
- 1.3 The key findings from the consultation indicate the following:
 - Overall there are no strong objections to the proposals – the vast majority of respondents appear to be understanding of the need to change the way the services are provided
 - A minority of comments refer to concern about the closure of clinics - 11 free text comments in the survey and 16 patient interview respondents note concern about or objection to the closure of clinic(s)
 - There is positive support for increasing the use of SH:24 / home testing, however there is some polarisation of views for various reasons, which are noted in paragraph 4.4
 - Respondents comments have requested slightly longer evening open hours than are currently proposed – this was the strongest and most recurrent theme of feedback
 - Findings of discussion groups and previous focus groups in June, suggest patients lack confidence in and awareness of the sexual and reproductive health services that are offered by primary care providers
- 1.4 Details of next steps and the timetable for implementing any agreed changes are noted at paragraph 6.0. We expect the consultation report to be published by 25 November.

2.0 Recommendations

- 2.1 The Trust Management Executive is asked to:-
 - a) **CONSIDER** the views of patient-public stakeholders outlined in the findings of the consultation and;

- b) **AGREE** the Trust's responses to the consultation and the recommendations for change
- c) **NOTE** the next steps and timetable highlighted at paragraph 6.0

Consultation on proposed changes to sexual and reproductive health services in Lambeth and Southwark: Report on the findings of the consultation and patient and public engagement activities undertaken between June and September 2016

1.0 Introduction and background

- 1.1 Since 2013, borough councils have been responsible for commissioning Public Health services, including sexual and reproductive health services. The Government significantly reduced the amount of money it gives to Lambeth and Southwark councils to fund these services. As a result, the councils have reduced the amount of funding for sexual and reproductive health services delivered by Guy's and St Thomas' NHS Foundation Trust (GSTT) and King's College Hospital Trust (KCH). With further reductions in funding expected between now and 2020, commissioners and providers across London and England continue to work to reconfigure services.
- 1.2 In response, between April and May both Lambeth and Southwark councils undertook a public consultation on changes to public health services commissioning that outlined proposals which both commissioners and providers agreed would best mitigate the impact of funding reductions to these services for patients and service users in the longer term:-
 - To have fewer clinics, but offer extended opening hours to support accessibility
 - Extend home-testing for asymptomatic patients, as currently provided by the online service SH:24
- 1.3 Following the consultation, the cabinets of both Lambeth and Southwark councils agreed to adopt the proposals. In order to meet its legal 'duty to involve', it was agreed that further patient and public engagement and wider public consultation would be undertaken by Guy's and St Thomas', to ensure the views of service users could inform the further development of the commissioning proposals. Between June and September, the Trust, with support from both councils, **successfully sought the views of over 1200 patient and public stakeholders.**
- 1.4 A table summarising the full range of patient and public engagement activities since June is included at Annex A. This report details the findings of the consultation process, which ran 5 weeks from 25 August and closed 30 September. The report also includes insights from the earlier patient and public engagement activities in June.

2.0 A summary of the proposals for change that were consulted on

2.1 Following the public consultation led by the councils, the proposals below were consulted on:

- Refer more asymptomatic patients (i.e. without symptoms) to 'home (self)-testing' by expanding and developing the existing online testing service SH:24
- Reduce the number of sexual and reproductive health centres from 6 to 3
- Increase the opening hours of clinics to provide longer weekday opening and weekend opening hours and continue to offer a combination of 'walk-in clinics' and 'advance booking appointments'
- Increase awareness and make much better use of sexual and reproductive health services that are already offered by other healthcare providers, including GPs and pharmacies

3.0 Engagement and consultation activities between June and September 2016

3.1 During the public consultation (25 August to 30 September), the following activities were completed when the views of over **600** stakeholders were sought, including, patients, staff, GPs, local residents and community voluntary organisations:

- 544 surveys (191 online and 353 paper)
- 39 semi-structured, one-to-one 20-minute interviews with service users, held in clinic consulting rooms (with patients recruited from the waiting room)
- 25 service users discussed their views as part of an open dialogue / group discussion in Burrell Street waiting room
- 16 patient-public stakeholders attended 3 specialist community focus groups
- 7 patient-public stakeholders attended a public meeting

3.2 This is a successful response given the transient nature of the patient population using these services and the topic matter itself, not necessarily being conducive to public discussion.

4.0 The findings of the consultation

4.1 The following section summarises the findings of the consultation under each of the main proposals. Where relevant it includes insights from the earlier patient and public engagement activities in June, which informed the development of the proposals for consultation. The report also includes verbatim comments from respondents and these are used to illustrate themes of responses.

4.2 The demographic profile of respondents is described as follows – further details are included at Annex B. Overall, the profile of respondents is broadly representative of the populations served by Lambeth and Southwark.

Consultation	Summary of demographics
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Activity	
September survey	<p>Lambeth residents 38%</p> <p>Southwark residents 34%</p> <p>Other boroughs (including outer London) 28%</p> <p>The majority of respondents are;</p> <ul style="list-style-type: none"> • White females aged 18 – 34 years (28%) • White males aged 18-34 years (11%) • Black females aged 18-34 years (10.62%) <p>Respondents described their gender and sexuality as;</p> <ul style="list-style-type: none"> • Heterosexual / straight female 58% • Heterosexual / straight male 17% • Gay, male 14% • Bisexual, male 2% • Bisexual, female 4%
September semi-structured interviews in clinic waiting rooms	<p>Lambeth residents 27%</p> <p>Southwark residents 48%</p> <p>Other boroughs (including outer London) 24%</p> <p>The majority of respondents are;</p> <ul style="list-style-type: none"> • Female (61%) • Male (39%) • Aged 18-34 (74%) • Described ethnicity as white (59%) or Black/Black British (30%) <p>And the majority of respondents described their gender and sexuality as;</p> <ul style="list-style-type: none"> • Heterosexual (68%) • Gay, male (18%) • Bisexual (9%)

4.3 Referring more asymptomatic patients (i.e. without symptoms) to ‘home (self)-testing’ by expanding and developing the existing online testing service SH:24

- 4.3.1 Although many respondents support the notion of self-testing and can see its benefits, there is some polarisation of opinion. This is reflected in the survey results and illustrated by some of the verbatim comments below. Interestingly, many people we have spoken to so far in discussion groups or interviews are **not** aware of SH:24.
- 4.3.2 Many patients are very interested in the idea of home testing, while others feel they would not have enough confidence in the self-testing option and prefer to see a healthcare professional – this appears to be about a lack of confidence in their ability to do the test and the reliability of the results. For those responding:-

- 65% thought people would use the online service

“I think it's overall, for your average patient, a good idea. My patients who I, as a GP, show the website to are keen to use it. There will always be a minority of patients who can't use website as above, whose needs must be catered for.” (GP – Survey Respondent, September)

“Great option especially for those who work and find it hard to visit meaning they don't get checked up as often as they should....I will be ordering them.” (Survey Respondent, September)

- 35% indicated there were reasons why they thought patients might be reluctant to use home testing, and these varied:-
- the ability to use or access the technology, to concerns about accuracy of self-testing and ‘getting it wrong’;

“I don't think it's safe that we test at home as we are not trained, so it might not be accurate” (User research, June)

- to concerns about access for, and impact on, vulnerable groups such as the young, people with a disability (e.g. visual impairment) and those for who English is not their first language.

“It seems like a good idea for most people although there may be people who need extra support and who may struggle with home testing - vulnerable young people/adults, elderly, non English speakers, learning disabilities etc.” (Survey Respondent, September)

- Respondents also noted a need for support in using the system and general education around sexual health and testing was highlighted, with a number of respondents suggesting an online chat service for this purpose:

“I will use this service in the future for check-ups. It's more comfortable, there's less waiting time and I'm ok with taking my own blood tests at home. They need to provide a specific delivery date and an online chat service if people need help.” (Clinic interviewee, September)

4.3.3 The survey asked respondents to indicate how they would prefer to order home-testing kits should they visit the clinic and be directed to SH:24. The responses indicate that a larger proportion of respondents would prefer to:-

- order a testing **kit for delivery to their home (69%)** before leaving the clinic, using the device provided and
- **63%** would **take away information about SH:24** and use their own device to order a kit

4.3.4 Whilst the majority preferred home delivery, a number of concerns were raised about the reliability of postal services and use of home addresses for such deliveries:

“I would use it, but it's not for everyone. I live at home with my parents, and my mum is nosy and would assume the worst if I was having a testing kit sent home.” (Clinic interviewee, September)

4.3.5 We also asked respondents to tell us how they would prefer to received the testing kit

- 76% would prefer the kit to be delivered to their home
- 29% would prefer to collect it from another location (e.g. an NHS community clinic – health centre or GP)

4.4 Reducing the number of sexual health centres from 6 to 3

4.4.1 Overall, there are no strong objections to the proposal to reduce the number of clinics from 6 to 3. One-to-one patient interviews in clinics and a waiting room discussion groups allowed the team to explore the views of service users, which could not be achieved as effectively in the survey. The findings are as follows.

- Patients seem to be understanding of the need to reduce the number of clinics given the financial situation.

“OK with closures, the plan makes sense. If Streatham Hill closed, I would go to Brook in Brixton. There's always a clinic nearby. If I have to travel further, that's what I'll have to do.”
(Clinic interviewee, September)

“It's ok to close the smaller clinics. Waiting times are a bit long at Walworth Road, but it's good that it will offer a full Sexual Health service.” (Clinic interviewee, September)

- A minority of comments refer to concern about the closure of clinics - 11 free text comments in the survey and 16 patient interview respondents note concern about or objection to the closure of clinic(s)

“I live near Walworth Road and didn't even know it was there. Tried to book an appt there but couldn't. The cuts are short-sighted. Centralisation lowers costs, but what about patient convenience?” (Clinic interviewee, September)

- Patients would have a plan for where to go if their nearest clinic closes (i.e. by utilising remaining clinics in the two boroughs)
- Some patients have voiced agreement with the closure of Lloyd Sexual Health Centre, as they would not travel there from the community

“Burrell Street and Lloyd are great for commuters and the easiest to access, though one of them SHOULD shut because they're too close together”. (Clinic interviewee, September)

- Waiting times in clinics are a concern for some and this was reflected in patient interviews, as well as comments in the survey – respondents are concerned waiting times may increase;
- but it is also acknowledged that home STI testing could help to alleviate some of this

“Burrell Street already faces long queues and days when appointments aren't possible. I am very concerned that if the other closures go ahead this will become even worse.” (Survey respondent)

“It's crucial that clinics can cope with the number of patients they're expected to see. I'm used to having to take a day off work to come to the clinic. (Clinic interviewee)”

4.4.2 We asked survey respondents to indicate which clinics they have used most often. The table below indicates those clinics used most (of 341 respondents who answered the question), currently.

