South East London Integrated Care System

NHS South East London

Southwark PLT

- LGBTQ+ Health Inequalities
- Trans Health and CliniQ
- The Bridge Clinic
- LGBTQ+ Sexual Health in Primary Care

February 2023

Agenda

Timings		Speaker	Timing
1.00pm	5 mins	Welcome	Chair – Russell Don
1.05pm	15 mins	LGBTQ+ Health Inequalities	Russell Don
1.20pm	15 mins	Trans Health and CliniQ	Michelle Ross
1.35pm	15 mins	The Bridge Clinic	Flora Cohen Dr Becky Stephens
1.55pm	15 mins	LGBTQ+ Sexual Health in Primary Care • PrEP • MPox • LVNDR	Dr Max Kelen Josh Wells
2.15pm	15 mins	Q&A Panel Session	All Speakers

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LGBTQ+ Health Inequalities

23% of LGBT people have at one time witnessed anti-LGBT remarks by healthcare staff
'LGBT in Britain. Health Report. Stonewall and YouGov'

Russell Don (he/him)

LGBTQ+ Staff Network Chair - SEL ICB

Programme Manager – Heathy Populations Team, Partnership Southwark, SEL ICB

LGBTQ+ Inequalities

- National and local evidence and research clearly demonstrates that LGBTQ+ people face significant inequalities in all aspects of life compared to straight counterparts
- This is in education, criminal justice system, housing, health and social care

- Evidence and research underestimates the scale of the problem due to poor ‘asking’ and recording of data and information on gender identity, sexual orientation and trans status

- All people from the LGBTQ+ community have a right to health and care services that specifically meet their needs

- In health and social care this is relates to:
  - access to care and treatment
  - provision of services that are inclusive
  - services tailored to their needs

LGBTQ+ History month – February 2023

- LGBTQ History Month was founded by Schools Out to mark and celebrate the repealing of section 28.
- Legislation was introduced in 1988 and repealed in 2001 in Scotland and 2003 in England
- Section 28 was part of the Local Government Act 1988, which stated that a local authority ***"shall not intentionally promote homosexuality or publish material with the intention of promoting homosexuality"*** or ***"promote the teaching in any maintained school of the acceptability of homosexuality as a pretended family relationship***"

- The effect of this on teachers and other school staff was that they became fearful of doing what they knew and felt to be the right thing
- This legislation has had a wider and lasting impact on society - negatively impacting on the way LGBTQ+ people were talked about and represented in society and feel about themselves

LGBTQ+ History month – February 2023

The aims of LGBTQ+ History month are to:

- Promotes inclusion and diversity and equality
- Celebration of LGBTQ+ culture and heritage
- Raise awareness and combated prejudice against LGBTQ+ people in history
- Educate and provide insight in to issues that LGBTQ+ community face
- Raise awareness of the impact and contribution that LGBTQ+ people have had in history and to the world
- Combat LGBTQ+ phobia, prejudice, discrimination, hatred, and violence

Illegal to be LGBTQ+

- 68 countries where it is illegal to be LGBTQ+
  - Sentences range from 2 years in prison up to life in prison
  - and / or flogging
- 32 of these countries are in the Commonwealth
- 13 countries where it is punishable to by death to be from the LGBTQ+ community
  - This is usually by stoning

LGBTQ+ Hate Speech and Hate Crime

Anti-LGBT+ hate crime is abuse or violence committed against someone because of their orientation or gender identity

This can include:

- Microaggressions
- Verbal abuse, such as calling someone anti-LGBT+ names
- Physical attacks
- Sexually threatening or violent behaviour
- Stealing or damaging belongings
- Blackmail, including demanding money not to ‘out’ you
- Doxing - act of purposely publicly providing personal information person
- Sending abusive or offensive messages
- Acting in a threatening or intimidating way
- Encouraging others to target LGBT+ people

LGBTQ+ Hate Crime

There is a significant rise in hate crime faced by the LGBTQ+ community

- In 2017, 21% LGBT people reported that they had experienced a homophobic, bi-phobic or transphobic hate crime in the previous 12 months, with this rising to 41% for trans people. LGBT in Britain – 'Hate Crime and Discrimination. Stonewall and YouGov Report'
- In 2019 European Assembly Report identification countries where LGBTQ+ hate crime was on the rise – the top four were **Russia, Poland, Hungary, and UK**
- During the first lockdown there was a 20% rise in LGBTQ+ hate crime reported in Southwark
- 2021 ONS data shows a significant rise in hate crime in the UK with over 100,000 reported hate crimes. Results showed:
  - 1/3 (30,507) were targeted at the LGBTQ+ community
  - transgender people seeing the largest proportional rise
    - 4,355 anti-trans incidents up by 56%
    - 26,152 sexual-orientation related hate crimes up by 41%
- https://galop.org.uk/news/galops-statement-on-the-release-of-the-2021-2022-official-statistics-for-hate-crime/

Health inequalities in primary care

- 14% of LGBT people have avoided accessing healthcare for fear of being discriminated against because of their LGBT identity '*2018 Stonewall Survey'*
- 33% of LGBT respondents thought that their GP did not meet their needs as an LGBT person **'***2017 LGBT Foundation Primary Care'*
- 72% said they thought GP practices could improve services they offer their LGBT patients **'***2017 LGBT Foundation Primary Care'*

- 40% of trans people who had a negative experience based in healthcare on their trans identity *'National LGBT Survey 2018'*
- 57% of trans people reported avoiding going to the doctor when unwell – '*The Trans Lives Survey 2021'*
- 80% of trans people experience anxiety before accessing hospital treatment due to fears of insensitivity, misgendering and discrimination prejudice '*LGBT Foundation survey 2017'*

Health inequalities in Physical Health

Physical Health and LTCs

- 55% of gay, bisexual and trans men were not active enough to maintain good health, compared to 33% of men in the general population. *The National LGB&T Partnership. 2016. Lesbian, Gay, Bisexual & Trans People and Physical Activity: What You Need To Know*
- 6% of bisexual respondents and 4.9% of gay and lesbian respondents were living with frailty, compared to 3.2% of all respondents '*2019 NHS GP Patient Survey'*
- In men aged 50+, being gay, bisexual, or another non-heterosexual orientation is associated with a heightened risk of long-term illness and health-related limitations *A 2020 Govt Evidence Review*

Smoking Rates

- The smoking rates among the LGBT community are substantially higher than the heterosexual / cis community
- Data shows that 18.8% of heterosexual people smoke, compared to 27.9% of lesbian women, 30.5% of bisexual women, 23.2% of gay men and 26.1% of bisexual men
- **Do we know if lesbian and bisexual women are accessing these services?**
- **Are smoking cessation services tailored to lesbian and bisexual women?**
- **What we do not know is the rates of lung cancer in the LGBT community and specifically rates of diagnosis, treatment, death, and survival rates?**

