Southwark Health and Adult Services Scrutiny Committee

December 2011

Lambeth, Southwark & Lewisham (LSL) HIV Care & Support Review

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Executive summary

This report provides an update on the progress being made across Lambeth, Southwark and Lewisham (LSL) in assessing the local needs of people living with HIV and reviewing the current portfolio of services providing HIV care & support services. The paper gives an overview of the rationale for this project, the project accountability and timelines including the engagement & consultation plans and presents proposed service model and future commissioning intentions across the three boroughs. These recommendations are subject to a 3 month public consultation which was launched on 7th November 2011 until 6th February 2012.

Recommendations

1. That that Committee endorses the engagement & consultation plans (Appendix E) for the project and comment on any recommendations for improvement.

2. That the Committee notes the proposed service model, options appraisal of current provision (Appendix C), and summary commissioning intentions from the project.

3. That the Committee comments on the project proposals to feed into the consultation process.

4. That the Committee notes the consultation process and events scheduled.

Appendices

Attached at **Appendice A** is an extract from the 2011/12 HIV Care and Support needs assessment of Southwark's HIV epidemiology. The data, intelligence and processes contributing to the needs assessment have informed the proposals made in this paper.

Attached at **Appendice B** is a breakdown of the current investment (11/12) and activity (10/11) by Borough for the portfolio of HIV Care and Support services being reviewed as part of this project.

Attached at **Appendice C** is the Summary of the Options Appraisal for current service provision

Attached at **Appendice D** is the Terms of Reference for the LSL HIV Care & Support Review Steering Group.

Attached as **Appendice E** is the project's Engagement & Consultation Plan.

Update on LSL HIV Care & Support Review- October 2011

1. Context

Sexual Health and HIV continues to be a major public health problem across Lambeth, Southwark & Lewisham (LSL). All three boroughs have some of the highest rates of HIV, Sexually Transmitted Infections (STIs) and teenage pregnancy in the UK. Such exceptionally high prevalence of sexual ill health reflects the level of deprivation and inequalities experienced by our communities.

LSL PCT's have invested significantly in sexual health & HIV over the last 5 years to ensure that local services are at the forefront of service provision and innovation that deliver the Quality, Innovation, Productivity and Prevention (QIPP) agenda. This has included a range of projects and service developments including:

- Modernising local services to provide integrated sexual health services providing contraception and sexually transmitted infections in a one-stop shop (initiated through the Modernisation Initiative for Sexual Health- 2003 to 2008)
- Provision of Emergency Hormonal Contraception (Morning after pill) and more recently oral contraception within Pharmacy
- Expansion of HIV testing within primary care as part the new registration process
- Provision of Opt out HIV testing in acute setting following a diagnosis of clinical indicator diseases (TB, Hepatitis, and Lymphona).

HIV is the greatest risk within sexual health, in terms of both the public health need and the financial costs associated with growth in diagnoses and diagnosing patients late. There has been a 50% increase in the number of people living with diagnosed HIV accessing care in LSL between 1999 and 2008[i] (an average 8% annual increase in the numbers of people accessing HIV care)[1]. If the local picture of exceptionally high levels of HIV infection continues at this rate, the costs of HIV treatment will double in the next 10 years (currently £26M in Lambeth, £20M in Southwark, and £11M in Lewisham).

NHS Southwark has identified HIV as a high priority issue in terms of prevalence and are currently working on delivering a number of strategies across the HIV pathway (including prevention, testing and treatment) as part of long term QIPP Plans, these include:

a) Promotion and expansion of HIV testing and treatment as a key prevention strategy to diagnose the undiagnosed[2]
b) Reducing late diagnosis[3] by ensuring that people are diagnosed early to maximise health and social care outcomes and reduce HIV related morbidity and mortality
c) Modernising HIV care & support services to reflect the changing needs of HIV positive patients in line with the epidemiological changes of HIV and biomedical advances of treatment.

[1] SOPHID 2008
[2] It is estimated that people who have undiagnosed HIV infection are 3.5 times[2] more likely to transmit HIV than those who are diagnosed, demonstrating the potential impact of effective interventions in reducing the undiagnosed population
[3] Late diagnosis (diagnosis with a CD4 count <200 will have had the infection for at least seven years) is the most important factor associated with HIV-related morbidity, mortality and inpatient care in the UK. The costs of treating a late diagnosed patient are estimated to be 200% higher[3] in the first year of HIV treatment, this estimate does not account for additional acute care costs incurred from associated HIV related illnesses

d) Developing a model of care for HIV as a long term condition which shifts the care of stable patients into non-specialist settings

The delivery of these strategies must be sustained in going forward if we are to successfully address the local spread of HIV. A needs assessment on HIV prevention was completed in 2010/11 and recommended the inclusion of 'HIV test and link' (into HIV treatment centres) as a composite part of HIV prevention strategies. Southwark already has a strong track record of expanding HIV testing in primary care as part of the new patient registration since April 2011. It is an objective of this review of HIV Care and Support to identify some level of efficiencies to reinvest and support the ongoing expansion of HIV testing locally.

With the proposed transfer of sexual health & HIV prevention commissioning into Public Health/Local Authorities (as outlined in the Health & Social Care Bill), HIV will need to be a priority for Health & Well Being Boards, Local Authorities, Commissioning Support Units and Clinical Commissioning Boards.

This paper specifically provides a summary of the review of HIV care & support services which will inform the 'modernisation of HIV care & support services to reflect the changing needs of HIV positive patients in line with epidemiological changes of HIV and biomedical advances of treatment' (strategy C outlined above).

2. The Public Health Need of HIV

In 2010, the HPA reported[4] that there are 6516 individuals resident in LSL living with HIV (2855 in Lambeth, 2301 in Southwark, and 1360 in Lewisham) with a further estimated 28% being unaware of their infection. LSL alone accounts for approximately 11%/24% of diagnosed HIV infections in the UK/London. Although Lambeth and Southwark are the two most affected boroughs in the UK with prevalence rates of 13.88 per 1000 and 11.25 per 1000 respectively; the average prevalence rate for HIV across London is 5.24% per 1000.

In the UK the pattern of HIV infection primarily affects two main client groups, men who have sex with men (MSM), and black African heterosexuals. These at-risk population groups are particularly over-represented in LSL, although the populations differ across the three boroughs. Within Southwark there is a 50/40 split of MSM and Black African heterosexuals living with diagnosed HIV, compared to Lambeth where there is a 60/40 percentage split and Lewisham where there is a 40/60 split

Late diagnosis of HIV (diagnosis with a CD4 count <350 which can be an indicative of infection for approximately 7 years) is the most important factor associated with HIV related morbidity and mortality and inpatient care in the UK. Recent definitions of late diagnosis have been revised, a CD4 count of <350 is now the recommended point at which anti retroviral treatment is initiated (HAART). Very late diagnosis is now indicated by a CD4 count < 200. Across LSL, approximately a quarter of the new HIV diagnoses were classified as very late in 2009. Late diagnosis accounted for 51% of new diagnoses in Lewisham; 50% in Southwark and in 45% Lambeth[5]. The three PCTs have selected the 'reduction of late HIV diagnosis' as their Staying Healthy target for HIV.

Significant advances in HIV treatment means that if diagnosed early, HIV is now a treatable medical condition and the majority of those living with the virus remain fit and well on treatment. This improved life expectancy has resulted in the shift in the age distribution of people living with HIV; showing clear signs of an ageing population. Of particular concern is the rapid increase in the number of patients over 50 years as these are likely to be affected both by long

[4] HPA (2010), Diagnosed HIV prevalence in Local Authorities in England, 2010
[5] HPA(2010) HIV Late Diagnosis in London December 201: Update for Commissioners

term anti-retroviral treatment (ART) side effects and age related chronic conditions such as cardio vascular disease, chronic obstructive pulmonary disease and diabetes requiring wider health and social care services for older people.

3. Rationale and Project Aims

Over recent years the wide availability of highly effective ART has transformed HIV from an almost universally fatal illness to a manageable chronic condition, if diagnosed early. With treatment advances it is now commonly accepted that most patients can be expected to have a near normal life expectancy and live active and fulfilled lives. Some however will have complex medical and social needs which can impact on health outcomes and onward HIV transmission.