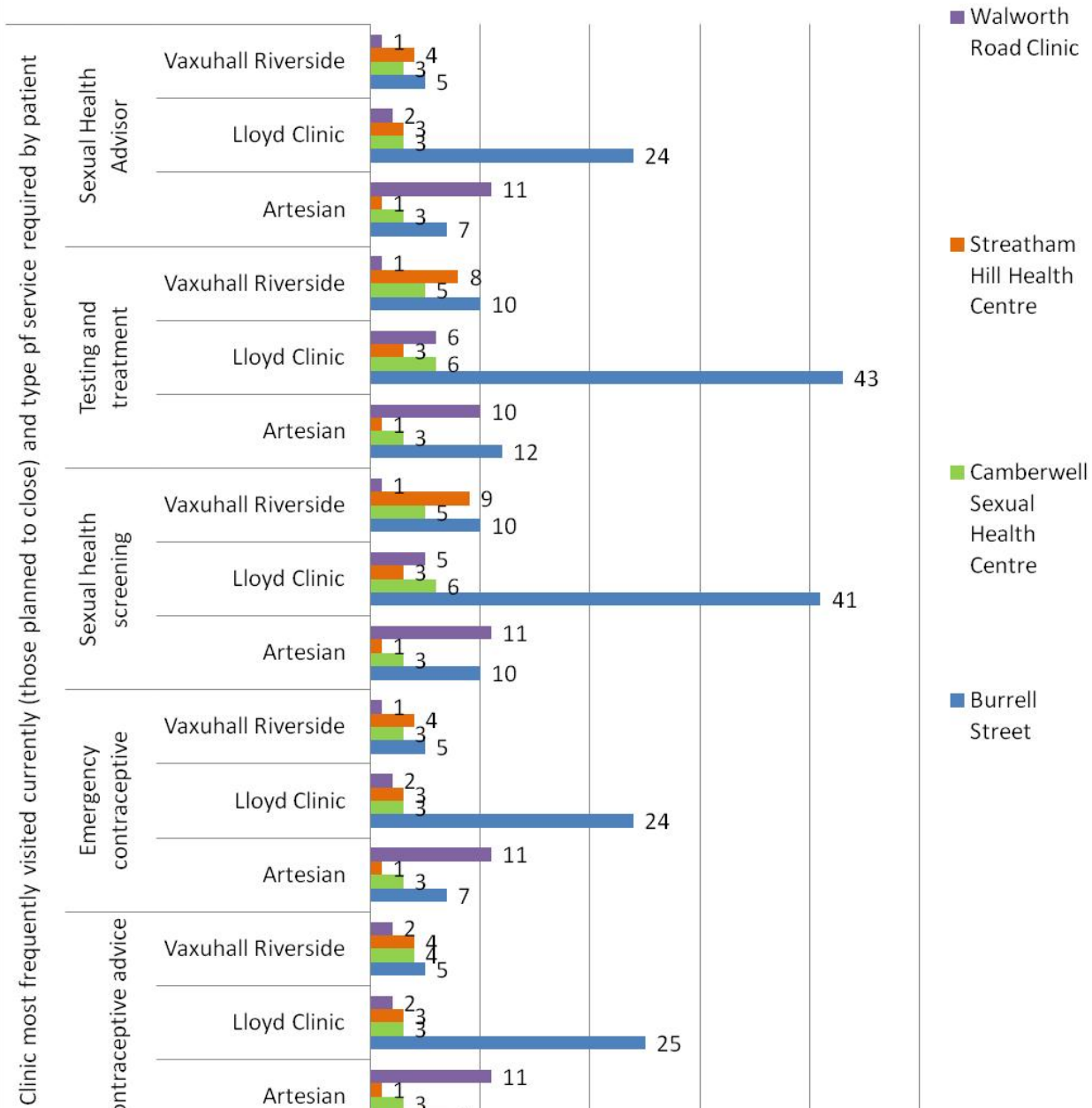
• 20% use Streatham Hill Health Centre	• 15% Burrell Street
• 19% Lloyd Clinic at Guys Hospital	• 12% Walworth Road
• 16% Vauxhall Riverside Health Centre	• 10% Artesian Health Centre

4.4.3 Q12 asked survey respondents which centre they would be mostly like to visit in the future. 237 people responded to this question (please refer to Annex D), but responses to Q10 indicate that only 151 respondents often use a clinic that is due to close (i.e. Artesian, Lloyd or Vauxhall Riverside). Of the 151 responses, 29% (44) are from boroughs other than Lambeth and Southwark. Responses from Q10 (If you use a sexual health centre, which one do you use most often) were cross-tabulated with responses to Q12. The number of respondents is small, however, the chart on page 6 indicates:-

- A larger number of patients who currently attend Lloyd Clinic might attend Burrell St in the future
- Patients who currently attend Artesian Health Centre may prefer to travel to Walworth Road or Burrell Street in the future
- Of those who currently attend Vauxhall Riverside (a much smaller no. of respondents), responses note a preference towards Burrell Street or Streatham Hill

Q10 If you use a sexual health centre, which one do you use most often?	
Artesian Health Centre	34
Lloyd Clinic (at Guy's Hospital)	64
Vauxhall Riverside Health Centre	53
Grand Total	151

Q12 Clinics where respondents would be most likely to attend, when clinic closes
(of those who most often attend a clinic that is planned to close Q10 = 151
respondents) - by service required by patient
NB: no of responses will not add up to 151, as respond



- 4.5.4 Although the consultation did not address this, comments during the public meeting and a very small number of comments from clinic interviews and survey responses (7 comments in total) indicated concern about the need for continuation of specialist clinics, such as clinics for younger people and male only clinics, for gay men.

4.5 Increase the opening hours of clinics to provide longer weekday opening and weekend opening hours

- 4.5.1 The consultation document highlighted the proposed opening hours of clinics and the survey asked respondents to select the most convenient Sunday opening hours for Burrell Street. Findings are as follows, with **Sunday, 10.30am – 5.00pm** being the most convenient.

Opening time options	*Sum of responses rated 'very' or 'fairly' convenient			Weighted average score
	Patient-public stakeholders	Trust staff and primary care providers	All respondents	
8.30am – 3.00pm	69.79%	69.49%	69.63%	0.74
9.30am – 4.00pm	74.47%	82.14%	75.81%	0.97
10.30am – 5.00pm	81.79%	82.26%	81.97%	1.26

**Columns do not add up to 100% because respondents were invited to complete a response in each row / option*

- 4.5.2 In June, the Trust sought the views of services users on the most convenient opening hours and the opening hours included in the consultation were informed by the earlier findings. Q16 of the consultation questionnaire invited general comments and suggestions - **17% (94) of respondents made comments**. The comments were analysed and coded thematically and the top 5 most frequently recorded are noted below.
- 4.5.3 The most frequently recorded comments suggest longer evening opening hours than currently proposed would be preferable and make services more accessible to the working age population.

“If you want someone to come along to support you, it’s easier to find someone to come after working hours” (User Focus Group, June)

“Later opening hours are preferable. 6pm is too early to close on a weekday, what happens to people who work?” (Consultation interviewee, September)

“Major clinics need extended opening hours into evenings and weekends for young people working irregular hours.” (Community special interest group for young People, September)

4.6 Increase awareness and make much better use of sexual and reproductive health services that are already offered by other healthcare providers, including GPs and pharmacies

4.6.1 The consultation and earlier patient and public engagement activities explored patient-public stakeholder awareness of sexual and reproductive services offered by primary care providers. Respondents were also asked to indicate which services they might prefer to use and why.

4.6.2 Some respondents are strongly against accessing sexual and reproductive health services in primary care for the reasons noted and the verbatim quotes reflect the themes gathered through recent patient interviews and earlier focus groups conducted in June:

- Dependent on the quality of their relationship with the GP
- Access to GP appointments, often difficult, with long waits for appointments
- Lack of confidence in GPs and pharmacists to deliver what patients consider to be ‘specialist services’
- Concerns that pharmacies do not have the facilities to offer enough privacy

“GP takes 3 to 4 weeks to get an appointment” (Clinic interviewee)

“Pharmacy services would be ok if it was as private as a sexual health clinic.” (Clinic interviewee)

“My GP is too close to home, the doctor knows my family. I would never have a check-up there’ (Clinic interviewee)

“I don’t like the thought of going to a GP. There are a lot of student doctors there and I don’t know if I would Trust there expertise. Also the waiting time is too long” (Clinic interviewee)

4.6.3 Fewer respondents were positive about the notion of accessing these services in primary.

“Testing at the GP would be a great service to offer. Ideal, actually.” (Clinic interviewee)

“Having sexual health services at the GP would be a great additional service. I have a good relationship with my GP” (Clinic interviewee)

“Pharmacy closer to home. No problem” (Clinic interviewee)

4.6.4 In general, survey responses indicate that **very few people are prepared to travel more than 30 minutes to access the required service**

4.6.5 Survey responses suggest that if patients needed to access sexual and reproductive health services offered by primary care providers (i.e. emergency contraceptive, Chlamydia test, regular contraceptive) service users would approach the following providers:-

Service need	Responses by provider (top 3 per service need where % responses are 25% and over)
Emergency contraceptive (taken with 72 hrs)	44% Pharmacy (under 30 mins travel) 26% Order online 25% Sexual health centre
Contraceptive advice and contraception	32% My local GP practice 31% a sexual health clinic (under 30 minutes travel 25% Order online - sent to my home
Regular contraceptive prescription	32% Order online - sent to my home 29% My local GP practice 27% Pharmacy near my home (under 30 minutes travel)
Post exposure prophylaxis	43% Sexual health centre (under 30 minutes travel) 29% GP practice where patient is registered
Testing and treatment	52% Sexual health centre (under 30 minutes travel) 27% Order online - sent to my home 25% My local GP practice
Sexual health advisor	56% Sexual health centre (under 30 minutes travel)

4.7 General comments on the proposals and suggestions for improvement

4.7.1 Q16 of the consultation questionnaire invited respondents to make general comments on the proposals and any other suggestions for improvement - **17% (94) of respondents made comments**. The comments were analysed and coded thematically - the top 5 most frequently recorded are noted on page 6.

Pos.	Most frequently recorded comments (of 94 comments received)
1 st	32% Request for long evening opening hours (later than those proposed)

2 nd	21% Other (broad range of comments that did not fit into any other category)
3 rd	13% Complaints about current waiting time and / or concern about these increasing
4 th	12% Objection to / concern about closure 12% Earlier morning opening hours
5 th	9% Support for weekend opening hours

5.0 Trust and commissioner responses to the public consultation

5.1 The table below summarises the key findings or themes that have emerged from the consultation, which require a response. An explanation is provided where neither the Trust nor commissioner can address the matter through the changes proposed in the consultation or additional changes.