Health inequalities in Mental Health

- In 2017, 1 in 6 LGBT people reported drinking almost every day in the last year, this compares to 1 in 10 adults in the general population who report drinking alcohol on five or more days per week. *Stonewall 2017*

- In 2017, 52% of LGBT people reported experiencing depression in the previous year. This includes 67% of trans people and 70% of non-binary people. 2018. LGBT in Britain. *Health Report. Stonewall and YouGov.*

- 24% of homeless people aged 16-24 are LGBT and 69% of these people believe parental rejection was a main factor in becoming homeless. *Albert Kennedy Trust. 2017. LGBT Youth Homelessness: A UK National Scoping of Cause, Prevalence, Response & Outcome*

- 45% of trans young people (aged 11-19) and 22% of cis LGB young people have tried to take their own life. Among the general population the NHS estimates this figure to be 13% for girls and 5% for boys aged 16-24. *School Report. Stonewall and University of Cambridge 2017*

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Trans Health

Michelle Ross

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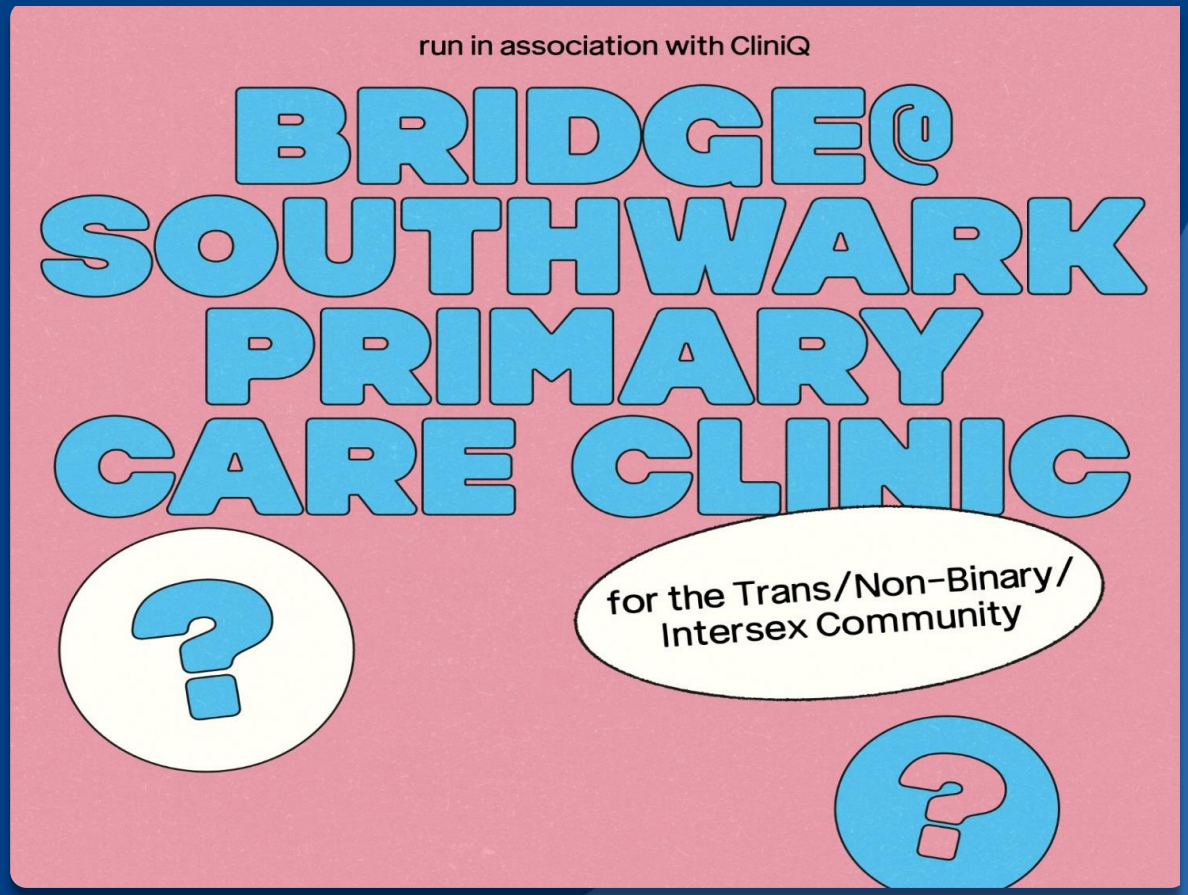
The Bridge Clinic



Flora Cohen

What we do

- Monthly evening clinic – 1st Tuesday of the month
- 2 GPs, Nurse, HCS, health and wellbeing mentor, and trained welcomer from CliniQ

Routine GP Care including

- Referrals to all services provided by your usual GP
- Contraception
- Health Checks
- Chronic disease checks (eg Asthma/Hypertension/Diabetes)
- Health and wellbeing referrals (where eligible)
- Talking Therapy Signposting
- Mental Health Support

Support with Gender Affirming Treatments

- Referral to a Gender Identity Clinic
- Prescribing in line with Shared Care Agreements from NHS GICs if service users prefer to access via the Bridge Clinic rather than via their registered GP
- Consideration of Bridging Prescriptions in line with GMC Guidance
- Support with GP records alteration of name/prefix/gender marker
- Cervical screening for trans masc and NB people

Community Focused

Many trans people have very poor experiences in healthcare, therefore working closely with the community is essential to provide a service that meets their needs and works for them

1. We work closely with the trans community
2. We were assisted in the development of the Bridge Clinic with advice from CliniQ
3. We continually ask patients for their feedback and endeavour to ask the community for their thoughts on everything we do
4. Majority of our team identifies as LGBTQ+
5. Outreach with local Trans community groups
6. Collaborative working with Trans and LGBTQ+ charities and advocates

How to access

- If you have a patient who would like to access the service, please email ih.bridgeatsouthwark@nhs.net

- Patients are triaged over email by Nurse, and then booked in to the appropriate appointment

Survey Feedback

Very good feedback so far

- 100% users are “very satisfied”
- 100% would return to the clinic
- 100% responded that their clinician had a good understanding of their needs

What can you do in your practice?