These issues signify a major concern in terms of managing the growth of new diagnosis, reducing onward transmission and responding to an ageing HIV+ population within existing financial envelopes. In addition, a number of currently commissioned services are jointly funded through health monies and Local Authority (LA) contributions through the AIDS Support Grant (ASG) (see appendix B for a breakdown by service) which will be subject to reductions in the Local Area Based Grants by April 2014. In light of the continually increasing patient populations, changing long-term care needs and the resource challenges, LSL commissioners have initiated a review of the existing portfolio of HIV care & support services and assessment of need to inform future commissioning intentions. This project aims to ensure that LSL provision for HIV care & support is modernised to reflect the changing needs of HIV positive patients in line with the epidemiological changes of HIV and biomedical advances of treatment.

The project objectives are:

- To carry out a comprehensive needs assessment for care & support needs of HIV positive service users reflecting the changing face of HIV as a long term condition
- Review current provision of HIV care & support services to identifying gaps and effectiveness of current provision
- Identify future commissioning intentions for services commissioned by LSL PCT and Local Authority AIDS Support Grant (ASG)
- Review current investment & release efficiencies to meet NHS & LA efficiency targets and provide funds for re-investment into 'HIV test & link to treatment prevention strategies'
- Mainstream HIV care & support within generic health & social care where appropriate as part of the normalisation agenda and recognition of HIV as a chronic long term condition.

4. Project Timescales, deliverables and accountability

4.1 Project Timescales & Deliverables

The project was initiated over the summer with the intention to complete by the beginning of September; the project is now it is final stages and will go out to public consultation for three months from 1st November until 31st January 2012. Consultation responses will be collated and considered by the steering group before finalising recommendations and future commissioning intentions in early February 2012. Recommendations for immediate implementation such as re-specifications and modernisation of existing providers and de-commissioning of any duplication will be initiated for April 2012. Any required procurement processes will be started immediately with the intention for services to start from September 2012.

4.2 This project consists of four key components:

a) Needs assessment & evidence review
b) Service review
c) Options appraisal & recommendations for future commissioning
d) Engagement & consultation

The key project deliverables are detailed in the table below including progress to date:

Table 4.1:HIV Care & Support Review Project Deliverables, timelines and progress to date

Deliverable	Timescales	Progress to date
a) Needs Assessment & Evidence Review • Population analysis: deprivation & mobility ▪ Demography and risk groups, migration ▪ Review of current HIV epidemiology and trends in LSL (SOPHID new /late diagnoses • Review of current national and international HIV prevention care & support guidance • Summary of biomedical treatment advances • Review of the evidence base and best practice for effective interventions including literature review	July/August 2011	All elements have been covered in a public health lead needs assessment and evidence review that was completed late August.
b) Service Review • Extensive service mapping (type of activities, outputs, location, target groups) ▪ Review of effectiveness of current provision ▪ Analysis of care & support service usage activity ▪ Analysis of mainstream HIV related activity (Social Care/Mental Health) • Gap analysis ▪ Value for money analysis	August/Sept 2011	Service review completed in September.
c) Options Appraisal & recommendations for future commissioning • Provisional options appraisal discussed with steering group • Final recommendations for consultation signed off by steering group • Equality Impact Assessment completed	Sept/Oct 2011	Options appraisal and recommended commissioning intentions endorsed by project steering group on October 18th 2011i.
d) Engagement & Consultation • Development of an LSL wide steering group • Steering group to be shadowed by Service User Reference Group (SURG) • Stakeholder pathway mapping event(s)	July 11-Jan 12	LSL Steering group running since June. Stakeholder mapping events held in July (including a separate Lewisham event attended by

• Public consultation across LSL		18 Health & Social Care Commissioners and providers). SURG have met three times during Sept/Oct and scheduled to meet early Nov to develop easy read report for distribution during consultation scheduled for Dec & January.

4.3 Accountability:

This project is being delivered by the LSL Sexual Health & HIV Commissioning Team with the support of the SEL SH & HIV Network. A project steering group has been set up across LSL to oversee the project (see appendix F for TORs). This group is chaired by Ruth Wallis, Lambeth DPH, and membership includes LSL SH & HIV commissioners, representation from all LSL Public Health departments, social care commissioners and provider leads from each LA, clinical leads from all local HIV specialist services and NHS Patient & Public Involvement leads. This group reports progress to the Lambeth Southwark and Lewisham Sexual Health & HIV Programme Board. Recommendations for future commissioning intentions will be made to PCT Clinical Commissioning Boards and Local Authority Commissioning Boards across LSL.

5. Engagement & Consultation Plan

An LSL wide Engagement & Consultation Plan (appendix E) has been developed with NHS Patient and Public Involvement Leads, which has subsequently been consulted on with the LSL Stakeholder Reference Group (SURG) and endorsed by the project steering group.

Engagement has been central throughout the project by ensuring that a wide range of stakeholders have been identified to oversee the project via the steering group. In addition, two successful stakeholder mapping events were held in early July (14th & 19th) to inform the service review process. Service user representation at the stakeholder events was significant, although this has been further strengthened with the development of a Service User Reference Group (SURG) to shadow the steering group. The intention is that this group will inform the agenda and discussion for the steering group and makes recommendations for consideration. The SURG will be an ongoing group that continues throughout the consultation phase and also goes onto support and inform subsequent implementation plans.

Consultation was launched on 7th November 2011 and run for three months until 6th February 2012 with clear processes for submitting written responses to the recommendations. During this time, two consultation events will be held in each borough, these will be open to all stakeholders including service users and members of the public. These events will be held across LSL on the following dates:

- 9th December 2011, 9.30am-12.30pm, Roben's Suite, Guys Hospital
- 12th December 2011, 2-5pm, Assembly Rooms, Lambeth Town Hall
- 13th December 2011, 9.30am-12.30pm, Lewisham Town Hall
- 5th January 2012, 6-9pm, Roben's Suite, Guy's Tower, Guys Hospital
- 9th January 2012, 6-9pm, Assembly Rooms, Lambeth Town Hall
- 10th January 2012, 6-9pm, Lewisham Town Hall

In addition, a number of focus groups will be held to discuss proposals with both MSM and Black African communities through existing services to ensure that both patient groups are sufficiently consulted. The SURG will also oversee the Consultation Process to ensure adequate service user engagement.

6. Portfolio of Services

The Services reviewed within this project are those that sit within the LSL Sexual Health & HIV Commissioning Team's portfolio. These include services that are jointly funded by health and Local Authority monies (via the ASG). A full breakdown of the services, including commissioned activity and cost by borough can be found in Appendix B. It should be noted that these services are commissioned as part of a number of collaborative commissioning arrangements, either across LSL or wider geographical areas. These arrangements will therefore need to be considered in the development of recommendations and will require necessary consultation with other potentially affected commissioners.

The steering group acknowledges that findings and recommendations made within this project could impact on services outside of the LSL sexual health & HIV commissioned portfolio such as paediatrics and social care. In this instance, findings and proposals will be noted within the project recommendations and discussed with relevant commissioners for further consideration.

7. Themes / findings to date

Stakeholder engagement, mapping of services and analysis of current service provision has been completed to inform this service review. This process has identified key themes or issues of concern amongst the current service provision. These include a lack of defined care pathways resulting in difficulty navigating the system and consistency in access to care, lack of clear thresholds of care amongst specialist services, duplication across services and case management functions, and a tendency to rely on specialist services for PLHIV resulting in inequality of access to mainstream health & social care services. In conclusion, it has been identified that there is a need for improved access to mainstream services, more effective use of specialist services/resources, better defined care pathways and thresholds of care, and stronger commissioning based on outcomes related to the changing needs associated with varying stages of the disease progression.