Respondents views – consultation findings that require a response	Trust or commissioner's response or resulting recommendation for change	Trust (T) or Commissioner (C) response ?
Extend and increase online / home-testing for asymptomatic patients		
Incorporate facilities that will enable asymptomatic patients visiting clinics to; a) order a test in the clinic or; b) provide information that will support patients who wish to, to leave the clinic and order it using their own device.	The Trust plans to install IT facilities (e.g. iPads or tablets) in Burrell St (what about order clinics?) for patients to order home-testing kits for collection from clinics or delivery to patients' homes. This service is currently provided at Camberwell Sexual Health Centre (provided by King's College Hospital NHS Foundation Trust). The Trust will also provide written information for patients who wish to leave the clinic and order the testing kit using their own device	T
Address the support needs of a) vulnerable or those patients whose sexual health is most at risk b) those who may not be	Online services have been designed to improve access to testing of asymptomatic patients and reduce pressure on the service, so staff can focus on providing care and treatment to those who need it most. The reception team will continue to use a	T

able to use online / home testing, c) Younger people, in particular where safeguarding may be a concern	triage form that has been developed and well-tested over the last five years, to identify vulnerable patients and those whose sexual health is most at risk, so the most appropriate member of clinic staff sees them.	
Reducing the number of clinics from 6 to 3		
Respondents are generally understanding of the need to reduce the number of clinics, but respondents are concerned about waiting times in clinics increasing as a result.	<p>The remaining clinics will be better staffed over three sessions each day, so the service can see more patients than we see at present in a clinic session.</p> <p>The service will also increase the number of bookable appointments to ensure that we can target patients who need the service most and support those who cannot access the walk-in service.</p>	T
A small number of respondents are concerned about the need to ensure continuation / availability of 'specialist clinics' (e.g. 'young people' and 'men only' clinic sessions) in the new service model.	Each session in every clinic will have a health advisor to ensure high quality counselling and support for high risk patients. All three clinics will have a multi-disciplinary teams that can manage all patients who present in the clinics. A senior doctor will be available at all times to support staff when there are concerns about higher risk or vulnerable patients	T
Increase the opening hours of clinics to provide longer weekday opening and weekend opening hours		
The Sunday opening hours most preferred by patient-public stakeholders = <u>10.30am – 5.00pm</u>	On Sundays, the clinic will open from 9am – 5pm. The Trust is keen to deliver an 8-hour service on both Saturday and Sunday. Patients using the services will be able to queue / register (?) from 9am, with the	T

	clinic session opening at 10am.	
Clinics should be opened longer in the evening on weekdays than currently proposed (i.e. beyond 6pm when clinics will close to further walk-in appointments) to ensure young people and the working age population can easily access services after core working hours	<p><u>The Trust is unable to offer additional hours beyond what is proposed, due to the financial constraints.</u></p> <p>The service recognises that later opening would be convenient for working patients. However, we believe that the combination of 7-day working, together with the ability to book appointments and opening hours of 10.5 hours each weekday provides good access overall.</p>	T
Increasing awareness and making much better use of primary care		
A need to increase awareness of and more information about what sexual and reproductive health services are offered by different primary care providers.	<p>Commissioners in Lambeth Council will work with SXT (an online sexual health information service) to ensure information about all sexual and reproductive health services offered by GP practices and pharmacies, to ensure that patients are signposted to the most appropriate service.</p> <p><u>Commissioners and local healthcare providers will publicise SXT more widely</u></p>	C
A need to address public confidence in sexual and reproductive health services offered by primary care providers, including GPs and Pharmacy.	The Trust provides training to local GPs as junior doctors and offers continuing professional development training to GPs and Pharmacists to ensure they have the necessary skills to provide sexual and reproductive health services. This work will continue with support from commissioners	T / C

6.0 Next steps

- 6.1 During the next few weeks, the Trust will continue to review the findings of the consultation and consider its response, in partnership with commissioners and other stakeholders. Some aspects of the consultation will require the response of commissioners e.g. those relating to access to sexual and reproductive health services provided by primary care providers. A timetable is noted below.

Timeline	Activity
Ongoing to 24 October	<ul style="list-style-type: none"> • Analysis of consultation responses (public and internal staff processes) and thematic coding of qualitative user engagement activities • Trust and commissioner liaison regarding the consultation response
27 October	<ul style="list-style-type: none"> • Consultation report (inc. internal staff and public consultation findings) and recommendations for response presented to the Trust Management Executive
27 October to 31 st March 2017	<ul style="list-style-type: none"> • Outcome of staff consultation, staff interviews and redeployment for new service model
By 25 November	<ul style="list-style-type: none"> • Public consultation report published online (summary version to be made available)
November– 31 st March 2017	<ul style="list-style-type: none"> • Phased implementation of agreed staffing changes
January to July 2017	<ul style="list-style-type: none"> • Phased implementation of site changes

7.0 Recommendations

- 7.1 The Board of Directors is asked to
- a) **CONSIDER** the views of patient-public stakeholders outlined in the findings of the consultation and;
 - b) **AGREE** the Trust's responses to the consultation and the recommendations for change / implementation
 - c) the next steps and timetable highlighted at paragraph 6.0

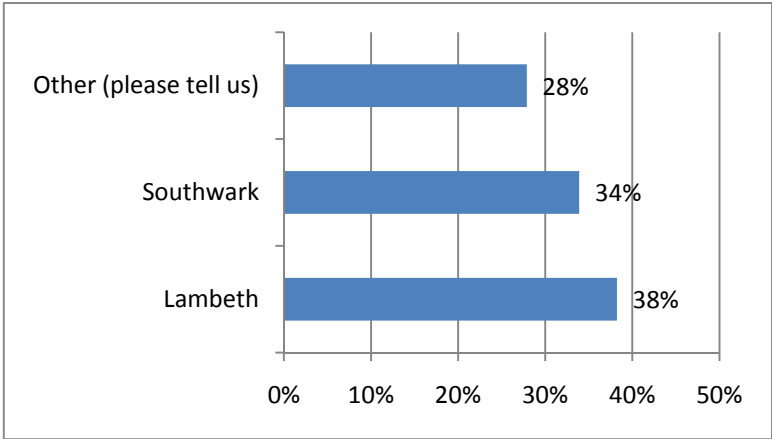
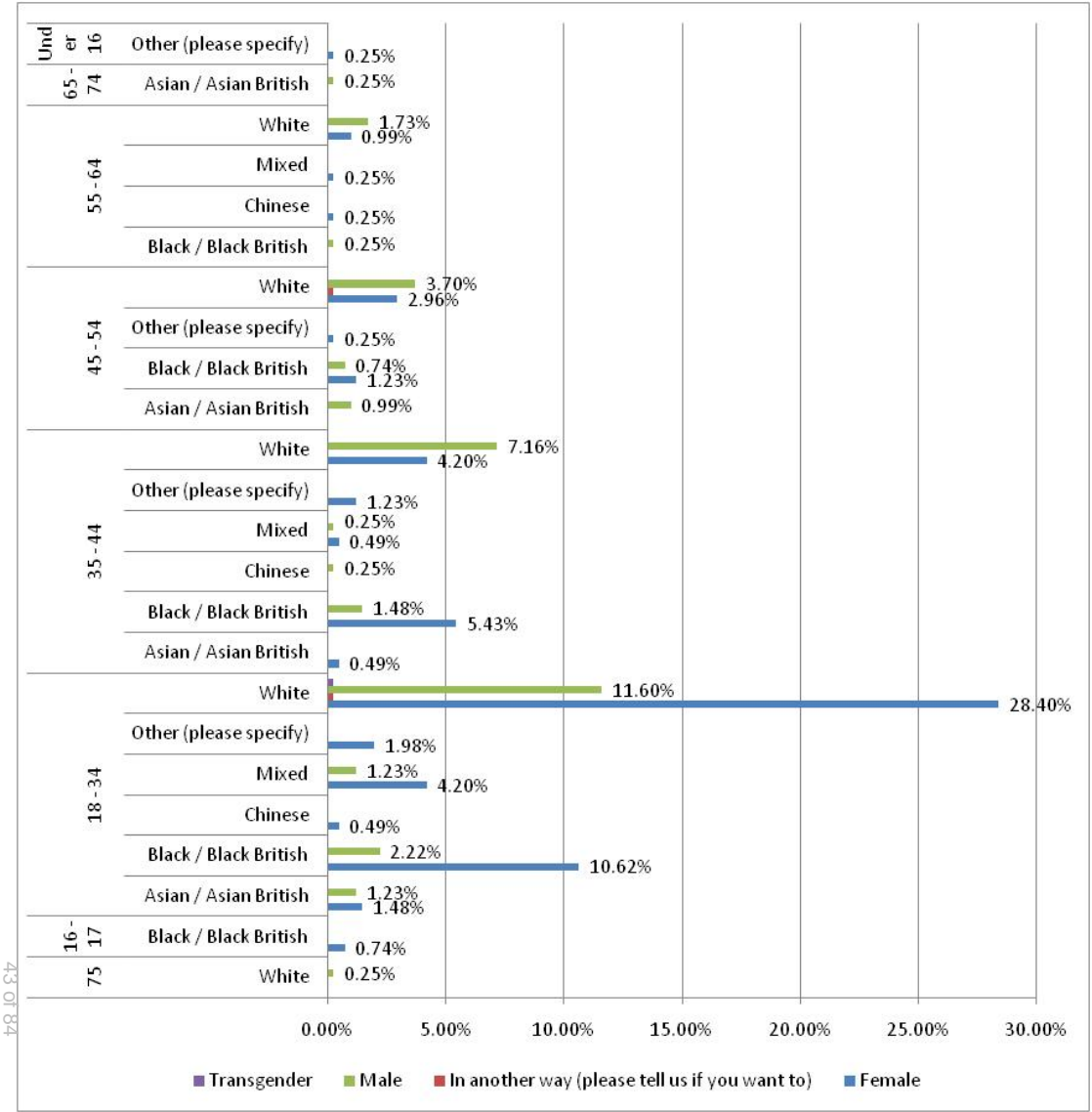
Robert Cook, General Manager, Specialist Ambulatory Services
 Dr Anatole Menon-Johansson, Consultant and Clinical Lead, Sexual and Reproductive Health Services
 Andrea Carney, Trust Patient and Public Engagement Manager

Summary of all Trust-led patient and public engagement and consultation activities conducted between June and September 2016