- Using correct language e.g. people's chosen pronouns
- Using gender neutral language e.g. "people who have smears"
- Understanding that some people identify as trans or non-binary
- Ensuring recalled for appropriate screening
- Coding "gender identity disorder" (even though this still isn't ideal term) rather than "transsexualism"
- New gender on notes = new set of notes
- Preferred pronouns can be added as pop up on EMIS
- Preferred name can be added as pop up
- Assist with signing documents such as passport letter (info pack)
- Guidance on documentation, coding and screening recall in info pack

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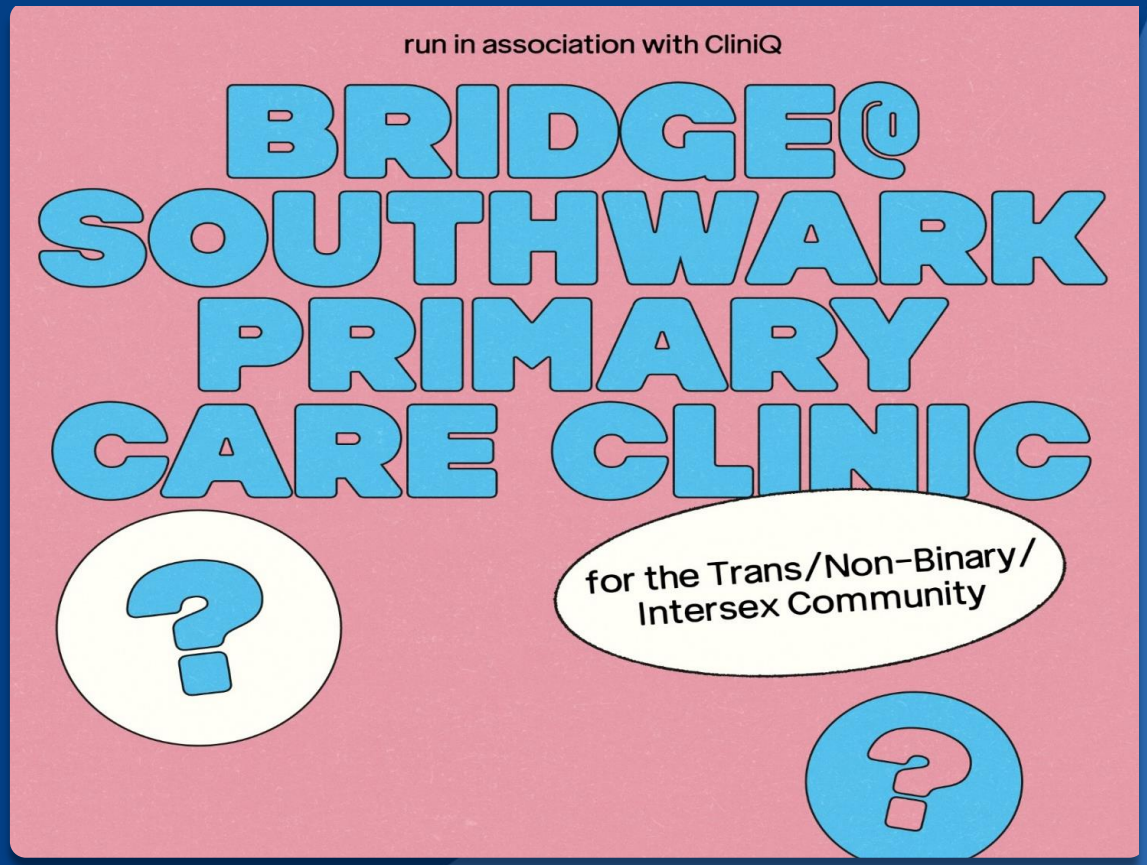
Prescribing Gender Affirming Hormones



Dr Becky Stephens

What are gender affirming hormones

- Gender-affirming hormone therapy is the primary medical intervention sought by transgender people. Such treatment allows the acquisition of secondary sex characteristics more aligned with an individual's gender identity such as breast development, fat distribution, muscle development, facial/body hair, voice pitch change
- Hormone therapy helps relieve Gender Dysphoria-this term refers to the potentially immense distress that some (not all) trans people experience as a result of incongruence between gender identity and assigned gender at birth (physical/social dysphoria)
- Rather than thinking about one set of hormones for a Trans Man and one for a Trans Woman it is better to think about Masculinising and Feminising pathways. This will be more inclusive of patients who are Non-Binary who may not want to achieve maximum Masculinisation or Feminisation and who will aim for lower target hormone levels
- Some patients will also require Gender affirming surgeries options e.g. chest reconstruction/augmentation, oophorectomy, orchidectomy and genital reconstruction surgery. Note if orchidectomy/oophorectomy need to continue Gender affirming hormones to avoid hypogonadism

What are bridging hormones?

- The current wait for an NHS Gender Identity clinic is more than 4 years locally.
- For most patients a 4 year wait is not acceptable. Patients may access care privately through a private GIC or may self source hormones through unregulated providers.
- In certain circumstances a GP can initiate hormone treatment to ‘bridge’ this gap in provision. These include:
  - when a patient has already started hormone therapy through self-medication or in another country,
  - when they are at risk of self-medicating,
  - or when a patient is considered at high risk of self-harm or suicide if their medical transition cannot begin imminently
- The General Medical Council recommends that these ‘bridging hormones’ be prescribed when indicated, when a GP feels competent to do so and has sought specialist advice. Specialist advice could be from a GIC, or transgender specialist GP or Endocrinologist, as GPs may face significant challenges in accessing specialist advice directly from a GIC**.**
- **The Royal College of GPs recommends that GPs take an overall ‘harm reduction’ approach whilst the patient awaits such specialist advice, which could include starting hormones before such a reply has been received from a specialist service.**

Who can prescribe bridging hormones?

- Every GP
- Hormone Prescriptions have always been done by GPs as GIC practitioners have not been commissioned to do so
- You must be ‘Competent’ Clear Guidelines
- You must ‘seek specialist advice’ by referring to a GIC (although you don’t have to wait for patient to be seen)
- Most patients fit the GMC criteria as self medication is common in the community and Gender Dysphoria causes intense distress with increased risk of suicidal ideation and self harm
- We are happy to discuss patients as well as see them at the Bridge

How do we assess patients for bridging hormones at The Bridge Clinic

- The Interim Gender Dysphoria Protocol and Service Guidelines state criteria for Hormones are-
- Persistent well documented Gender Dysphoria
- Capacity to make an Informed Decision and to be able to consent to treatment
- Age at least 17
- If significant medical/mental health concern these must be reasonably well controlled
- Even if patients have been assessed privately we take a fresh history of Gender Dysphoria, a medical history and explore the person's ideas, concerns and expectations around hormone treatment
- We do not expect patients to 'prove they are trans-gender' rather we make sure patients are fully informed about the expected effects, side effects, risks and reversibility of any changes. We use a consent form kindly given to us by the Brighton GP team which will be shared in the slide pack
- We discuss and offer referral to NHS assisted conception services for pre treatment gamete storage
- All patients are referred to an NHS GIC in order to fulfil the RCGP and GMC guidance but also to make sure they will have a widely recognised shared care agreement wherever they move to in the UK. This is also necessary for a Gender Recognition Certificate and for assessment of any surgical options