7.1 **Proposed Service Model:**

To take this forward, commissioners have developed a proposed service model to modernise services to reflect the changing needs of PLHIV and address the issues identified through the service review. This has enabled identification of future commissioning intention. The proposed service model aims to deliver the following principles:

- Ease of navigation across services through clear defined and well published care pathways
- Use of appropriate levels of care in response to the individuals needs during the progression of their disease
- Equality of access to mainstream health & social care services
- Phased implementation of the new system to ensure continuity of patient care and sustainability of specialist knowledge and skills.
- Effective and appropriate use of resources
- Shift of care from specialist services where clinically appropriate

The service model has been broken down into three key specific components which have been briefly detailed below:

i) Access to mainstream services: This report proposes that mainstream health and social care services should be considered the primary option for all non-complex care needs of PLHIV. The model specifically identifies access to primary care, mental health, community services, intermediate and palliative care as care needs that should be prioritised for improved access to mainstream services. This will require varying degrees of service redesign across these care pathways which may include raising awareness amongst specialist HIV agencies as referring agents, development of referral protocols, and training and development of the workforce within mainstream health & social care services. Implementation Plans will need to be developed across each care pathway and the development of shared care arrangements across primary care and specialist HIV treatment services will be prioritised within this programme of work

ii) Provision of interim specialist support services to facilitate the mainstreaming of HIV as a long term condition: There is a long term commitment to ensure PLHIV have appropriate and equitable access to mainstream health and social care services in line with other long term conditions. However, it is acknowledged that this change in culture and shift of care pathways will take some time. It is therefore proposed that certain specific care needs will require specialist resources during a development phase but that these services are interim services that will be decommissioned over time as mainstream pathways become embedded. The care needs identified for this specialist resourcing in the development phase include: counseling/low level psychological support for mild and moderate anxiety and depression, specialist mental health services for PLHIV and day care services for physical rehab.

iii) Specialist services for specific HIV related needs:

It is recognised that there are specific HIV related needs, specifically at significant points of an individual's disease progression or with complex patients, which require specialist services that cannot be provided within mainstream health & social care. It is therefore proposed that such specialist services remain an essential part of the local service models. The following services are considered essential services:

- Specialist HIV treatment services (responsible for prescribing of anti-retro viral treatment and other medical interventions)
- Specialist advice & advocacy services for PLHIV (acknowledging the complexity and discrimination involved with PLHIV accessing health & social care services)
- Specialist Peer Led/Mentoring Programmes for PLHIV (commissioned with clear health & social care outcomes such as expert patient programmes, newly diagnosed courses, and positive self management)
- Specialist Family Support for PLHIV (providing support to pregnant women and a holistic family approach to families infected and affected by HIV), Specialist Community Nursing Services for PLHIV (providing intense case management and community nursing services to complex patients)
- Specialist services for HIV related cognitive impairment (providing specialist HIV related cognitive impairment interventions.

Following the development of the above proposed service model a detailed options appraisal was conducted on the current service provision to identify commissioning intentions for each of the existing commissioned providers. This options appraisal considered the risks and benefits of three options for each of the existing services within the reviewed portfolio; maintain status quo/no service change, remodel & redesign, decommission/re-commission. These options were discussed and preferred options endorsed by both the Project Service User Reference Group and Project Steering Group (please see summary in appendix C)**.**

7.2 Recommendations / Commissioning Intentions

Recommendations for service developments and commissioning intentions have been highlighted throughout the report. The table below summarises how the proposed service model will be implemented under the three key components of the model: Improving Access to mainstream services; Provision of Interim Specialist support services to facilitate mainstreaming HIV as a long term condition and Specialist services for HIV related needs.

Commissioning Intentions associated with the proposed service model		
Services	**Delivery Mechanism**	**Financial Implications/ funding source**
i) Improving access to mainstream services		
Primary Care	Pilots of 'shared management' to: • Improve access to primary care services • Develop involvement in case management	i) Cost neutral ii) Potential need for pump priming
Mental Health	Shift of activity from specialised services to: • IAPT • Community Mental Health Services	Potential need for transfer of resources from specialist HIV services to mainstream services
Community Services	Access to mainstream services	Potential need for transfer of resources from specialist HIV services to mainstream services
Intermediate Care	Access to mainstream services	Potential need for transfer of resources from specialist HIV services to mainstream services
Palliative Care	Access to mainstream services	Minimal activity hence expected to have no significant cost pressure
ii) Provision of interim specialist support services to facilitate mainstreaming HIV as a long term condition		
Counselling	Potential renegotiation of existing provider/Tender for new service	Reduction in existing contract value
Specialist Mental Health Services for PLHIV*	Redesign/Respecify	Reduction in existing contract value
Day care for physical rehab	Maintain spot purchasing arrangements with reduction in activity	Potential for reduction in existing contract value
• **Specialist services for specific HIV related needs**		
HIV Treatment Services	Service Improvement through specialised commissioning	To be included in costs under national tariff, potential for short term funding
Advice & Advocacy	Potential renegotiation with existing provider/Tender for new service	Within existing contract value
Peer Led/Mentoring Programme	Tender for new service	Need to cost up new service, shift of £86k from existing peer support provision
Family Support	Redesign/Respecify	Maintain existing contract value
HIV Community Nursing Services	Redesign/Respecify	Potential for reduction in existing contract value
Community & Inpatient HNCI	Maintain cost & Volume contracting arrangements	Within existing contract value

* Future work is required on assessing the need for community services for HIV specific Mental Health needs i.e. HNCI long term

7.3 Financial Implications:

It is not yet possible to ascertain accurate financial implications of the proposed service model at this point and this requires further work which will be undertaken during the consultation process. However, there has been no additional service needs identified during this process and no additional cost pressures are envisaged as a result of the proposed recommended service changes. The initial financial assumptions regarding the proposed service changes have been highlighted in the table overleaf that lists the proposed commissioning intentions.

Key areas that require immediate further work include:

- Scoping of potential efficiencies to be released from shift of activity over three years
- Efficiencies released from decommissioning and redesign of services
- Cost of shifted activity in mainstream services
- Costs of re-tendered service provision

It is recognised that there is potential to release productivity and efficiency savings from the proposed service changes. Such efficiencies will be prioritised in the following areas:

- Reinvestment in the expansion of HIV testing as the key HIV prevention strategy across LSL
- Investment in mainstream services to increase capacity required to manage with shift from specialist HIV services to mainstream services
- Reinvestment into the HIV care pathway to mange growth in new infections
- Efficiencies required as a reduction to the Comprehensive Spending Review

8. Results of consultation

8.1 See section 5 and appendix G for details of the projects Engagement & Consultation Plans. The results of the formal three month consultation process will be collated, published and considered for any necessary revisions to project recommendations/proposals in February 2012.

9. Organisational implications

9.1 Risk management:

The increasing HIV prevalence and in particular continuing high levels of late diagnosis in these vulnerable populations present great challenges for public health and local health and social care services. Nationally, late HIV diagnosis has become the single highest largest risk factor for HIV related mortality and is associated with survival by about a decade. NHS Southwark is implementing national testing guidelines to reduce undiagnosed and late diagnosed HIV as well as tackling HIV related stigma through HIV training and education to health professionals. If the planned proposals for increasing earlier diagnosis are successful, Southwark's figures will initially increase further, which will have initial resource implications for commissioners although these will be offset by costs avoided in the long term from the reduced onward transmission of HIV and reduction in HIV associated acute and social care costs.

9.2 Equalities impact assessment:

An equalities impact assessment (EEIA) screening has been drafted following the finalisation of recommendations and the development of the options appraisal and summary commissioning intentions. This will be further developed during the consultation process.

9.3 **Community safety implications:**
The focus for this report is the prevalence of HIV and local actions to reduce morbidity and mortality of HIV infected individuals. There are no direct community safety implications.