Activities	Progress update and comments
	Trust-led patient and public engagement activities June to July 2016 (to inform consultation proposals)
Online and paper service user questionnaire	<ul style="list-style-type: none"> • 588 survey responses <ul style="list-style-type: none"> ○ 91 online ○ 497 paper
User focus groups	<ul style="list-style-type: none"> • 6 x patient / user focus groups recruited from waiting room spaces in all 6 clinics • Total of 21 participants • Used to explore:- <ul style="list-style-type: none"> ○ User awareness of range of services offered by the Trust and test awareness of the providers ○ To explore options for future consolidation of clinics and notion of reducing clinics, using visual stimulus with key facts and figures about the clinics ○ Distance people are prepared to travel to access services ○ What influences people's choices of service provider
	Public consultation 25 August to 30 September
Online consultation document and questionnaire	<ul style="list-style-type: none"> • Publicised on the Guy's and St Thomas' NHS Foundation Trust website, with signposts from both council websites • Also publicised via the Trust's communications channels including monthly Team Briefing (for staff at GSTT), fortnightly King's Health Partners News (for staff at GSTT, KCH, SLAM and KCL), monthly e-GiST (for Foundation Trust members and key stakeholders), digital screens in our hospitals, news story on the Trust website • Link distributed by Public Health commissioning network and CCGs • Link publicised / distributed by Healthwatch • Shared with Foundation Trust Governors by email upon launch and discussed at a Governors working group on 13 September
Public information display (A0 posters) installed all clinic sites	<ul style="list-style-type: none"> • In situ for the duration of the consultation
Consultation questionnaire	<ul style="list-style-type: none"> • 544 survey responses (from a broad range of respondents, including patients, Trust staff, GPs,) <ul style="list-style-type: none"> ○ 204 online ○ 341 paper
3 community focus groups for specialist interest groups	<ul style="list-style-type: none"> • 3 community focus groups were completed <ul style="list-style-type: none"> ○ MSM focus group ○ Brook Young People's group ○ BME women's group
Discussion forums and one-to-one interviews in all six clinic waiting rooms	<ul style="list-style-type: none"> • 39 patients consulted through open discussion forums or one-to-one interviews with patients from clinic waiting rooms in all 6 clinic sites

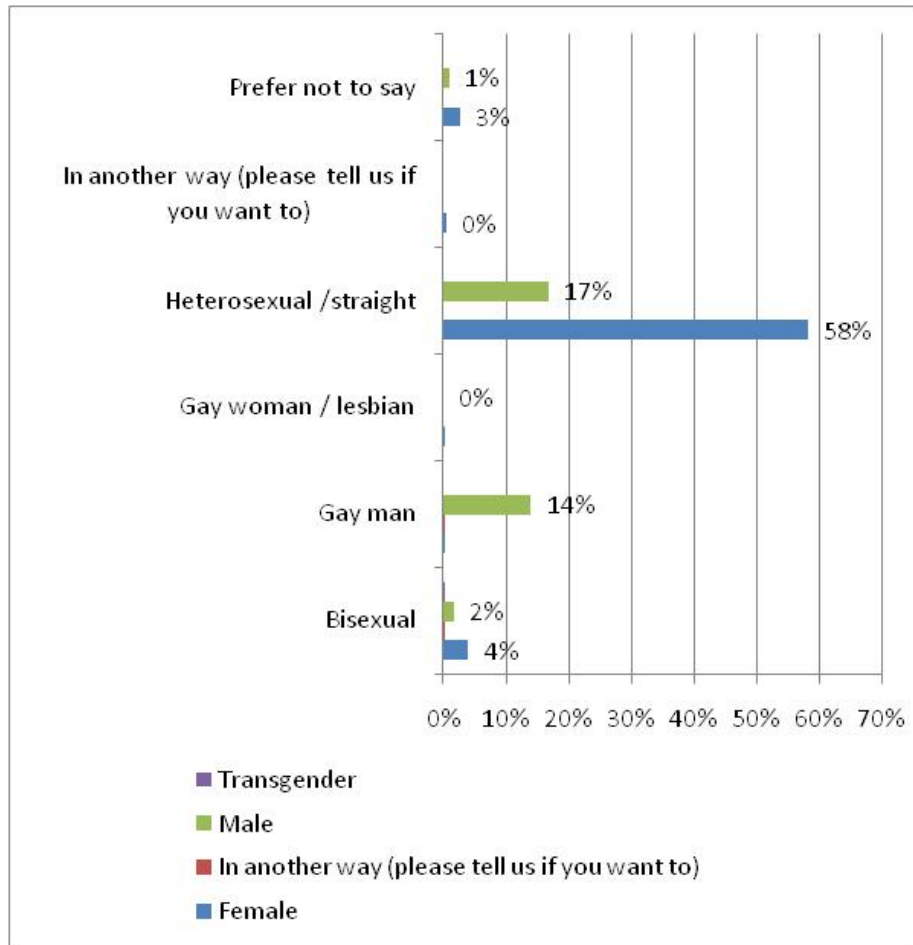
Summary demographic profile of respondents

% of respondents by borough

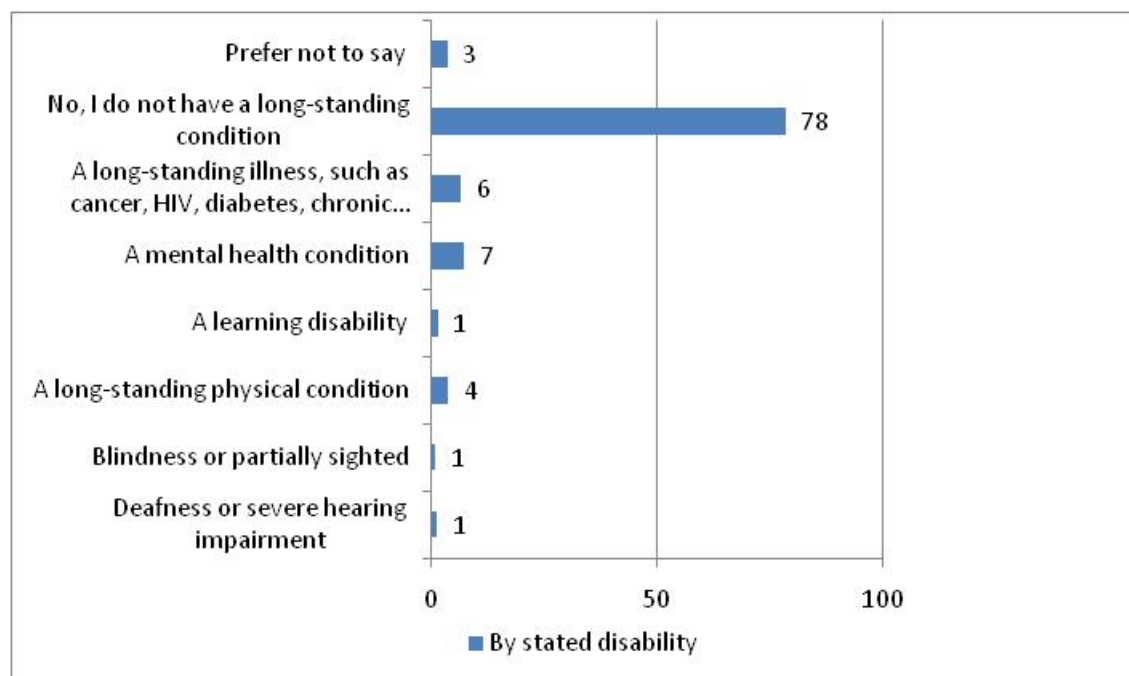


Respondents by age and ethnicity

Respondents by sexuality and gender (%)



% of respondents with stated long-standing condition or disabilities



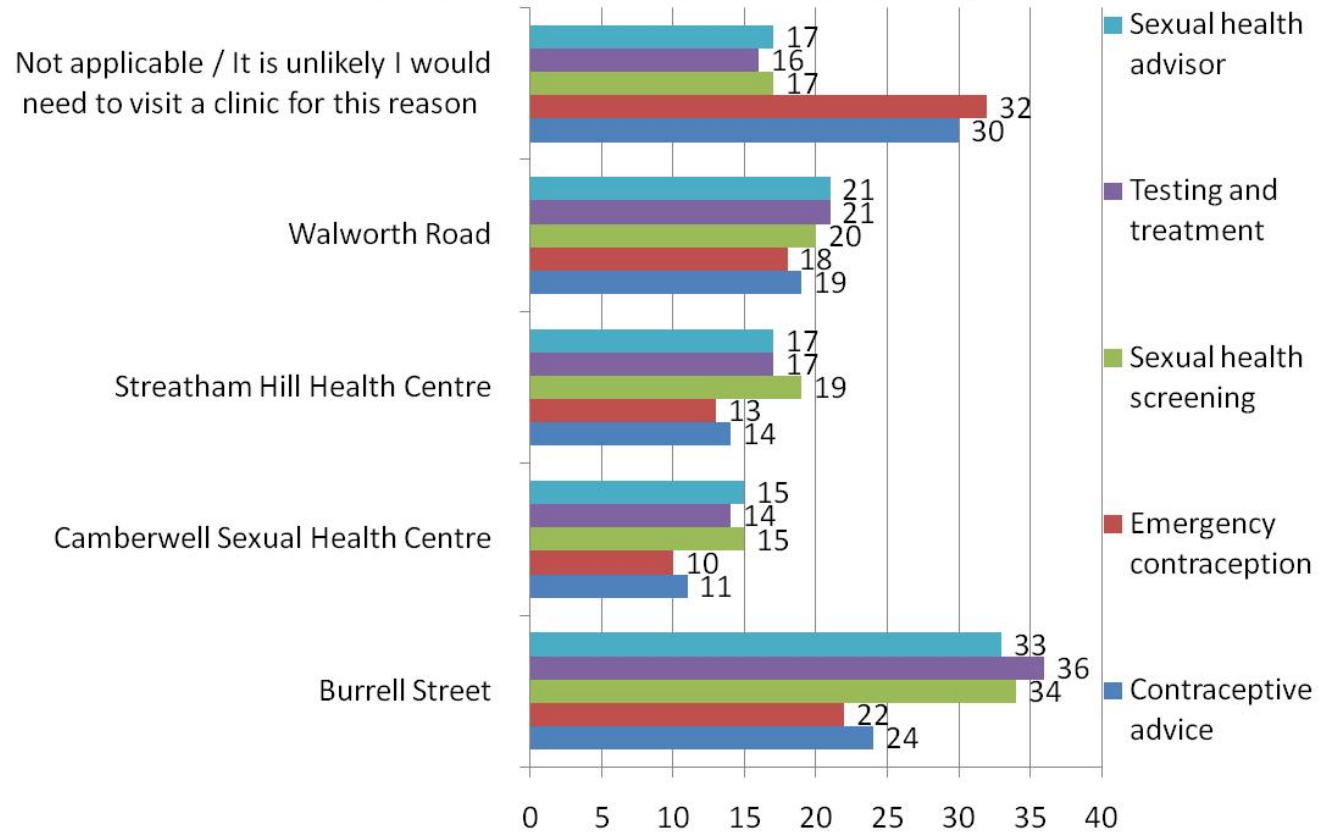
Demographic profile of respondents who participated in the patient interviews across the 6 clinic sites