Masculinising Hormones

- Prescribed to people who are assigned female at birth who wish to develop masculine secondary sexual characteristics
- These patients mainly identify as a Trans Man or as Non-Binary
- There are no NICE guidelines for gender affirming hormones and so we use the Tavistock Guidelines which are the same as are used when a patient has been seen there and there is a shared care protocol in place
- We make sure patients are aware of the effects, benefits and risks of the medications used. At the Bridge prescriptions are issued as acute with sufficient supply until the next monitoring blood test and review is required

Tavistock Guidelines

- Available on the Tavistock website under shared care guidelines-easy to follow protocol!
- https://gic.nhs.uk/wp-content/uploads/2022/12/Shared-Care-Protocol-Trans-Masculine-v12.3_approved-22.12.2022.pdf
- First choice is short acting testosterone injectable as Sustanon (current shortage so use testosterone enentate)- can be taught to self administer (trough levels pre injection, peak levels 1 week afterwards)
- Second line testosterone gel (testosterone levels 4-6 hours after gel application)
- Third line longer acting testosterone Nebido-not suitable for self administration
- Starting dosage, dose range and levels to titrate to are all on the shared care protocol with very clear instructions
- Monitor for polycythaemia, liver dysfunction, lipid abnormalities and endometrial hyperplasia-again there are clear instructions on the shared care protocol. Acne is common and patients may need treatment as per the cis patient

- First line: Injectable Testosterone: Sustanon 250 mg (IM) 4 weekly. Testosterone Enantate can be seen as equivalent. Sustanon should not be used in clients with nut allergy
- Doses of short acting testosterone preparations at 250 mg 2-4 weekly are usually adequate to suppress menstruation, and the aim of therapy is to achieve trough testosterone levels at the bottom of the normal male range (10-12 nmol/l) on the day of the injection just before it is administered, and to achieve peak testosterone levels in the high normal male range (25-30 nmol/l) one week after the injection
- Monitoring should be performed in the steady state, at the time of the 4th injection. Both the trough and peak testosterone levels need to be measured
- Titration of the trough value is achieved by varying the length of time between the injections, by weekly intervals (2). Titration of the peak value is achieved by varying the dose administered with each injection, by 50 mg each time. Focus on the trough level first. If both trough and peak levels are too high it is best to adjust the dosing frequency first and then the dose

Monitoring requirements

- 3-6 monthly initially then annually once dosage stable
- FBC (watch HCT and if over 0.48 switch to transdermal testosterone or reduce dosage. If this doesn't bring it down refer to Haematology)
- LFTs-usually mild and significant changes are rare so consider other causes
- Lipids-Testosterone associated with increased trigs and reduced HDL-manage as you would a cis gender patient
- Endometrial lining-theoretical risk of endometrial hyperplasia so consider 2 yearly USS pelvis if patient agrees
- Testosterone aim for 15-20 nmol/l
- BP/BMI
- Testosterone can cause vaginal dryness and vaginal estrogen may be needed
- If amenorrhoea is not achieved by adequate testosterone levels then consider introduction of cyproterone orally or a GnRH analogue-usually decapeptyl IM

Feminising hormones

- Prescribed to people who are assigned male at birth who wish to develop feminine secondary sexual characteristics
- These patients mainly identify as a Trans Woman or as Non-Binary
- There are no NICE guidelines for gender affirming hormones and so we use the Tavistock Guidelines which are the same as are used when a patient has been seen there and there is a shared care protocol in place
- We make sure patients are aware of the effects, benefits and risks of the medications used.
- At the Bridge prescriptions are issued as acute with sufficient supply until the next monitoring blood test and review is undertaken

Feminising Hormones (2)

- Available on the Tavistock website under shared care guidelines-easy to follow protocol!
- https://gic.nhs.uk/wp-content/uploads/2022/12/Shared-Care-Protocol-Trans-Feminine-v10.3_approved-22.12.2022.pdf
- First choice on the website is oral estrogen but to reduce risk we offer Topical estrogen gel/patch as first line in most patients (as with HRT in cis woman at the peri-menopause)
- Starting dosage, dose range and levels to titrate to are all on the shared care protocol with clear instructions
- Main issues are an increase in thromboembolic risk and small increase in breast cancer risk. Smoking cessation/weight management and appropriate screening advice

Monitoring Requirements

- Prolactin-significant hyperprolactinaemia in up to 15% but very rare to have a prolactinoma-refer to endocrinology if prolactin more then 1000
- LFTs-rarely significant increases in LFTs
- Estradiol-aim for 400-600 pmol/l 48 hours after a patch applies or 4-6 hours post gel or 24 hours after oral estrogen
- Testosterone 0-3 nmol/l

- If testosterone is not adequately suppressed with optimised estrogen doses consider adding a GNRH analogue such as Leuproprelin (with 3 months of cyproterone to prevent testosterone surges) clearly explained on the shared care protocol

How can you help?

- Consider upskilling yourself so you are confident following shared care protocols and/or initiating Gender Affirming medication

- Signpost patients to The Bridge Clinic – you are welcome to sit in for training

- Further Training -
  - Read ‘Transgender Health’ A Practitioners Guide to Binary and Non-Binary Trans Patient Care
  - Review the Guidelines on the Tavistock Website and the Bridge consent forms in the slide pack
  - Attend the CliniQ conference on April 29 2023

Questions

If you have questions not answered today please feel free to email the Bridge clinic on ih.bridgeat southwark@nhs.net or rstephens1@nhs.net

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LGBTQ+ Sexual Health in Primary Care

Dr Max Kelen

GP in South London

Sexual Health Doctor at Camberwell Sexual Health Centre

Trans Health Doctor at CliniQ and Bridge Clinic

Sexual History

- Don’t assume a heteronormative or monogamous answer!

- Last sex? Casual or regular partner?
- Gender of partner(s)
- Type of sex – Anal? Top/bottom?
- Condoms? PrEP?

- Any immediate risks e.g. unprotected receptive anal intercourse in last 72h?