9.4 **Environmental implications:**
N/A

9.5 **Staffing and accommodation implications:**
N/A

9.6 **Any other implications:**
N/A

10. Timetable for implementation

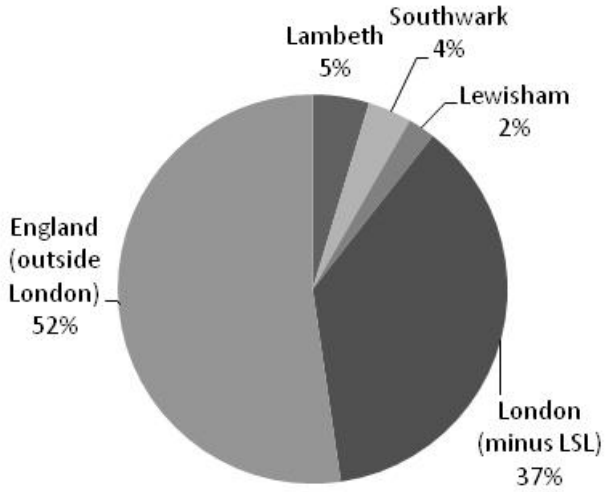
The key project milestones were:

- Review completed including recommendations, future service model, summary commissioning intentions **Mid October 2011**
- Three month consultation process**- 7th Nov 2011 to 6th Feb 2012**
- Final commissioning intentions and implementation plans signed off- **Early Feb 12**
- Initial service changes & decommissioning of duplication- **April 2012**
- Procurement of any new service provision- **Feb to July 2012**
- New service starts- **Sept 2012**

APPENDICE A: Lifestyle and Risk Factors: HIV

Lambeth, Southwark and Lewisham (LSL) have some of the greatest numbers of individuals known to be living with HIV in the UK. Based on SOPHID[6] in 2009, the 6,400 patients in LSL accounted for approximately 11% of the total caseload in England and 23% (almost one quarter) of all cases in London (Figure 1). For people aged 15 – 59 years, the prevalence of HIV in 2009 was 1.3% in Lambeth (highest in the UK), 1% in Southwark (2nd highest in the UK) and 0.7% in Lewisham (8th highest in the UK), all of which are significantly higher than the average prevalence of HIV in London at 0.5%.

Figure 1: Percentage of persons with HIV, by residential locality in England 2008 (based on SOPHID)



Southwark's HIV profile[7]

Sex

There were 2,197 Southwark residents accessing HIV-related care in 2009, 1,597 males and 600 females. This was the second highest PCT number in the SE London sector and equated to a prevalence rate of 11 and 4 per 1000 population for males and females respectively. Compared to 2008, increased rates were seen in both male (4% increase) and female patients (3%). The male to female ratio remained at 2.7, with 27 male patients to every 10 female. Compared to the overall UK rates by sex, the rate for males was over seven times higher, and more than six times higher for females in Southwark.

Age

In both sexes, the greatest numbers accessing HIV-related care were aged in the 35-44 year group (42% of all PLHIV accessing care, and 44% and 39% of males and females respectively). For men this equated to an age-specific prevalence rate of 25 per 1000, and for women 10 per 1000.

Ethnicity

The highest numbers of patients accessing care were white males and black Africans females, accounting for 66% and 74% of all male and female patients respectively. However, the prevalence rates were highest in black Africans for both sexes – 14 per 1000 in males and 27 per 1000 in females, respectively, compared to 12 and 1 per 1000 in those of white ethnicity, and 10 and 4 per 1000 in black Caribbean males and females, respectively. Between 2008 and 2009, prevalence rates increased for males and females for all ethnicities analysed, except black Caribbean males. Southwark had the highest known HIV prevalence rate in Caribbean males in the SE London sector.

Route of infection

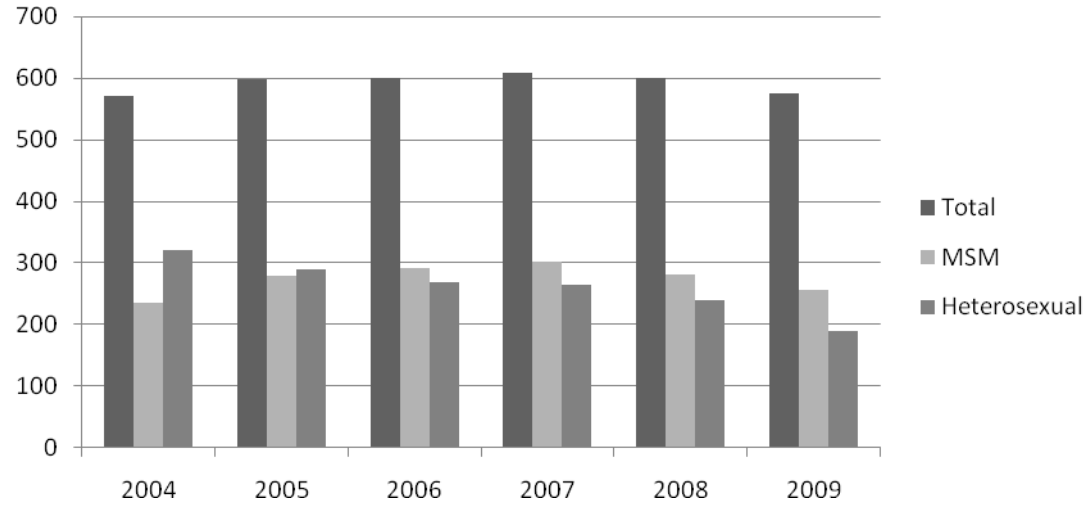
[6] SOPHID Survey of Prevalent HIV Infections Diagnosed
[7] Extracts from HPA SEL HIV report, 2009.

The largest proportion of patients resident in Southwark were infected via MSM (52%, n=1,135). Infection via heterosexual transmission was responsible for 39% (n=860). Other routes of infection, including IDU, mother to child transmission and via blood-borne products, accounted for a further 4% (n=85).

Incidence of new infections across LSL

Figure 2 illustrates the number of new HIV diagnoses in persons living in LSL at time of diagnosis 2004-2009. Annually there were between 550-600 new diagnoses among LSL residents. While heterosexually acquired diagnoses have steadily decreased since 2004, new diagnoses for MSM have remained stable. These local trends are in line with trends across England and the decrease in heterosexually acquired infections (largely acquired in sub-Saharan Africa) is thought to be due to changes in national immigration regulations). In the UK in 2009, it is thought that of new diagnosis among MSM four out of five probably acquired their infection in the UK. Of heterosexuals diagnosed in the UK in 2009, a third probably acquired their infection heterosexually in the UK.

Figure 2: Number of new HIV diagnosis[8] in LSL by mode of acquisition 2004 – 2009 (based on HPA linked SOPHID/HARS)



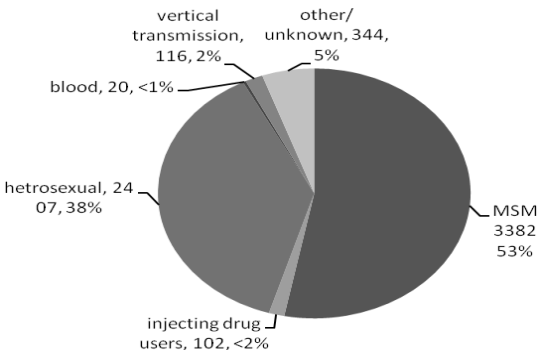
Population Characteristics

Routes of transmission

Figure 3 below illustrates the proportional breakdown by route of HIV acquisition for patients resident in LSL in 2009. Patients who acquired infection through sex between men accounted for 53%, followed by heterosexually acquired infections (38%). Other infection routes only accounted for only 9%, of which the route of infection was unknown in 5% of cases.