Demographic group	Demographic category	June survey	June Focus Groups	September survey	September Clinic waiting room interviews	September Public Meeting
Gender	Male	144 (31%)	9 (43%)	140 (34%)	13 (39%)	2 (40%)
	Female	323 (69%)	12 (57%)	274 (66%)	20 (61%)	3 (60 %)
	Transgender	2 (0.42%)	0 (0%)	1 (0.24%)	0 (0%)	0 (0%)
Sexuality	Bisexual	30 (6%)	1 (5%)	26 (6%)	3 (9%)	1 (20%)
	Gay man	49 (11%)	5 (24%)	59 (14%)	6 (18%)	1 (20%)
	Gay women/lesbian	7 (2%)	0 (0%)	1 (0.24%)	0 (0%)	0 (0%)
	Heterosexual/straight	364 (78%)	13 (62%)	315 (75%)	23 (68%)	3 (60%)
Age	Under 18	8 (2%)	9.5 (2%)	4 (1%)	0 (0%)	0 (0%)
	18-34	346 (74%)	17 (81%)	267 (64%)	25 (74%)	0 (0%)
	35-44	80 (17%)	0 (0%)	88 (21%)	5 (15%)	2 (40%)
	45-54	26 (6%)	2 (9.5%)	41 (10%)	4 (12%)	0 (0%)
	55-64	7 (1.50%)	0 (0%)	15 (4%)	0 (0%)	3 (60%)
	Over 65	1 (0.21%)	0 (0%)	2 (0.48%)	0 (0%)	0 (0%)
Ethnicity	Asian/ Asian British	19 (4%)	2 (9.5%)	19 (5%)	3 (9%)	0 (0%)
	Black/ Black British	105 (22%)	5 (24%)	98 (23%)	10 (30%)	2 (40%)
	Chinese	10 (2%)	0 (0%)	4 (1%)	0 (0%)	0 (0%)
	Mixed	33 (7%)	2 (9.5%)	28 (7%)	0 (0%)	0 (0%)
	White	274 (58%)	11 (52%)	254 (61%)	20 (59%)	3 (60 %)
	Other	28 (6%)	1 (5%)	15 (4%)	1 (3%)	0 (0%)

All 237 responses to Q.12 You chose / ticked a clinic that is likely to close in the future. Please could you tell us which sexual health centre you would be most likely to visit in the future instead, if you had to visit for the any of the following reasons?

NB: The data includes respondents who do not necessarily attend a clinic that is due to close – it is likely that respondents to the paper survey did not follow the question routing instructions.

% of respondents preferred clinic by service need (of those who would have previously attended a clinic that is expected to close no. = 237)



Summary of findings from special interest community focus groups

	Clinic Closures	Opening Times	Online provision/SH:24	Primary Care
Gay men living with HIV	<ul style="list-style-type: none"> Expressed concern about the cuts and potential long term impact on public health 	<ul style="list-style-type: none"> Recognised varying individual needs - no consensus on opening hours Suggested split shifts Display waiting times at lunchtime 	<ul style="list-style-type: none"> Not heard of SH:24 Questioned how counselling and contract tracing would work 	<ul style="list-style-type: none"> Pharmacists not deemed trustworthy Mixed views on GP services; varying experiences of GP care in relation to sexual health and HIV.
Young People	<ul style="list-style-type: none"> Felt GP autonomy in deciding whether to offer sexual health services driving people into clinics. 	<ul style="list-style-type: none"> Major clinics need extended opening hours into evenings and weekends for young people working irregular hours. 	<ul style="list-style-type: none"> Little awareness of SH:24 Use if quick and easy with minimal information taken. Discreet packaging, set delivery hours and turn around of results important. Concerns over confidentiality-sample loss and privacy implications of this. Click and collect widely supported. Operability across tablet and Smartphone operating systems deemed crucial. 	<ul style="list-style-type: none"> Nurses in other services, including adult sexual health services, patronising & judgemental towards young people. Staff in young people's services had better attitude and knew how to work effectively with young people: "They don't treat us as lesser just because we are younger" Feel GP's and pharmacists should be trained on how to be 'young people friendly'
BME women	<ul style="list-style-type: none"> Some happy to travel by bus to a clinic Others prefer to access a clinic within walking distance. Felt sexual health clinics needed better promotion. 		<ul style="list-style-type: none"> Women who are parents less likely to use SH:24 for confidentiality reasons – in case their children found it in their browsing history. 	<ul style="list-style-type: none"> Confidence in GPs to provide good quality care and make them feel comfortable. Difficulties in obtaining GP appointments quickly, in seeing a female GP and in not having a regular GP so having to retell their story each time.

Annex B - Financial Requirement to deliver staffing model

		Current structure WTE	New structure WTE	Saving WTE	Current structure £	New structure £	Saving £
Changing grades	Nurse B6	13.84	11.00	2.84	£631,083	£500,995	£130,088
	HCA - Nurse B3	17.00	11.00	6.00	£460,354	£302,060	£158,294
	Nurse B5	3.34	3.34	0.00	£122,573	£126,148	£(3,576)
	CNS - Nurse B7	12.20	11.00	1.20	£658,811	£588,742	£70,069
	Health Advisors - PAMs B7 / B8A	11.47	11.00	0.47	£628,690	£608,349	£20,341
	Staff Grade Doctor	8.10	2.80	5.30	£402,506	£224,000	£178,506
	Associate Specialist	3.70	3.40	0.30	£550,587	£360,400	£190,187
	Senior Drs (Consultant)	7.14	5.80	1.34	£961,519	£696,000	£265,519
	Junior Drs	14.00	7.30	6.70	£759,732	£759,732	£0
	Receptionists - B3	17.57	14.00	3.57	£480,172	£384,440	£95,732
Outreach team	Chlamydia Screening Administrator - A&C B3	1.00	1.00	0.00	£27,329	£27,329	£0

	Nurse B8A	1.00	1.00	0.00	£68,617	£68,617	£0
	Nurse B7	1.00	1.00	0.00	£48,599	£48,599	£0
	Nurse B6	2.00	2.00	0.00	£88,316	£88,316	£0
Recall team	Results Administrator - A&C B3	0.88	0.88	0.00	£24,050	£24,050	£0
	Results and Partner Notification Coordinator - A&C B4	1.53	1.53	0.00	£47,799	£47,799	£0
	Results Team Leader - A&C B5	1.00	1.00	0.00	£53,121	£53,121	£0
	Results Co-ordinator - Nurse B4	1.00	1.00	0.00	£33,403	£33,403	£0
Psychosexual team	Consultant	0.20	0.20	0.00	£21,343	£21,343	£0
	Nurse B7	0.21	0.21	0.00	£11,340	£11,340	£0
Other A&C	Patient Access Officer - B3	2.00	2.00	0.00	£54,658	£54,658	£0
	Medical Secretary - B4	2.00	2.00	0.00	£62,482	£62,482	£0
	Clinic Co-ordinator - B4	2.92	2.92	0.00	£91,224	£91,224	£0
	Business Co-ordinator - B6	1.00	1.00	0.00	£52,209	£52,209	£0

Other Nursing	Matron - B8A	1.00	1.00	0.00	£68,617	£68,617	£0
	Sisters - B7	2.93	3.00	(0.07)	£158,223	£158,223	£0
		130.03	102.38	27.65	£6,567,358	£5,462,197	£1,105,161

Equality and Equity impact assessment initial screening framework

- 1 The framework provides a consistent and systematic way to complete EEIAs. The questions not only offer structure, but a prompt to help you to make the best possible policy decisions. Many questions would need to be answered as part of good policy development.
- 2 The questions are not exhaustive, so as you complete the template, there may be additional questions that need to be asked and answered. The framework provides an outline of the sort of information needed to satisfy our legislative requirements. Although the template addresses all of the legislative strands of equality, policy managers are also urged to think about specific demographic groups that may be at risk of being disadvantaged by a decision.

Single identity or multiple identities – what makes most sense?

“There is little that unites LGBT needs. Rather there are a range of overlapping communities which make more sense if considered in relation to other demographic categories such as gender or race. Thus, there are Black Gay men and Lesbians, Older Gay men and Lesbians, Lesbian and Bisexual women etc. When seeking to define needs and develop models of community development for the LGBT population of Lambeth, it is worth using this model of communities rather than seek to identify a single over-arching community.”
Lambeth LGBT matters research (Sigma 2006)

Initial screening template

1. Policy aims

1.1	Proposal, service, programme, strategy or procedure being assessed	<input type="checkbox"/> Offering patients looking for Sexual and Reproductive Health (SRH) services a "one stop shop" approach, with fewer clinic sites but open longer and offering a fuller range of interventions <input type="checkbox"/> Promoting the use of online services available 24/7 in order improve accessibility and reduce waiting times <input type="checkbox"/> 7 day working across SRH staff (except medical secretaries and Junior doctors) <input type="checkbox"/> 1 in 4 weekend working <input type="checkbox"/> Opening hours harmonisation and increased hours at weekends <input type="checkbox"/> Sites consolidation driven by budget reductions <input type="checkbox"/> Reduction of Workforce (clinical and non clinical) driven by budget reductions
1.2	Name of person responsible (policy manager) and contact details	<input type="checkbox"/> Robert Cook, General Manager Specialist Ambulatory Services, GSTT <input type="checkbox"/> Dr Anatole Menon-Johansson, Clinical Lead for Sexual and Reproductive health Services, GSTT <input type="checkbox"/> Dr Kate Langford, Deputy Medical Director, GSTT
1.3	Is this a new, existing or revised policy/function	<input type="checkbox"/> New public consultation