- If regular partner – any other partners?
- Number of partners in last 3m?
- Risky Sex – sex parties, Saunas/Sex on premises, Sex Work, chemsex, fisting

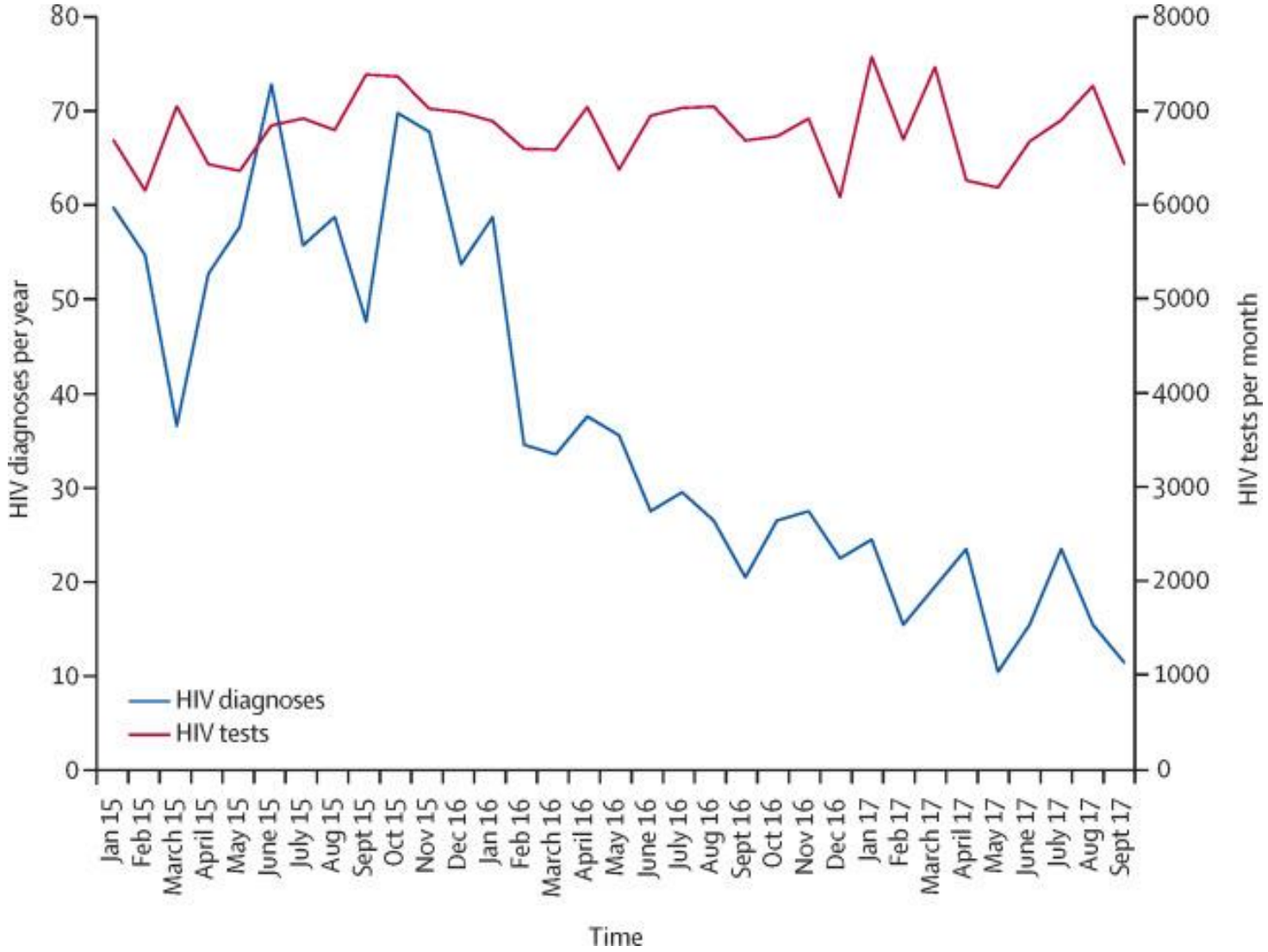
STI Screening

STI Screening

- CT/GC Swabs are for body parts, not genders
- Triple site sampling for MSM – Throat and rectal swabs, Urine Sample
- Base on sexual history for trans/NB patients
- Blood tests should include HIV, syphilis and consider Hep B/C serology
- Symptomatic patients should always be assessed at a Sexual Health clinic

HIV: U=U and TasP

- HIV is a treatable chronic illness with the same life expectancy as general population
- Most people take one pill per day
- Undetectable = Untransmittable
- If a person is on ARVs and their viral load is undetectable, they CANNOT transmit HIV to another person
- Treatment as Prevention


HIV diagnoses per year
HIV tests per month
HIV diagnoses
HIV tests
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PrEP and PEP

- Pre-exposure Prophylaxis
- Daily or Event Based Dosing
- Highly effective
- Minimal SEs or complications

- FREE ON NHS!!!

- Monitoring involves annual UPCR/renal profile and regular STI screening

- GP Role in increasing access!

https://prepster.info/

PEP

- Post-exposure Prophylaxis
- If sexual risk in last 72 hours
- Can access from A&E and STI Clinics
- https://www.bashhguidelines.org/media/1269/pep-2021.pdf
- On call HIV/GUM SPR

Section 4: Summary table on PEP eligibility

	Source HIV status			
	HIV positive		Unknown HIV status	
	HIV VL unknown / detectable	HIV VL undetectable	From high prevalence country / risk-group (e.g. MSM) [a]	From low prevalence country / group
SEXUAL EXPOSURES				
Receptive anal sex	Recommend	Not recommended [b]	Recommended	Not recommended
Insertive anal sex	Recommend	Not recommended [b]	Consider [c,d]	Not recommended
Receptive vaginal sex	Recommend	Not recommended [b]	Generally not recommended [c,d]	Not recommended
Insertive vaginal sex	Consider [c]	Not recommended	Generally not recommended [c,d]	Not recommended
Fellatio with ejaculation	Not recommended	Not recommended	Not recommended	Not recommended
Fellatio without ejaculation	Not recommended	Not recommended	Not recommended	Not recommended
Splash of semen into eye	Not recommended	Not recommended	Not recommended	Not recommended
Cunnilingus	Not recommended	Not recommended	Not recommended	Not recommended
OCCUPATIONAL AND OTHER EXPOSURES				
Sharing of injecting equipment	Recommended	Not recommended	Generally not recommended [e]	Not recommended
Sharps injury	Recommended	Not recommended	Generally not recommended [c,f]	Not recommended
Mucosal splash injury	Recommended	Not recommended	Generally not recommended [c]	Not recommended
Human bite	Generally not recommended [g]	Not recommended	Not recommended	Not recommended
Needlestick from a discarded needle in the community			Not recommended	Not recommended

Details of footnotes can be found in the full BASHH 2021 PEP guideline document online. https://www.bashh.org/guidelines