Figure 3: Number (and percentage of total PLHIV) patients in LSL accessing HIV care in 2009 (based on HPA SOPID)

[8] New HIV diagnoses (NB figures may vary from the HPA SEL HIV report as a more sophisticated methodology was used in this report)

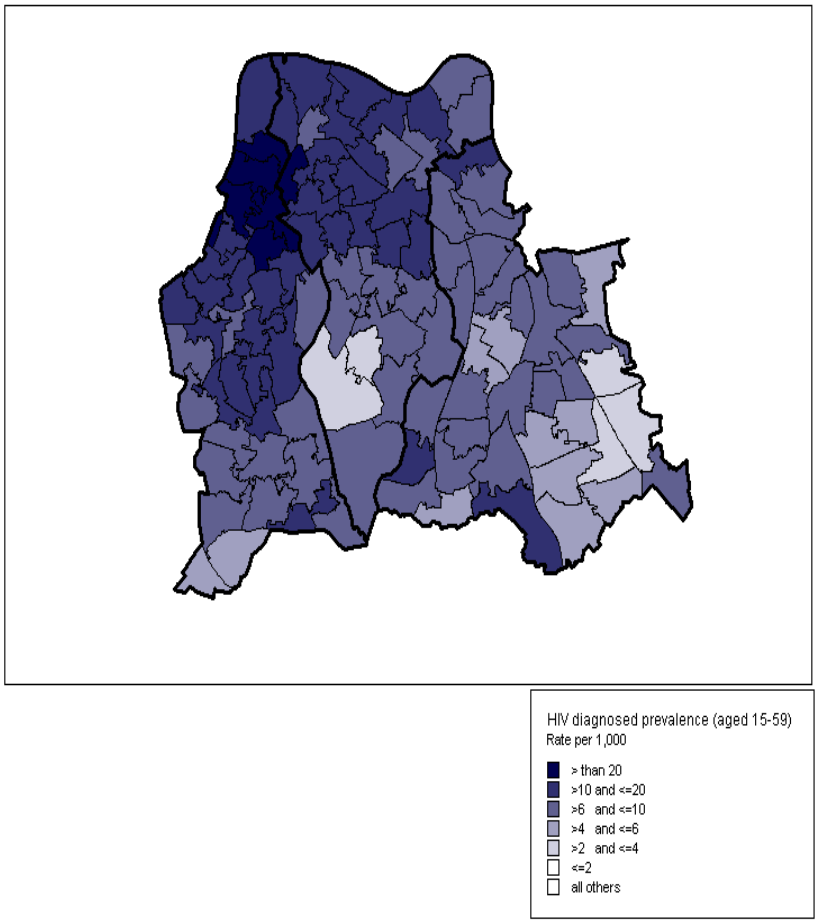


People of different ethnic groups living with HIV were more likely to have acquired their infections via different routes. In 2007-2009 in SEL (Figure 11), MSM was the most common route of acquisition for white males (82% of all infections in white males), while black African patients of both sexes were more likely to have been infected via heterosexual transmission (90% of all infections in those of BA ethnicity). The majority of black Caribbean patients were infected via sex between men and women (55%) but there was also a significant number in the black Caribbean male population who were infected via MSM (40%). For other routes, the majority of infection of HIV transmitted via mother-to-child occurred in black African women (89% of all infections via this route, n=136), while infection from IDU occurred mainly in white patients (82%, n=103). No data for LSL was available at the time of writing this report.

Geographical Distribution

There are distinct small area residential distributions between both groups. At small area level, the MSM epidemic is largely concentrated around north Lambeth and Southwark (which has a large resident MSM community, up to 16% of the male population in Lambeth) and clustering in these areas is likely to continue. In contrast the residential distribution of BA with HIV is more dispersed across LSL, with higher concentrations around mid Lambeth and Southwark, and Northern and Southern Lewisham. The distribution of BA living with HIV is largely congruent with the most deprived areas in LSL. Figure 4 shows the diagnosed HIV prevalence in persons aged 15-59 years by Middle Layer Super Output (MSOA) level (MSOAs are sub-PCT geographical areas similar to wards of approximately 7,500 people in 2009). In particular, the northern parts of Lambeth and Southwark had a diagnosed HIV prevalence greater than 1%, making HIV a common chronic condition in those areas.

Figure 4: HIV diagnosed prevalence by MSOA in LSL 2009 (based on HPA SEL HIV report)



The Changing face of HIV

The introduction of anti-retroviral therapy (ART) in 1995, has transformed HIV infection from a fatal disease to a chronic infection. The principle of ART for HIV is that the drug regime suppresses viral replication. At present there are five classes of therapeutic agents, primarily used in combination (usually three drugs) to ensure viral suppression. ART is highly effective but also expensive; drug costs currently account for approximately 65% of the London HIV consortium costs. Based on 2009 cost estimates, the lifetime drug treatment cost total £200,000 - £360,000 per patient[9]. Today, people diagnosed and treated in the early phase of HIV infection can expect a near normal life span with fewer side effects compared to earlier drug regimens. As a result of the availability of highly effective ART, opportunistic infections, AIDS defining conditions and the need for inpatient care declined significantly; and the service needs of most patients changed to an outpatient based model. This service model initially focused on the monitoring of effective pharmacological viral suppression and immune status. However there is increasing evidence on the incidence and prevalence of co-morbidities in long-term treated patients (e.g. ART side effects, drug-drug interaction, co-infections) in addition to common age related co-morbidities of an ageing patient population.

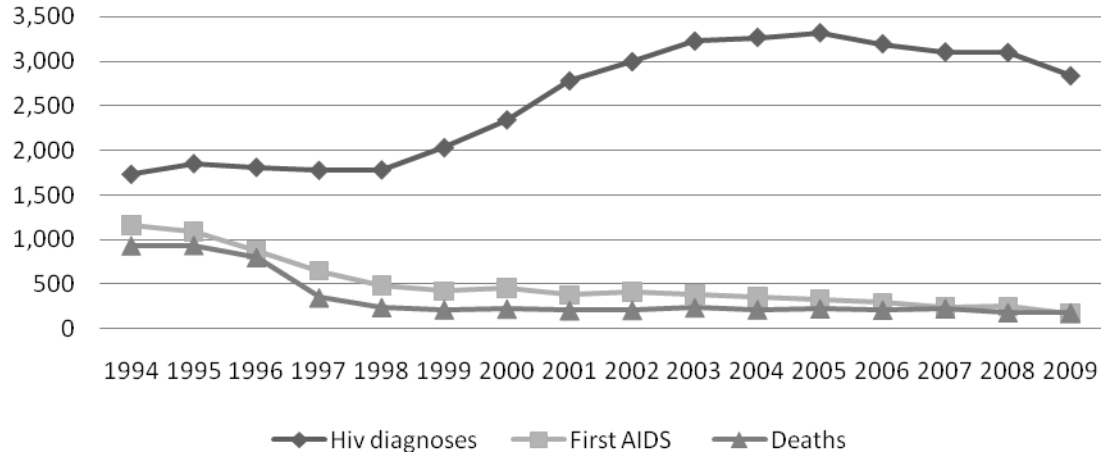
At a pan-London level there are clear signs of ageing HIV patient cohorts. It can be expected that within the next 5-10 years, the number of patients over 55 years of age will increase rapidly, given the size of the current aging cohort. Figure 5 shows the number of new HIV diagnoses, first AIDS diagnoses and deaths in London between 1994 and 2009. A key feature of this graph is the impact of the availability of ART on HIV related deaths since 1995/6.

It shows:

[9] NICE 2011, Increasing the uptake of HIV testing amongst men who have sex with men. Available from: http://guidance.nice.org.uk/PH34

- A steep increase in HIV incidence from 1999 to 2004, followed by a year-on-year decrease in line with the national trend.
- More than a 6 fold decrease in new AIDS diagnoses in London from 1994 to 2009.
- A corresponding decline in deaths over the same period.

Figure 5: Number of new HIV cases, AIDS diagnoses and deaths among PLHIV, by year of diagnosis in London, 1994 – 2009[10]



The ageing HIV population (National)

HIV infected adults aged 50 years and over accessing care more than tripled between 2000 and 2009 from 2,432 to 12,063, representing one in five adults seen for HIV care in 2009. This is due to an ageing cohort of people previously diagnosed, as well as an increase in new diagnoses among the over 50s. New diagnoses among older adults more than doubled between 2000 and 2009, and accounted for 13% of all diagnoses in 2009. Two-thirds (67%) were diagnosed late, with a CD4 cell count less than 350 per mm^3. Adults diagnosed when aged 50 years and over were more likely to present late compared with younger adults (15-49 years). A recent study showed that the risk of short-term mortality (death within a year of diagnosis) was 2.4 times higher for older adults compared with younger adults, and older adults diagnosed very late (<200 per mm^3) were 14 times more likely to die within a year of their diagnosis compared with those diagnosed earlier.

The age distributions show clear signs of an ageing cohort. The number of older patients is likely to grow substantively over the next 5- 10 years, as the high numbers of patients in older age groups (40-49 years in 2009) are ageing (Figure 6). Of particular concern is the rapid increase in patients over 50 years, (approximately 1,000 patients in 1999; 5,000 patients in 2009), as these patients are likely to be affected by both long-term ART side effects and age related chronic conditions such as cardiovascular disease, chronic obstructive pulmonary disease, and diabetes. There is currently insufficient data on the incidence/prevalence of these conditions in HIV infected patients, but is likely that ageing will pose additional clinical management challenges for this group.