1.4	What does this policy, service, programme, strategy intend to achieve?	<p>We know that demand for SRH services is growing and is likely to continue to grow, but we do not know at present what funds will be available in future years to fund this growth in activity. We do know that councils have experienced reductions in Public Health grant and have passed some of these reductions on to service providers.</p> <p>The Government requires SRH services to have an open access policy and it is clear that we must run these services in a different way, so we can continue to provide care to people who need it most and manage the expected growth within reducing budgets. To do this we propose to:</p> <ol style="list-style-type: none"> 1. Refer more patients who do not have symptoms (asymptomatic patients) and attend clinics for tests for sexually transmitted infections (STIs) to 'home (self)-testing' by expanding and developing the existing online testing service already provided by SH:24 2. Reduce the number of sexual health centers from 6 to 3. 3. Align the opening hours of the 3 remaining clinics on weekdays and increase the opening hours to provide longer weekday and weekend opening hours 4. Continue to offer a combination of 'walk-in clinics' and 'advance booking appointments' 5. Increase awareness and make better use of SRH services that are already offered by other healthcare providers, including GPs and pharmacies <p>We do not propose to reduce the number of patients we manage within the services as we expect the changes we are proposing to enable us to maintain the required capacity.</p> <p>We propose to retain the following clinics:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Burrell Street <input type="checkbox"/> Streatham Hill Health Centre <input type="checkbox"/> Walworth Road <p>We propose to close the following clinics:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Artesian Health Centre <input type="checkbox"/> Lloyd Clinic (at Guy's Hospital)
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		<div><div></div><div>Vauxhall Riverside Health Centre</div></div>
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1.5	How does this fit into wider strategic objectives/priorities?	<ul style="list-style-type: none"> □ Since 2013, local councils have been responsible for Public Health. Like other councils, Lambeth and Southwark receive a Public Health grant from the government, which is used to fund a range of services to improve the health and well-being of local residents, including SRH health services (testing, treatment and contraception). □ The proposed changes are part of a London wide process of transforming SRH services which Lambeth and Southwark councils are signed up to alongside 28 other London boroughs which will see simpler/low risk testing activity shift online and clinic sites rationalised. Papers on these wider strategic objectives were approved by both council Cabinets in the autumn of 2015 and are available online. □ In 2015/16 and 2016/17, the Government significantly reduced the amount of money it gave to Lambeth and Southwark councils to fund Public Health services and there will be further cuts over the next 3 years. In addition, the councils are under significant financial pressure because of the rising demand for open access sexual health services. In particular, the money they spend on genitourinary medicine (GUM) has increased every year since 2013. □ A new London-wide tariff for Sexual & Reproductive Health services will be introduced in April 2017. The tariff determines the price paid to services for the care and treatment of patients. It is possible this new tariff will present further financial challenges for the Trust in the coming years. □ All London boroughs are struggling to maintain the same level of funding for these services and most sexual health commissioners are looking for ways to change sexual health services in the same way that we are in Lambeth and Southwark. Like other healthcare providers, Guy's and St Thomas' NHS Foundation Trust must continue to provide services with far less money. Between now and 2020.
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2. Evidence base

3 To make good, defensible decisions, it is critical that evidence is identified and reviewed. There are a number of different places from which to gather evidence, both internally (i.e colleagues, reports, bulletins) and externally (i.e research, other professionals, reports). Both qualitative and quantitative evidence is useful and will help to provide the evidence base that will help to make better assessments.

4 The minimum legal standard for completing EEIAs is to assess the impact of a policy decision on ethnicity, gender and disability. We do not want to just meet the minimum standard, we want to go beyond that and assess across the **REGARDSS** strands (**race, ethnicity, gender, age, religion/belief, disability, sexual orientation, socioeconomic inequality**).

5. This EEIA also takes into consideration our role as a representative of the state, and our delegated responsibilities to ensure the **human rights** of staff, the public and our patients are protected and enshrined in everything that we do.