Chemsex

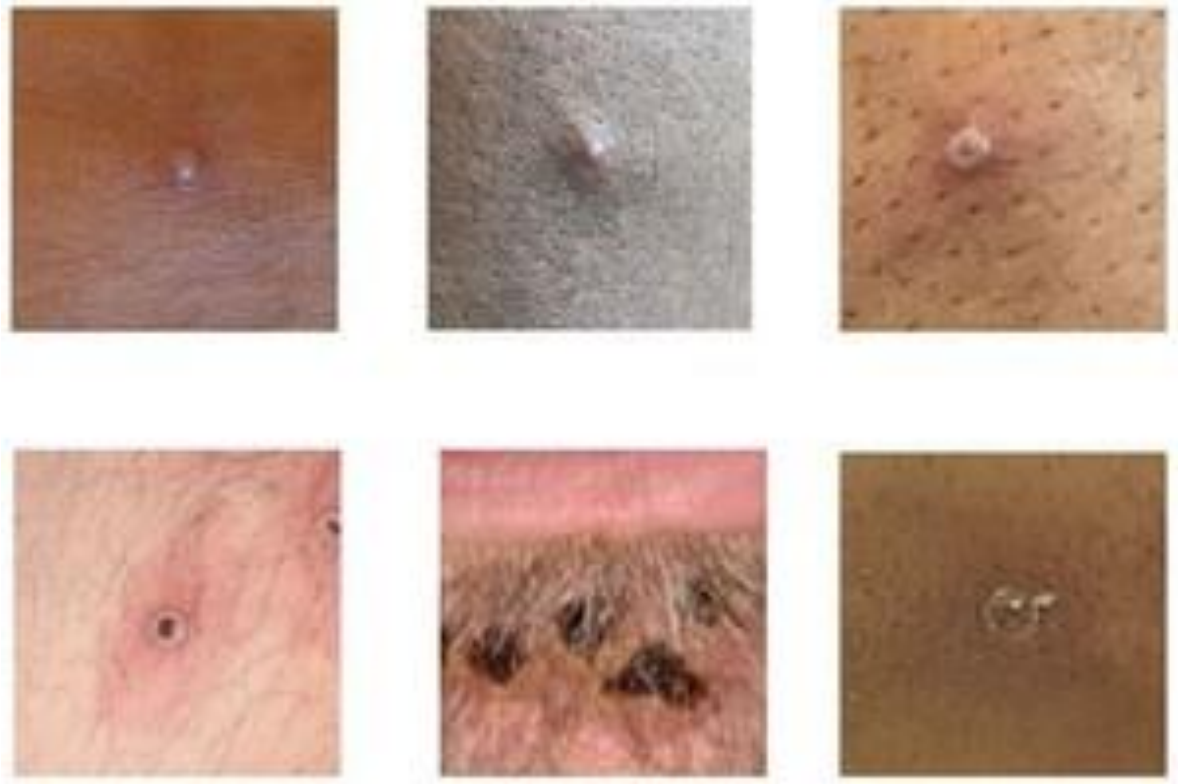
- Sex associated with certain drugs: GHB, Crystal Meth, Mephedrone
- Slamming = Injecting
- Associate with high risk of STIs, HIV transmission, sexual violence and dangerous substance misuse
- Harm reduction Strategies e.g. safe GHB dosing and needle exchange if ’slamming’
- **Axis Clinic @ Kings**
- https://www.kingshealthpartners.org/assets/000/001/754/AXIS_Poster_original.pdf?1516870186
- **Antidote/London Friend**
- https://londonfriend.org.uk/antidote/

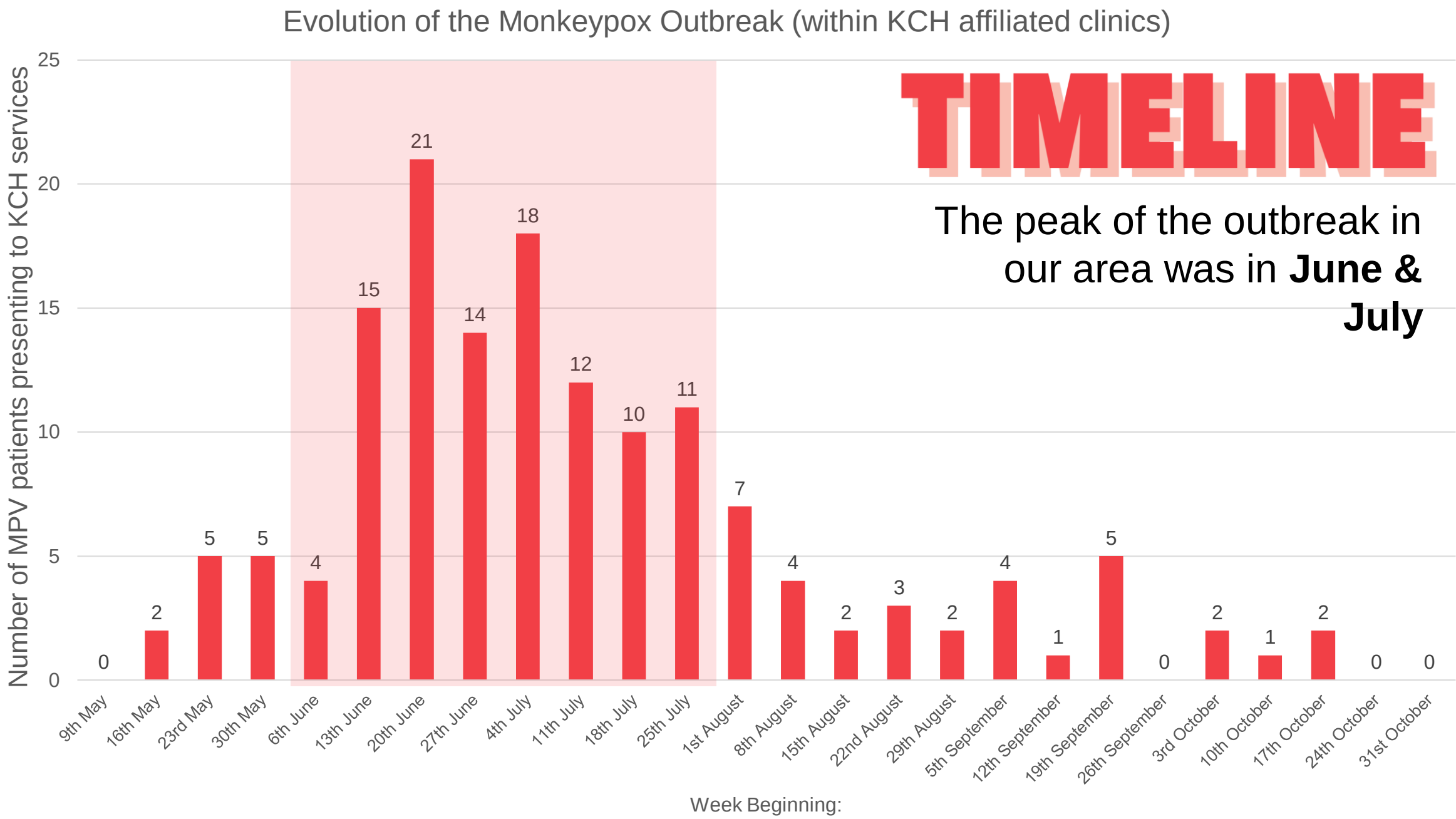
Vaccinations

- MSM and Trans Patients can get vaccinated at any Sexual Health Clinic for:
  - Hepatitis B
  - Hepatitis A
  - HPV
    - (protects against genital warts as well as anogenital/oropharyngeal cancers)
  - MPox