The data in the tables below was provided on request from the HPA and provides baseline data on the number of LSL residents aged 60 years and over with diagnosed HIV.

Residents aged 60+ living with diagnosed HIV

		Aged 60+	
Area of residence	PCT of residence	Male	Female
Lambeth, Lewisham & Southwark	Lambeth PCT	85	23
Lambeth, Lewisham & Southwark	Lewisham PCT	36	17

[10] HPA: New HIV Diagnoses to end of June 2010 Available from: http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1238055337604

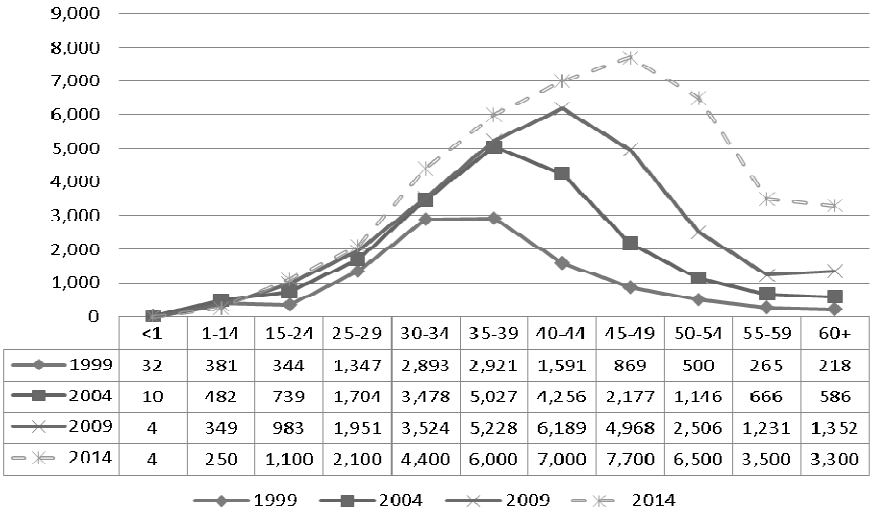
Lambeth, Lewisham & Southwark	Southwark PCT	65	18

Residents aged 65+ living with diagnosed HIV

		Aged 65+	
Area of residence	PCT of residence	Male	Female
Lambeth, Lewisham & Southwark	Lambeth PCT	32	14
Lambeth, Lewisham & Southwark	Lewisham PCT	21	6
Lambeth, Lewisham & Southwark	Southwark PCT	29	7

The second key observation is the increase in patients aged 15-24 years, which is likely to be a cohort effect from children with HIV growing older rather than new diagnoses. Transitional care planning (from child to adult HIV services) for this cohort is challenging and will require some consideration. Overall, there is cohort complexity amongst adolescents living with HIV, and early data from small numbers suggests that multidisciplinary transition services can improve healthcare experiences for young people. Adolescents living with HIV have additional complex medical and psychological stressors, many of which are not typically seen in other chronic diseases of childhood but potentially impact throughout transition and into adult care. Transition from paediatric to adult services occurs at a time when adolescents living with HIV are managing the wide spectrum of change associated with later adolescence and particularly influencing independence and autonomy, sexuality and personal identity.

Figure 6: Age distribution of patients accessing HIV care in London, 1999, 2004, 2009; and estimated for 2014



	<1	1-14	15-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60+
1999	32	381	344	1,347	2,893	2,921	1,591	869	500	265	218
2004	10	482	739	1,704	3,478	5,027	4,256	2,177	1,146	666	586
2009	4	349	983	1,951	3,524	5,228	6,189	4,968	2,506	1,231	1,352
2014	4	250	1,100	2,100	4,400	6,000	7,000	7,700	6,500	3,500	3,300

(Note: 2014 estimated numbers are for illustrative purposes only. Methodology: 5 year age specific number from 2009 (base) plus expected number of 5 year age specific new diagnoses)

APPENDICE B: Portfolio of Services (based on 10/11 activity and 11/12 forecasted spend)

Service (Provider) *Description of Service*	Lead Commissioner	Lambeth Expenditure (ASG/LA funding)	Lambeth Activity/ Outputs	Southwark Expenditure (ASG/LA Funding)	Southwark Activity/ Outputs	Lewisham Expenditure (ASG/LA Funding)	Lewisham Activity/ Outputs	LSL Total Expenditure (Total ASG/LA funding)	LSL Activity/ Outputs for 10/11 (* where stated commissioned activity as opposed to 10/11 performance data.)
CASCAID (SLAM) Specialist HIV Mental Health Service for people infected or affected by HIV	LSL Mental Health	£578,230	Approx 45%	£408,249	Approx 35%	£241,707	Approx 20%	£1,228,187	3350 appts (2711 attendances excluding DNAs & cancellations) 310-350 clients at any one time
HIV Community Nursing Service (GSTT Community Services) Case Management and ongoing medical support for people living with HIV.	NHS Lambeth Community Contract/ SH & HIV	£225,611	Approx 45%	£159,288	Approx 28%	£94,308	Approx 26%	£479,207	Approx 2776 face to face contact per annum. Approx 250 clients at any one time
Family Support (Positive Parenting & Children) Family Support Service delivered through a social care model for infected and affected parents, children & adolescents	LSL SH & HIV	£105,353 (50%/ £52,677)	Approx 43% of family work	£74,382 (50%/ £ 37,191)	Approx 25% of family work	£44,039 (50%/ £22,020)	Approx 31% of family work	£223,774 (50% / £223,774)	3000 hours of home*, community, or clinic based family support per annum. Estimated 100 families per annum.
Mildmay Residential & Day Care (Mildmay) Services for HIV related cognitive impairment and physical rehab	North East London Cluster	£343,940,	709 residential bed days & 269 day care days	£224,373	496 residential bed days & 81 day care	£139,896	254 residential bed days & 12 day care	£708,209	See PCT spit
Muslim Peer Support (African Advocacy Foundation) Muslim Peer Support	LSL SH & HIV	£3,019	Awaiting data	£2,526	Awaiting data	£2,455	Awaiting data	£8,000	50 group meeting per annum* Work with 40 families per annum*

Services									
Christian/Faith Based Peer Support (LEAT) Christian/faith based peer support service	LSL SH & HIV	£3,019	Awaiting data	£2,526	Awaiting data	£2,455	Awaiting data	£8000	25 group meeting per annum (10 clients per session)*
South London HIV Partnership (Partnership of Providers commissioned across South London -broken down by service below (a-g))	Croydon HIV	£343,617 (40%/ £137,447)		£267,113 (40%/ £106,845)		£159,490 (40%/ £63,796)		£770,220	See Below
a) First Point (Metro) Assessment & referral service	*Croydon HIV*	*£58,437*	*Awaiting Data*	*£45,426*	*Awaiting Data*	*£27123*	*Awaiting Data*	*£130,987*	*1216 assessment across South London/estimated 53% LSL= 644 assessments*
b) Advice & Advocacy (THT)	*Croydon HIV*	*£59,895*	*Awaiting Data*	*£46,559*	*Awaiting Data*	*£27,800*	*Awaiting Data*	*£134,272*	*547 Individuals seen LSL (57% of South London Activity)*
c) Counselling (THT)	*Croydon HIV*	*£48,474*	*Awaiting Data*	*£37,682*	*Awaiting Data*	*£22,499*	*Awaiting Data*	*£108,656*	*263 hours of counselling per annum* across south London No LSL Split activity*
d) Health Trainers (THT)	*Croydon HIV*	*£59,895*	*Awaiting Data*	*£46,599*	*Awaiting Data*	*£27,8000*	*Awaiting Data*	*£134,255*	*3000 sessions/800 individuals* Approx 47% LSL*
f) Peer Support (THT)	*Croydon HIV*	*£34,260*	*22%*	*£26,632*	*17%*	*£15,902*	*17%*	*£76,795*	*Approx 472 clients per annum 56% of total activity*
e) Monitoring, verification & Evaluation (NAW Solutions	*Croydon HIV*	*£20,249*		*£15,740*		*£9,398*		*£45,387*	*No service activity*
g) Infrastructure & programme office	*Croydon HIV*	*£62,405*		*£48,511*		*£28,965*		*£139,883*	*No services Activity*
Total Health Funding		***£1,432,669***		***£983,329***		***£590,623***		***£3,006,621***	
Total ASG/LA Funding		***£190,123***		***£144,036***		***£85,816***		***£419,975***	
TOTAL		**£1,621,792**		**£1,127,365**		**£676,439**		**£3,425,597**	

4. **N.B. More comprehensive activity information will be available from the service review.**

APPENDICE C: Options Appraisal for current service provision

Following the development of the proposed service model a detailed options appraisal was conducted on the current service provision to identify commissioning intentions for each of the existing commissioned providers. This options appraisal considers the risks and benefits of three options for each of the existing services within the reviewed portfolio; maintain status quo/no service change, remodel & redesign, decommission/re-commission. These options were discussed and preferred options endorsed by both the Service User Reference Group (SURG) and Project Steering Group. The options appraisal also identifies potential resource implications of the recommendations.