2.1	<p>What qualitative and quantitative information and evidence would enable you to make the best assessment and what do they say regarding equality? (consider health needs assessments, public health input, research, consultations, stakeholders, local and national reports etc)</p>	<p>Scope of assessment: We provide services for clients across London and England. Of those who have visited our services in 2015, the breakdown around borough of residence is 25% Lambeth, 29% Southwark, 35% other London Boroughs, 5% outside London and 7% unknown. This assessment relates to the 54% of service users who are Lambeth or Southwark residents,</p> <p>RACE</p> <p>General: Nationally, ethnicity has a key effect on the level of risk of poor sexual health between particular groups of people. For example, there is a higher prevalence of Sexually Transmitted Infections (STIs) among African and Caribbean communities and a lower prevalence among Asian communities, when compared with the white British population (Shahmanesh et al., 2000; Low et al, 2001).</p> <p>The HPA report <i>Sexually transmitted infections in black African and black Caribbean communities in the UK: 2008 report</i> highlights the following:</p> <ul style="list-style-type: none"> □ Black African and black Caribbean communities in the UK are disproportionately affected by STIs. The higher prevalence of STIs in both the black African and the black Caribbean populations means that, even though the levels of high-risk sexual behaviour may be similar to those of other communities, there is an increased risk of acquiring an infection. □ The black Caribbean community is disproportionately affected by bacterial STIs, especially gonorrhoea. Data from the Gonococcal Resistance to Antimicrobials Surveillance Programme (GRASP) in 2007 shows that, among heterosexuals diagnosed with gonorrhoea at 26 GUM clinics, 26 per cent were black Caribbean and 6 per cent were black African. <p>In Southwark: 39.7% of the population belongs to the White group, 60.3% to Black, Asian and Minority Ethnic groups.</p> <p>In Lambeth: 56% of the population belongs to the White group, 44% to Black, Asian and Minority Ethnic groups.</p> <p>Attendances at our Sexual Health Centres belong 46.8% to the White group, 36% to Black, Asian and Minority</p>
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	<p>Ethnic groups (with 17.2% race not collected or was refused)</p> <p>The evidence below demonstrates the inequalities in sexual health faced by Black and Minority Ethnic groups, in particular, black African and black Caribbean residents.</p> <p>Sexually Transmitted Infections (STIs): Of the Sexually Transmitted infections diagnosed within our services in 2015; 51% belonged to the White group, 35% to the Black, Asian and Minority Ethnic Groups (with 14% race was not collected or was refused)</p> <p>HIV: An estimated 107,800 people are living with HIV in the UK in 2013. Along with men who have sex with men (MSM), black Africans are the groups most affected by HIV infection. (LASER 2014) In 2014, 2932 adult residents (aged 15 years and older) in Southwark received HIV-related care: 2195 (number rounded up to nearest 5) men and 740 (number rounded up to nearest 5) women. Among these, 51.2% were white, 28.6% black African and 4.9% black Caribbean. With regards to exposure, 57.0% probably acquired their infection through sex between men and 38.4% through sex between men and women. Southwark has a higher proportion of HIV diagnosis in heterosexual men and women compared to London and England rates.</p> <p>In 2014, 3,646 adult residents (aged 15 years and older) in Lambeth received HIV-related care: 3,020 (number rounded up to nearest 5) men and 630 (number rounded up to nearest 5) women. Among these, 61.3% were white, 17.6% black African and 5.7% black Caribbean. With regards to exposure, 68.0% probably acquired their infection through sex between men and 27.1% through sex between men and women. (PHE Laser Report)</p> <p>Nationally the proportion of undiagnosed HIV remains particularly high amongst black African men (38%).</p> <p>Termination of Pregnancy: There appears to be considerable variation in abortion rates by ethnic group. An analysis of abortions performed by local providers for Lambeth, Southwark and Lewisham between 2008 and 2013 (excluding privately funded abortions) shows that the rates are much higher in the Black and 'other' ethnic groups. The</p>
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	<p>reasons for this are not currently well understood and may relate to barriers to accessing contraceptive services. These may include: a lack of awareness of contraceptive methods available; cultural acceptability of the available methods; logistical issues such as location and opening times; and language barriers.</p> <p>Health Inequalities and BME Communities</p> <p>Evidence gathered locally during the consultation on the Lambeth, Southwark and Lewisham Sexual Health Strategy and from research, (eg African Health and Sex Survey, 2013-14, Sigma Research, LSHTP, A Review of research Among Black African Communities Affected by HIV in the UK and Europe, Medical Research Council) indicates that these health inequalities are driving factors including:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Late Diagnosis of HIV <input type="checkbox"/> Difficulties in accessing services, including HIV testing services <input type="checkbox"/> Difficulties in accessing information about HIV and HIV prevention <input type="checkbox"/> Deprivation and immigration status <input type="checkbox"/> HIV stigma <p>Reproductive and sexual health services in Southwark and Lambeth have been shown to be good at meeting the sexual health needs of key priority groups, particularly younger people and BME populations. In 2012-13 black residents in those boroughs were twice more likely to use the service than others. (LSL Sexual Health Strategy and Epidemiology Report)</p> <p>Reproductive and sexual health services in Lambeth and Southwark have been shown to be good at meeting the sexual health needs of key priority groups, particularly younger people and BME populations. In 2012-13 black residents in those boroughs were twice more likely to use the service than others. (LSL Sexual Health Strategy and Epidemiology Report)</p> <p>The transformed services will continue to target BME communities given the burden of sexual ill health that these communities carry. Online services and clinic receptions will stream those BME residents who are vulnerable and at risk into clinics to access both medical help and, where appropriate sexual health promotion interventions. Self-sampling 'click and collect' services will provide quick and easy access to testing for those who seek anonymity. There is no anticipated reduction in the capacity of the service. Access will be improved for BME residents as the online service will free up appointments within the clinic service. Translators and language line are available for service users who may need further assistance with accessing</p>
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	<p>the service and to offer support to negotiate the pathway</p> <p>The impact on race is thus positive</p> <p>GENDER</p> <p>Attendances to our services show 55% are female and 45% are male. We have over 4,500 attendances for LARC (Long Action Reversible Contraceptives) and Medical Gynaecology.</p> <p>Nationally in 2015 newly diagnosed Sexually Transmitted Infections (STIs) were attributed to 53% female and 47% Male. Locally 57% were Male and 43% Female</p> <p>Locally within our services in 2015 57% of those with new diagnosed STIs were Male and 43% female. Our attendances from females are largely focused on Pregnancy and Maternity.</p> <p>Data from the digital sexual health service (SH24) indicates that the service is more popular with women than with men (63% of users are women). Online services and clinic receptions will stream those women who are vulnerable and at risk into clinics to access both medical help and, where appropriate sexual health promotion interventions. There is no anticipated reduction in the capacity of the service. Access will be improved for women both via the digital service and via increased capacity in clinics to see the most in need.</p> <p>The impact upon gender is Positive</p> <p>AGE</p> <p>Nationally there are clear inequalities in the sexual health of young people. It has been shown that they have relatively high rates of unintended pregnancies and sexually transmitted infections (STIs), with the exception of HIV.</p> <p>Locally in our Centres we see 22,657 clients between the ages of 15-34 (71.4% of our total attendances) of those tested they make up 67.56% of all positive tests for STIs.</p>
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		<p>Chlamydia is most often asymptomatic, a high detection rate reflects success at identifying infections that, if left untreated, may lead to serious reproductive health consequences. The detection rate is not a measure of prevalence. PHE recommends that local areas achieve a rate of at least 2,300 per 100,000 resident 15-24 year olds, a level which is expected to produce a decrease in Chlamydia prevalence. Areas already achieving this rate should aim to maintain or increase it, other areas should work towards it. Such a level can only be achieved through the ongoing commissioning of high-volume, good quality screening services across primary care and sexual health services.</p> <p>Reproductive and Sexual Health Services in Lambeth and Southwark have been shown to be good at meeting the sexual health needs of key priority groups, particularly younger people and BME populations. In 2012-13, the community sexual health services reached 8% of 15-24 years old residents in Lambeth and Southwark.</p> <p>Data from the digital sexual health service (SH24) indicates that the service is highly popular with young people (35% of users are under 24). Feedback on the service indicates that young people value the anonymity, the confidentiality and the speed at which the service delivers results. Test kits will not have to be delivered to young people's homes but via a 'click and collect' service thus guaranteeing confidentiality. Research indicates that digital technology is the most preferred route for young people to access many services, including health services (Use of Digital Technology, RCN, 2016).</p> <p>Digital services and clinic receptions will stream those young service users who are vulnerable (including all under 16) and at risk into clinics to access both medical help and, where appropriate sexual health promotion interventions. There is no anticipated reduction in the capacity of the service. Access will be improved for young people both via the digital service and via increased capacity in clinics to see the most in need. It is also worse noting that service users can access the service via smartphones and mobile sites, and this is how most young people access online information.</p> <p>The impact on young people is thus positive</p> <p>SEXUALITY</p> <p>The number of STI diagnoses in Men who have Sex with men (MSM) has risen sharply in England</p>
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	<p>in recent years. Gonorrhoea is the most commonly diagnosed STI among MSM and, given recent increases in diagnoses, is a concern due to the emergence of antimicrobial resistance in <i>Neisseria gonorrhoeae</i>. Several factors may have contributed to the sharp rise in diagnoses among MSM including condomless sex associated with HIV seroadaptive behaviours and the use of recreational drugs during sex (chemsex). More screening of extra-genital (rectal and pharyngeal) sites in MSM using nucleic acid amplification tests (NAATs) will also have improved detection of gonococcal and chlamydial infections in recent years.</p> <p>Attendances showed in 2015 75.8% of our clients were heterosexual, 15.6% were homosexual/bisexual males and 8.3% were homosexual/bisexual females. (8.3% was not recorded or clients refused) of STI's detected across our Service 28.49% were in men who have sex with men (MSM).</p> <p>There is specific concern around increasing sexual risk taking behaviours in MSM associated with recreational drug use and correlated with a rise in HIV and STI diagnoses.</p> <p>There is evidence to show that for many MSM the internet is a preferred route for access to services and health interventions and a key platform for delivering STI and HIV interventions (eg The Health and Wellbeing of BME, gay and other MSM, 2014, PHE). The current London HIV Prevention Programme delivers a raft of digital sexual health and HIV prevention interventions targeted at MSM that have been well evaluated. Lambeth and Southwark's current digital sexual health service is well used by MSM (14% of users are MSM) but still not as popular as clinics. The service will be adopting marketing that is more suitable and targeted at MSM with the aim of increasing uptake. This will be done by advertising in specialist press, local venues, research studies recruitment targeted at MSMs</p> <p>Digital services and clinic receptions will stream those MSM who are vulnerable (and at risk into clinics to access both medical help and, where appropriate sexual health promotion interventions. There is no anticipated reduction in the capacity of the service. Access will be improved for MSM both via the digital service and via increased capacity in clinics to see the most in need.</p> <p>The impact on sexual orientation is thus positive</p> <p>PREGNANCY AND MATERNITY</p>
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		<p>The rate per 1,000 women of long acting reversible contraception (LARC) prescribed in primary care was 16.1 for London and 32.3 per 1,000 women in England. The rate of LARCs prescribed in sexual and reproductive health (SRH) services per 1,000 women aged 15 to 44 years was 33.0 for London and 31.5 for England (PHE LASER Report).</p> <p>Digital services and clinic receptions will stream those women who are vulnerable and at risk into clinics to access contraception advice and interventions. Those who have complex contraception needs (ie either as a result of physiological, medical, social or psychological need) will find it easier to access an appropriately qualified clinician.</p> <p>Digital services will provide (as SH24 currently does) detailed and easy to read information on the range of contraception available, where to access it and the best methods to meet need. The Councils are working with the CCG to pilot online simple contraception (the CCG commissions the simplest contraception). This will have the benefit of increasing access to simple contraception and freeing up clinical consultation time in both sexual health clinics and general practice.</p> <p>It is particularly important to consider the groups of women who are most at risk of not having contraception – those who use substances/different ethnic – this group will be engaged with to consider whether the pilot might meet their needs</p> <p>The impact on pregnancy and maternity is thus positive</p> <p>SOCIO-ECONOMIC FACTORS</p> <p>Socio-economic deprivation (SED) is a known determinant of poor health outcomes and data from GUM clinics show a strong positive correlation between rates of acute STIs and the index of multiple deprivation across England. There is also evidence of greater domestic violence in areas of deprivation, particularly during recessions, which also has a relationship with poor sexual health. The relationship between STIs and SED is probably influenced by a range of factors such as the provision of and access to health services, education, health awareness, health-care seeking behaviour and sexual behaviour.</p>
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		<p>Digital services and clinic receptions will stream those who are most vulnerable and at risk into clinics to access help. As well as screening for sexual risk the clinic will screen (as is current practice) for domestic violence and drug use. Those with the greatest sexual health need will find it easier to access the help they need and clinicians will have more time to spend with those with more complex needs.</p> <p>The impact on Socio-economic factors is thus positive</p>
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2.2	If there are gaps in the evidence how will this be generated?	<p>Gender Reassignment We have very little national or local data in relation to gender re-assignment, although it has been estimated that there are 20 transgender people per 100,000 population suggesting that of the 89,000 clients we saw in 2015 approximately 16-18 were transgender.</p> <p>The impact is thus unknown</p> <p>Disability There is limited data and research available on the needs of people with learning disabilities or physical disabilities. Disabled people who may find it hard to travel to clinics will be able to access digital services and, if they require it, have test kits delivered to the door. Those disabled people who cannot access digital services will be able to access services via the clinic reception and will be streamed into clinic services as appropriate. Using digital services also allows for the use of assistive technology software to be used to improve access to information, advice and guidance – particularly for people who are sensory impaired.</p> <p>Promotion of the changes to Sexual and Reproductive Health services will be shared with the 3 boroughs community learning disabilities team, and discussed with their patients and carers.</p> <p>The impact on disability is thus positive</p> <p>Religion and Belief There is limited evidence on the relationship between religion and belief and sexual health. However, evidence gathered locally during the consultation on the Lambeth, Southwark and Lewisham Sexual Health Strategy indicates that:</p> <ul style="list-style-type: none"> □ The role faith leaders play is important in relation to delivering work in the sexual health promotion and HIV prevention work in the community □ Involving local faith organisations eg churches and mosques is important in relation to delivering work in the sexual health promotion and HIV prevention work in the community <p>The impact is thus unknown</p>
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		<p>Marriage and Civil Partnership</p> <p>There is a lack of evidence on the relationship between marriage and civil partnership -and sexual health. Data is collected in all sexual health services on marriage and civil partnership and future research eg service reviews, can capture information on service use and the characteristic.</p> <p>The impact is thus unknown</p>
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2.3	<p>Does the evidence show that there are different population groups who have different needs or who are suffering inequality (i.e. consider health inequalities, poorer progression for staff, difficulties in retaining certain staff, differing experiences of the service etc) across the REGARDSS strands</p>	<p>There is no evidence that shows that as a result of these changes and this policy any group will be disadvantaged.</p> <p>Staffing is not considered as part of this assessment; please refer to staff specific assessment.</p>
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2.4	<p>Internal Involvement and Consultation: (e.g. with Departments, Staff (including support groups), academic partners, local authorities)</p> <p><i>Does this initiative affect the experiences of staff? How? What are their concerns?</i></p> <p><i>How have you consulted, engaged and involved internal stakeholders in considering the impact of this proposal on other public policies and services?</i></p> <p><i>What forms of consultation, engagement and involvement have been most effective?</i></p> <p><i>What positive and adverse impacts were identified by your internal stakeholders?</i></p>	<p><i>Staffing is not considered as part of this assessment, please refer to staff specific assessment.</i></p> <p>Patient and Public consultation activities to date: Together with the Councils, the Trust has sought and will continue to seek the views of:-</p> <ul style="list-style-type: none"> <input type="checkbox"/> Patients / service users (current) <input type="checkbox"/> Healthwatch and their membership <input type="checkbox"/> Local residents <input type="checkbox"/> Community voluntary organisations (as bodies who both support service users and providers SRH services) <input type="checkbox"/> Staff <input type="checkbox"/> Patient-public Foundation Trust Governors <input type="checkbox"/> Overview and Scrutiny Committees in both boroughs <p>Between April and June both Lambeth and Southwark councils undertook a public consultation on the proposed changes to public health services commissioning in response to a significant reduction in the Public Health Grant designated to local authorities by central Government. This included a reduction in funding for clinic-based sexual and reproductive health services delivered by Guy's and St Thomas's NHS Foundation Trust</p> <p>In order to meet its legal 'duty to involve' and seek further insight from service users with which to inform the further development of the commissioning proposals, Guy's and St Thomas', in consultation with commissioners, undertook the following: -</p> <ul style="list-style-type: none"> <input type="checkbox"/> 6 user focus groups (1 at each clinic site, facilitated by an independent researcher and a Trust officer) <input type="checkbox"/> A user questionnaire (made available online and paper and distributed across all clinic sites)
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		<p>Positive and adverse impact raised by stakeholders</p> <p>Stakeholders identified the following key positive impacts:</p> <ul style="list-style-type: none"> <input type="checkbox"/> We are not reducing capacity of the service but developing alternative delivery methods of care. <input type="checkbox"/> On line services appeal to over 50% of the current service users <input type="checkbox"/> Increased access to same day appointments and walk in service <input type="checkbox"/> Increased/Harmonized opening hours across all 3 remaining sites <input type="checkbox"/> 7 day opening at Burrell Street with increased opening hours and access <input type="checkbox"/> One stop shop service <p>Potential adverse impacts are:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anxiety surrounding using an online STI self care system <input type="checkbox"/> Streatham Hill SRH service will be closed at the weekend and Burrell Street is a longer distance to travel for Lambeth patients than previously. <input type="checkbox"/> Waiting times if needing to access primary care services for contraception and emergency contraception <p>Further Planned Stakeholder engagement on the planned changes:</p> <p>The findings of both the council's and the Guy's & St Thomas' NHS Foundation Trust patient and public engagement activities will inform the final stage of the process, when both the Trust and Lambeth Council (as lead commissioner) in collaboration with Southwark Council, will undertake a 4-week 'documentary consultation' on the final proposals which we anticipate will commence on or around 22 August (pending the outcome of internal staff-side pre consultation), consisting of face to face and online activities, including:-</p> <ul style="list-style-type: none"> <input type="checkbox"/> 6 x 'drop-in discussion forums' in the open waiting rooms of each clinic, led by service staff <input type="checkbox"/> A public information display and accompanying consultation questionnaire installed in each site for the duration of the consultation period <input type="checkbox"/> An online consultation document and questionnaire that will be publicized more widely and directed to key stakeholders, including community interest groups
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3. Assess the impact on equality and human rights

6 Considering the information above, what is the impact of this policy or function on the differing strands of equality? Don't only think about single REGARDSS strands; consider the fact that people have multiple identities. On closer inspection, a very specific demographic may be suffering greater inequality than the headline figures may show. It is important to interrogate these assumptions to reduce the risk of enacting a policy that inadvertently increases inequality.