MPox

- Unexplained rash (usually genital) or proctitis
- Flu Like Symptoms
- High risk group (MSM)
- Most people isolated at home with a mild illness
- Hospital admissions were for pain, systemic complications or isolation




Evolution of the Monkeypox Outbreak (within KCH affiliated clinics)
Number of MPV patients presenting to KCH services
Week Beginning:
9th May
16th May
23rd May
30th May
6th June
13th June
20th June
27th June
4th July
11th July
18th July
25th July
1st August
8th August
15th August
22nd August
29th August
5th September
12th September
19th September
26th September
3rd October
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17th October
24th October
31st October
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TIMELINE
The peak of the outbreak in our area was in **June & July**

Contraception for Trans Masc

- If AFAB, Is there a pregnancy risk (i.e. penis in vagina sex)
- Testosterone is not contraceptive even if periods stop
- Testosterone highly teratogenic so contraception important
- Avoid Estrogen (i.e. combine hormonal contraception) as interacts with Testosterone, otherwise all contraceptives are fine to use
- Some e.g. POP, DMPA and IUS may be useful in inducing amenorrhoea

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LVNDR Health – Co-development of LGBTQ+ digital health services

Josh Wells (he/him) – Senior Clinical Lead

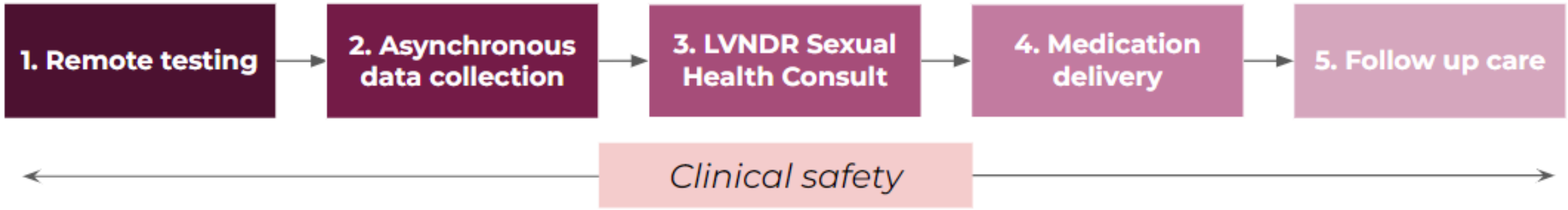
lvndr

South East London Integrated Care System

The LVNDR Clinic

NHS South East London

An accessible, patient-first experience that elevates sexual health and wellbeing



CareQuality Commission

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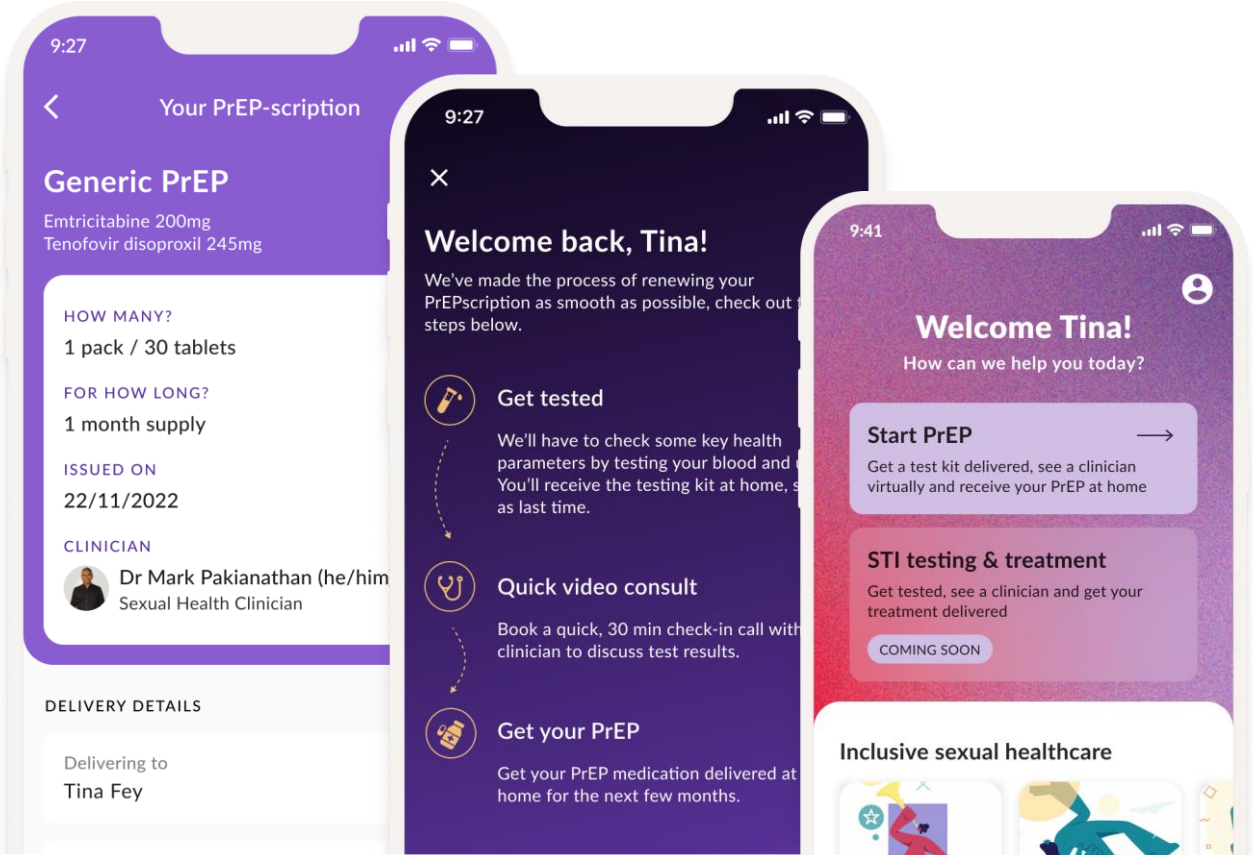
🏳️‍🌈 LVNDR Patient Mobile App

For Service Users

Inclusive, Holistic, & Personalised Care.