Figure 3.1 summaries the endorsed recommendations for each of the current commissioned services reviewed within this project.

Current Service (Provider)	Recommendations for future commissioning:
CASCAID (SLAM)	**Remodel & respecify** to provide an interim service which support shift to & capacity building within mainstream services. Release efficiencies from immediate shift/decommissioning and plan for **phased reduction in service/contract value**. Future direction of travel to explore need for specialist service to provide HIV specific Mental Health Services not delivered in mainstream mental health services such as HIV related cognitive impairment services
HIV CNS (GSTT Community Services)	**Remodel & Respecify** to ensure delivers to most complex services focusing on hospital discharge planning, provision of step down community nursing packages, case management of co-morbid and complex social issues, complex adherence programmes. Review case mix and required capacity for services in line with remodelling, **potential reduction in contract value.**
Family Support (Positive Parenting & Children)	**Remodel & Respecify**, maintain contract value but respecify to improve outcomes and focus existing service.
Mildmay Residential & Day Care (Mildmay)	Inpatient HIV related neuro-cognitive impairment (HNCI): **maintain status quo** of spot purchasing arrangements and placement panels. Outpatient HNCI: **maintain status quo** of spot purchasing arrangements and placement panels. **Potential to reduce activity** levels through shift to CASCAID/existing community physical rehab services. Inpatient Physical Rehab: **maintain status quo** of spot purchasing arrangements and placement panels. **Immediate Reduction in activity** levels through shift to intermediate care services with intention to **decommission** over time Outpatient Physical Rehab: **maintain status quo** of spot purchasing arrangements and placement panels. **Immediate reduction in activity** levels through shift to community rehab services/CNS with intention to **decommission** over time
Muslin Peer Support (AAF)	**Decommission** existing provision; consolidate with other peer support, **Recommission:** design and tender for new peer led/mentoring programme.
Christian/Faith Based Per Support (LEAT)	**Decommission** existing provision; consolidate with other peer support, **Recommission:** design and tender for new peer led/mentoring programme.
First Point (Metro-SLHIVP)*	**Decommission** mainstream assessment & referral service in Specialist HIV treatment services.
Advice & Advocacy (THT-SLHIVP)*	**Decommission & recommission** advice & advocacy service
Counselling (THT-SLHIVP)*	**Decommission & recommission** interim service with **phased reduction** and **intention to decommission** over time
Health Trainer (THT-SLHIVP)*	**Decommission**, mainstream provision through specialist HIV treatment agencies/Health Advisors/Peer led newly diagnosed programmes
Peer Support (THT-SLHIVP)	**Decommission** existing provision; consolidate with other peer support, **Recommission:** design and tender for new peer led/mentoring programme.

NHS Lambeth

APPENDICE D: Terms of Reference for HIV Care & Support Steering Group

Lambeth, Southwark & Lewisham (LSL) HIV Care and Support Needs Assessment Steering Group
Terms of Reference, July 2011

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1. Membership

Ruth Wallace DPH –Lambeth (CHAIR)
TBC-Lewisham Council Commissioning Lead
Peta Smith, Southwark Council Commissioning Lead
Elizabeth Clowes, Lambeth Council Commissioning Lead
Murad Ruf/Emma Robinson- Public Health Consultant,
Ruth Hutt – Public Health consultant, Lewisham
Gillian Holdsworth –Public Health Consultant, Southwark
Ali Young –Senior Sexual Health Commissioner
Jess Peck, Commissioning Manager, Sexual Health & HIV, LSL Alliance
Sima Chaudhury –Lead Commissioner SLHP NHS Croydon
Gary Alessio- SEL SH & HIV Network Coordinator
David Bello- Lambeth Council Social Services Lead
Jon Newton- Southwark Council Social Services Lead
Audrey-Marie Yates- Joint Commissioning, Contracts and Brokerage Unit, Adult Social Care Lewisham Council
Mary Poulton- King's HIV Service Lead
Nick Larbalestier- GSTT HIV Service Lead
Charles Mazude -LHNT HIV Service Lead

2. Frequency

The HIV Care and Support Needs Assessment Steering Group will meet monthly for the duration of the project. This is expected to be for a period of no more than 6 months, June- November 2011.

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3. Purpose of the group

This group will provide a multi-agency approach to oversee and monitor the delivery of the LSL HIV Needs Assessment and Service Review Project against the agreed PID and project plan.
The group will:

- ensure that the necessary milestones and products are met within set timelines
- review quality of products
- provide an advisory capacity in the analysis of information obtained within the project
- make recommendations for future commissioning intentions (for consideration by relevant commissioning groups)
- commit to collaborative working across Lambeth, Southwark & Lewisham where feasible and appropriate
- contribute to the development of a strategy for HIV as a long term condition.

4. Governance

The HIV Care and Support Needs Assessment Steering Group reports progress to the Lambeth Southwark and Lewisham (LSL) Sexual Health & HIV Programme Board that in turn reports into 'Planned Care' QIPP groups across LSL and into Local Clinical Commissioning Groups across LSL.
Recommendations for future commissioning intentions will be made to PCT and Local Authority Commissioning Boards and Scrutiny Panels, and Clinical Commissioning Consortia Groups across LSL. In addition, recommendations will feed into the PCT QIPP Planning process for 2012/13.

5. Ways of working

Agendas and supporting papers will be circulated 3-5 days in advance of meetings. Action notes of each meeting will be recorded and submitted to members within 14 working days of each meeting, and reviewed at each meeting.

6. Quoracy

There should be representation from each borough at all meetings where possible. The minimum number of members required in order to take decisions is 5 members were there is representation across the 3 boroughs.

7. Evaluation and Review

The Steering Group will oversee the delivery of the project against the agreed PID and project plan.

APPENDICE E: Communication & Engagement Plan

Communications and Engagement Action Plan for the HIV Care and Support Needs Assessment / Service Review

List here the communications / engagement objectives again so that you can refer to them in the first column.