3.1	What opportunity is there to promote equality of opportunity, good relations or increase participation?	<ul style="list-style-type: none"><input type="checkbox"/> The services are focusing on continuing to deliver optimal care targeting vulnerable and hard to reach populations (young people, MSM, BME, LGBTQ...)<input type="checkbox"/> The priorities of the service are also to promote service delivery to the local communities and therefore working in partnership with local other service providers (GPs, Pharmacies, Commissioners and local governments) to ensure this is achieved<input type="checkbox"/> Online testing will promote quick access to care to a new and existing service users but also promote on site access to patients who have more complex needs – the use of technology will support more assistive technology software to make information more accessible for people who are sensory impaired. A simple 'how to use the online site tutorial' could be considered for development<input type="checkbox"/> Geographically, the 3 proposed sites are situated in a manner that most Southwark and Lambeth residents will be able to access one of the clinics easily. They also have good transport links<input type="checkbox"/> Provide a one stop-shop model of care where patients' experience will be enhanced and also promotes the expertise of the healthcare professionals
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3.2	What are the potential negative or adverse effects?	<ul style="list-style-type: none"> <input type="checkbox"/> A proportion of existing service users who are attendees to visit a specific site that has been proposed to close may choose to attend other clinics in London out of Boroughs <input type="checkbox"/> Online testing for asymptomatic patients may be a deterrent for testing in some populations (Lack of trust in home testing, anxiety around validity of results, no access to internet, patients for whom English is not their first language, for example) <input type="checkbox"/> Risk of missing vulnerable adults as no face to face consultation in online testing (risk of CSE, gangs, Drug use, DV for example) <input type="checkbox"/> Service users may feel that if there are less clinics and potentially less staff the waiting times may be longer and that their care may be delayed <input type="checkbox"/> Some of the proposed sites will need some alterations/work and therefore financial investment to ensure that we are able to deliver a level 3 service in each centre.
3.3	<p>What is the potential for negative or adverse effects assess</p> <p>likelihood (1 = unlikely, 5 = certain)</p> <p>severity (1 = very mild, 5 = very severe/ risk of death)</p> <p>numbers of people affected (1 = very few, 5 = almost everyone)</p>	<p>3</p> <p>3</p> <p>3</p>
3.4	Is there public concern about possible discrimination/ unfairness/ inequality?	No concerns identifying discrimination unfairness and inequality raised by patients and public. A patient survey was conducted for 3 weeks in June 2016 and 588 questionnaires were returned. Also Focus groups were held across the 6 sites.

3.5	<p>How much evidence is there to support these conclusions?</p> <p>1 = none 2 = little 3 = some 4 = substantial</p>	4
3.6	<p>What ability do we have to;</p> <ol style="list-style-type: none"> 1. Alleviate or change unfair, adverse or discriminatory effects? 2. Promote and enhance positive effects 	<p>.</p> <ol style="list-style-type: none"> 1. Engage service users in the consultation process and showcase our innovations in care delivery 2. Educate patients and assist them through the process of online testing. The services plan to have IPads in situ to help patients that have attended to negotiate this new care pathway 3. Promote Click and collect 4. Ensure the online service comprises a robust assessment to ensure any vulnerable service user is captured and referred to appropriate care provider 5. Promote the use of the virtual queuing system that will be operational in all sites <ol style="list-style-type: none"> 1. Engage and work in partnership with all stake holders by holding meetings and introduction forums to the new service and transformation project 2. Encourage staff in clinics to engage with patients and answer questions and assist them through the care pathways

Human Rights

3.7	Could the policy or function affect an individual's human rights? Consider specifically the articles below of the Human Rights act (1998): Article 2 – Right to life Article 3 – Right not to be tortured or treated in an inhumane/degrading way Article 5 – Right to liberty Article 7 – Right to no punishment without law Article 9 – Right to respect for private and family life and correspondence	No aspect of the proposals has been identified to compromise any individual's human rights
3.8	What steps can be taken to negate this?	Not applicable as no risk identified

4. Screening assessment and next steps

Based on the answers above, a decision needs to be made on how to proceed. This will require a decision to be taken on whether a detailed and full EEIA is required; if further information is required and will definitely include an action plan that will, at a minimum, monitor the impact of the policy.

4.1	Give an overview of the action that needs to be taken now?	<input type="checkbox"/> Launch of the Staff consultation on 22 nd August 2016 <input type="checkbox"/> Followed by Public consultation on 25 th August 2016 <input type="checkbox"/> Engage service users and the public with one to one interviews to be facilitated by staff in September 2016 across all 6 existing venues <input type="checkbox"/> Ensure that the proposed sites are fit for purpose <input type="checkbox"/> Changes to be effectively communicated to patients, public and stakeholders via different avenues ensuring the information reaches all target groups <input type="checkbox"/> Ensure that the implementation of the proposal is effective by 1 st April 2017
4.2	Complete an action plan to highlight the next steps that need to be taken	

Action	Responsibility	Timescale
Launch full public consultation	Andrea Carney - Trust public and engagement manager	25 th August 2016
Facilitation with service users interviews across all existing sexual and reproductive services	Jay Jarman – Lead Health Advisor Robert palmer – Lead psychotherapist	All 6 current sites completed by 30 th September 2016


<p>To collate the information from the public consultation and derive analysis and report findings.</p>	<p>Andrea Carney - Trust public and engagement manager</p> <p>Anatole Menon Johansson – Clinical Lead for Sexual and Reproductive Health</p> <p>Robert Cook – General Manager for Specialist Ambulatory Services</p>	<p>Analysis Period : TBC Consultation period with stakeholders:</p>
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Marketing campaign launched reaching existing service users, public, stakeholders and local referral services.	<p>Matt Akid – Head of Media and Corporate Communications</p> <p>Anatole Menon Johansson – Clinical Lead Sexual and Reproductive Health</p>	Ongoing
Work commences to ensure three departments fit for purpose and able to deliver the ideal clinic model providing level 3 services.	Anatole Menon Johansson – Clinical Lead Sexual and Reproductive Health	To be implemented by 31 st March 2017
Full implementation of proposed changes		1 April 2017

4.3	<p>Does the screening show either;</p> <p>That there could be differential or adverse effects on different population groups</p> <p>The evidence so far supports the potential for differential effects</p> <p>There is not enough evidence to rule out differential effects</p> <p>There is substantial public concern about differential effects</p> <p>If the answer is yes, a full EEIA is required.</p>	<p>As the screening and assessment demonstrate above, the evidence show that the proposals will not have a negative impact on the public and will not affect negatively their human rights</p>
4.4	Is this policy or function a lawful positive action initiative?	Yes
4.5	If a full EEIA is not required, please summarise your reasons	<p>We do not consider that the consultation will cause affected the publics and service users to suffer inequality or discrimination in terms of REGARDSS (Race, Ethnicity, Gender, Age, Disability, Sexual orientation, Socioeconomic). There will be no impact on human rights</p> <p>However, this will be monitored on an ongoing basis and appropriate action taken to mitigate against any possible inequality</p>

Assurance

Name of lead	Robert Cook, General Manager Specialist Ambulatory Services, GSTT
Lead director	Dr Kate Langford, Deputy Medical Director, GSTT

Additional public Board meeting	Guy's and St Thomas'  NHS Foundation Trust	
2017/18 – 2018/19 Operational Plan – sign-off cover note	14th December 2016	BDA/16/24

This paper is for:		Sponsor:	CEO
Decision	✓	Author:	COO, finance, strategy teams
Discussion		Reviewed by:	Martin Shaw, Simon Steddon
Noting		CEO	✓
Information		EDs	✓
		Board Committee	✓ Draft Plan reviewed on 23 rd November
		TME	✓ Circulated w/c 12 th December
		Other	

1. Introduction

The Trust's 2017/18–2018/19 Operational Plan will be submitted to NHS Improvement by 23rd December.

This follows submission of the Draft Plan on 24th November, discussed at both the Trust Board in Committee on 23rd November and a specially convened Service Strategy Working Group of the Council of Governors on 21st November.

Some elements of the plan are still to be finalised as:

- The Trust has not yet received all feedback from NHS Improvement. An update will be provided at the Board meeting.
- Contract negotiations are still underway for both local and specialised commissioning. An update presentation will be provided at the Board.

The Board is asked to:

- Approve the plan to date (noting a finance update will be provided at the Board), delegating authority to the Chief Executive and Chair for final sign-off w/c 19th December.

2. Updates since the draft plan

The written plan is the same as the Draft Plan with minor amendments to the 'Quality Improvement Plan Summary' (2.2), typo/ phrasing changes and the addition of summary priorities for Evelina London and Adult Local Services. A finance plan update will be provided at the Board meeting.

The Trust has not received specific formal feedback on the draft plan to date. Our ongoing engagement with NHS Improvement (cancer 62 day, A&E 4 hour performance and RTT) informed the improvement action plans in the Draft Plan. This has not changed in the current draft of the final plan. However, we are preparing for our first oversight performance meeting on 12th December. Any feedback will be provided at the Board.

3. Next steps

Following sign-off, the plan (written plan and all accompanying spreadsheets) will be uploaded to NHS Improvement's portal by 23rd December. We will upload this final plan to BoardPad in parallel.

This is a not-for-publication version. The public version of the plan will be completed in early January for formal sign-off at the January public Board/ Council of Governors. There will be further opportunity for Governors to discuss all aspects of the plan, linked to internal business planning, at the Service Strategy Working Group (SSWG) on 17th January.

A full business planning update, including our internal planning position, will be provided at the January public Board.

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