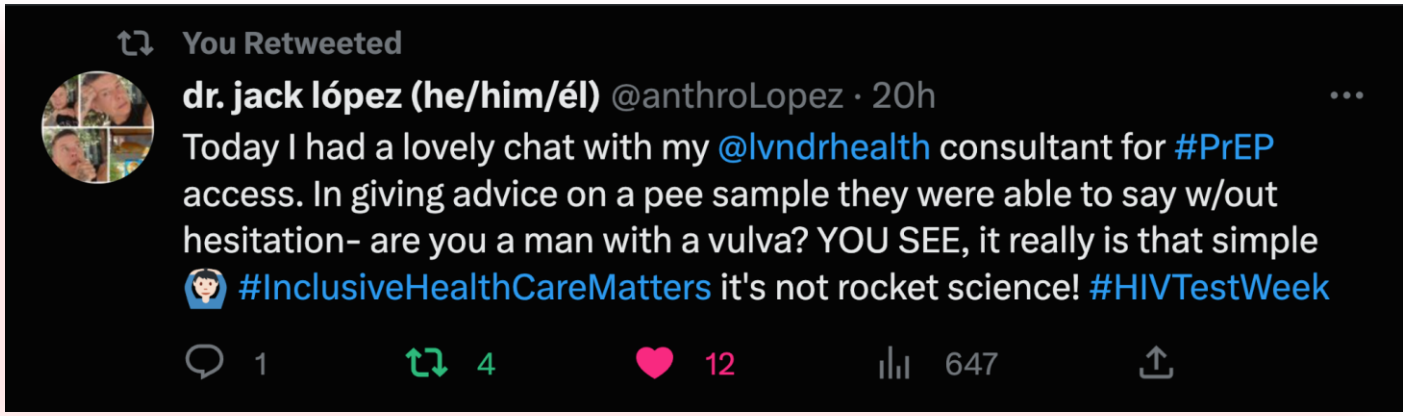
Service Offering Includes:

- 🧪 Remote testing
- 👩🏾‍⚕️ Video consultations with LGBTQ+ specialist clinicians
- 💊 Discreet medication delivery



Patient Love

LVNDR Health
@lvndrhealth



South East London Integrated Care System

NHS South East London

🏳️‍🌈 LVNDR Clinician Dashboard

New Safeguarding Alert created
Immediate Action
Dr Mark Pakianathan
22 Jul 2022 at 10:01

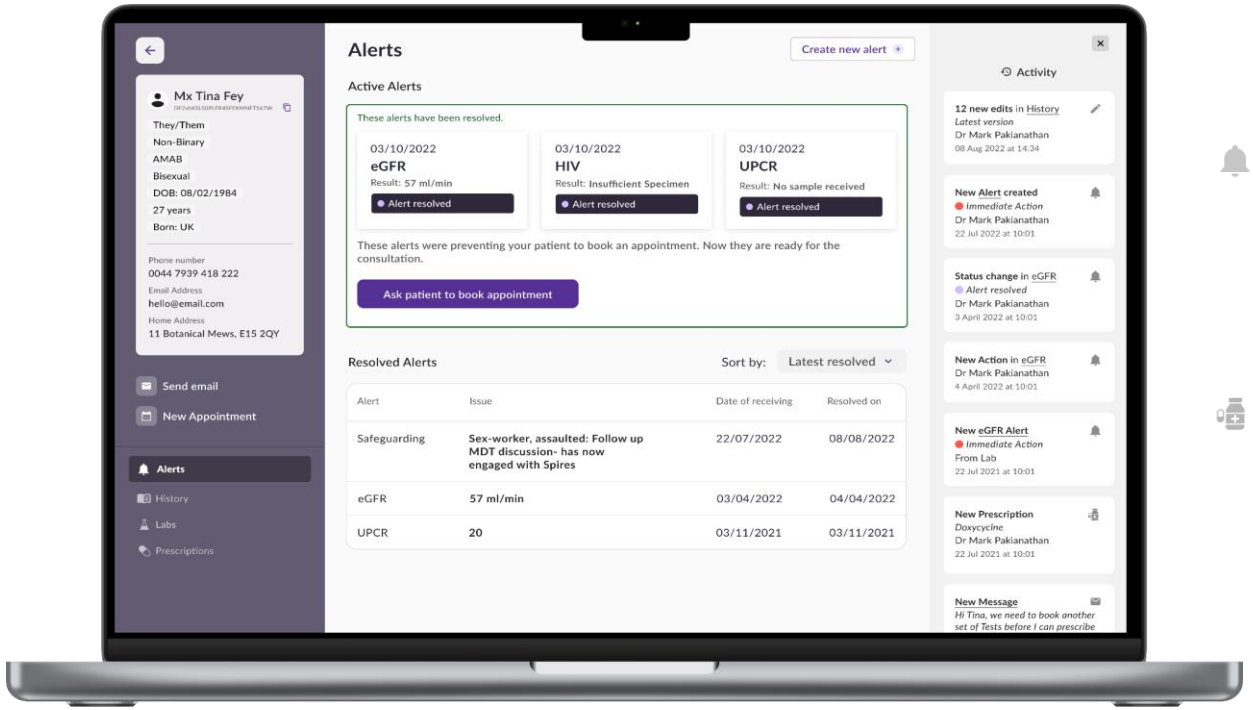
For Clinicians & Care Providers

Comprehensive, Seamless, & Effective Care.

Status change in eGFR
Alert resolved
Dr Mark Pakianathan

Service Offering Includes:

- 📝 Asynchronous medical and sexual history
- 💪 Automated clinical efficacy and safety support functions for testing, prescribing, and monitoring
- 🔍 GUMCADv3 reporting capability
- 📊 Longitudinal population health assessment



✨ LVNDR Service Outcomes

We have a 100 NPS Score from all SUs/patients.

Metrics	Value to Patient and Health Partners
NPS Score (/100)	100
Customer Satisfaction (/5)	4.8 vs Standard Care 3.0
System Usability Scale Score (/100)	85 vs average 68
Likelihood of Switching to LVNDR if publicly available (/5)	4.8

** Net promoter score (NPS) is a widely used market research metric of customer loyalty and is predictive of business growth.*
*** The System Usability Scale (SUS) is an industry standard tool - reliable for measuring the usability of digital products. (Target >68)*

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lvndr

Reimaging Holistic LGBTQ+ Health

Southwark Council

Let's make a difference together

Digital Health London

sifted / backed by FT FINANCIAL TIMES

THE TIMES

Forbes

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