1. Brief cluster & PCTS to address concerns / queries in relation to HIV Care and Support NA
2. Inform LSL Overview & Scrutiny Processes and allow for engagement & consultation throughout review
3. Engage with stakeholders throughout the review process
4. Develop Service User reference Group for NA/ Service Review to act as a shadow Board and to start beginning September
5. Consult with public, patients and key stakeholders across LSL on review findings & recommendations including focus groups and wider engagement activities

Objective Target	Activity required	Timescale/ Milestone	Lead/ Resource required	Risks/Mitigating Action	Performance Indicators /Evaluation
1	*Brief cluster & PCTS to address concerns / queries in relation to HIV Care and Support NA* • Meetings with PPE leads (LSL) and Communication leads within Cluster • Preparation of Communications briefing about Need Assessment, process, time lines and engagement • Briefing to PCT and Clinical Commissioners	Mid July Mid August Mid August	JP/AY/ CF KS	Public unawareness generates high levels of concern and lobbying	(a) Briefing available (b) Monitor level of public queries monthly
2	*Inform LSL Overview & Scrutiny Processes and allow for engagement & consultation throughout review* • Finalise OSG dates across LSL: Lambeth 19th Oct (report end of Sept) Lewisham 9th Nov (report 31st Oct), Southwark Dec 7th (report 25th Nov) • Prepare presentation/ briefing on NA/ Service review engagement plans for LSL Stakeholder Group meeting 17th August (sub group of Cluster	End July Mid August Mid August Beg Sept Beg Sept	JP/AY/RW JP/AY/RW JP/AY JP/AY	R: Service Review not complete and rec's not ready: MA: Provide progress report including extensive engagement R: Scrutiny Leads/ BSU leads not	Scrutiny dates finalised Reports submitted against deadlines Scrutiny leads briefed

Objective Target	Activity required	Timescale/ Milestone	Lead/ Resource required	Risks/Mitigating Action	Performance Indicators /Evaluation
	Commissioning Board) • Develop scrutiny paper • Identify Health Lead Councillors across LSL and brief prior to Scrutiny meetings • Brief BSU Managing Directors in advance of Scrutiny meetings • Arrange subsequent OSG dates to present recommendations & consultation feedback	 Beg Sept Sept-Nov Sept-Dec Jan-March	 AY/JP AY/JP AY/JP AY/JP	sufficiently briefed MA: Early intervention with Leads	
3.	*Engage with stakeholders throughout the review process* • Inform providers of review Process • Plan Stakeholder mapping event with providers and service users • 14th July -Lewisham LA event (attended by 18 LA Commissioners and providers, mapping existing Social care pathways, providers, services and NRPF) • 19th July – LSL Stakeholder event to map client journeys, services, referral pathways and gaps • LA Southwark and Lambeth event • Stakeholder Event results written up • Ensure service user feedback/intelligence informs service reviews • Consult with providers on Service reviews	July July July July End of Aug Sept August August	AY/JP/GA AY/JP/GA AY/JP/GA AY/JP/GA AY/JP/GA AY/JP/GA AY/JP/GA AY/JP/GA	R: Providers attendance low and non representative MA: Promote with managers and Dept leads , chase confirmed attendees Ensure information about event and intended outcomes of event are clear Do not gain a full picture of Social care pathways including NRPF for all LSL LA's	Good attendance Event Outcomes met Information gathered useful and contributes to service developments /changes
	Develop Service User reference Group for NA/ Service		JP/AY/GA/	R: SURG not	SURG in place for

Objective Target	Activity required	Timescale/ Milestone	Lead/ Resource required	Risks/Mitigating Action	Performance Indicators /Evaluation
4.	*Review to act as a shadow Board and to start beginning September* • Recruit service users onto a Service User Reference Group (SURG) that will shadow project Steering groups • Recruit through (South London HIV Partnership (SLHP) as have data network and MVE work stream; HIV services patient reps (GST, Kings); Family Support Provider (PPC) particularly for younger people • Develop role outline and briefing for recruiters • Agree incentives and travel expenses • Assign lead to work with Service Users / PPE chair • Book meeting dates and room for first meeting early Sept (confirm date) • Develop draft TORs / outline • Co-ordinate meetings for lifespan or review and implementation phases • Ensure SURG feeds into Project steering group	Early /Mid Aug Early Aug Early Aug Early Aug Early Aug Mid Aug End of Aug Ongoing Ongoing	CF	representative PLHIV in LSL MA: Ensure recruiters have briefing outline of project and vision of SURG	September 2011
5.	*Consult with public, patients and key stakeholders across LSL on review findings & recommendations including focus groups and wider engagement activities* • Launch of final review and recommendations • Hold two public consultation events in each borough 1. 9th December 2011, 9.30am-12.30pm, Roben's Suite, Guys Hospital 2. 12th December 2011, 2-5pm, Assembly Rooms, Lambeth Town Hall 3. 13th December 2011, 9.30am-12.30pm, Lewisham Town Hall 4. 5th January 2012, 6-9pm, Roben's Suite, Guy's Tower, Guys		JP/AY/GA/ CF Mid Oct Nov- Jan Nov- Jan Nov- Jan	R: Consultation events not sufficiently promoted MA: Engage PPE support and guidance on format and promotion of the event	Events well attended from user representative PLWHIV in LSL Legacy document developed Responses to consultation made publically available

Objective Target	Activity required	Timescale/ Milestone	Lead/ Resource required	Risks/Mitigating Action	Performance Indicators /Evaluation
	Hospital 5. 9th January 2012, 6-9pm, Assembly Rooms, Lambeth Town Hall 6. 10th January 2012, 6-9pm, Lewisham Town Hall iii) Hold Focus group with white MSM, Migrant/non migrant African men & women as part of consultation iv) Ensure review findings/recommendations goes to SURG & peer support forums v) Inform/consult OSG on review findings/recommendations/consultation responses vi) Collate Consultation responses vii) Publish consultation and final review/recommendations		Nov- Jan Jan/Feb Jan/Feb		

COMMUNICATION AND ENGAGEMENT LOG

This log is a record of all the communication and engagement activity undertaken.

Date	Activity undertaken	Completed by	Notes
28th June 13th July	Meetings with PPE leads LSL Meeting with Communication leads SEL Cluster Engagement Plan completed	JP/GA JP/GA JP	Engagement/ Communications template provided / Ref group job roles
14th July	Lewisham LA Stakeholder mapping, Led by Ruth Hutt, Consultant in Public Health (NHSLew). Attended by 18 staff from Lewisham Social Care, CASCAID, HIV CNS, Alexis Clinic (HIV Specialist Services), joint commissioning team and 1 service user from Lewisham. 3 hour meeting to map client pathways into Social Care including Non Recourse to Public Funds (NRPF). Also outlined current generic, specialist HIV and voluntary sector support currently used by PLHIV.	RH / GA	The emerging themes from the event • That specialist HIV services are perceived as 'safe havens' • Disclosure of HIV status is still a major issue and potentially a barrier to accessing generic services • PLHIV need to travel out of Lewisham for many support services. For this reasons services which do home visits or provide transport are favoured • There is a tendency to refer straight into specialist services rather than go via generic services both on the part of the individual & the HIV clinicians (e.g. Go to CASCAID rather than CMHT, HIV specialist rather than GP) • There is a lack of local peer support groups available- loss of positive place means services don't know where to refer to (new group in New Cross identified) • Body & Soul highlighted as a popular service, even though currently not commissioned • A reluctance to use faith groups for support due to a mixed experience and concerns about

			the quality and accuracy of information and support given. • Training needs were identified for generic services and faith leaders.
19th July	Stakeholder Mapping event Robens Suite Guys attended by 67 staff across LSL Provider portfolio; HIV services, voluntary sector and commissioners Event write ups completed end July	RH JP/GA/RH	Preliminary notes completed, core themes: Clarified client pathways (in and out) Service usage Preliminary mapping of LA pathways (follow up meetings needed)
30th June 25th July 29th July Beg July	Paper to Lew CCCB 30th June Paper to Lam CCCB HIV NA/ Service Review paper presented at Lewisham Adult Joint Commissioning Board Recruitment process for Service User reference groups started with SLHP Nathan Williams	RH RW JP JP	Emails sent, phone confirmation 3/8, JP to develop briefing
4th Aug 8th Sept	LA meeting Southwark –Tooley Street LA meeting Lambeth – LBL Streatham	JP/AY JP/GA	**Southwark:** Led by Sexual Health & HIV Commissioning Team with Southwark Physical Disabilities Team Attended by 1 Senior Commissioning Manager for Children's Services; 1 Commissioning Support Officer and 1 Team Leader for the Physical Disabilities Team. **Lambeth:** Attended by the Team Manager and a Specialist Practitioner for Physical Disabilities in Lambeth and the Team Manager for the NRPF Team
12th Oct	SURG meeting 1 –TORs, methods of working agreed and project update.	JP/GA	**Attended by 5 LSL service users**
26th Sept	SURG meeting 2 –TORs signed off, update on Needs Assessment, Options Appraisal reviewed.	JP/GA	**Attended by 6 LSL Service users**
11th Oct	SURG meeting 3 – Options Appraisal revisited	JP/GA	**Attended by 6 LSL Service Users**
8th Nov	SURG meeting 4 (planned)	JP/GA	