The Elton John AIDS Foundation

'Zero HIV' Social Impact Bond

Final report on investment, implementation, and impact

SIB active: November 2018-December 2021

Report published: March 2022

In partnership with:

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Executive Summary

The EJAF Zero HIV SIB was developed from a series of conversations from 2015 onwards between EJAF, public health and commissioning teams in Lambeth, Southwark and Lewisham, and NHS England, who were looking for a new way to tackle the plateauing of HIV diagnoses. Following an ethnographic study, universal HIV testing was identified as the most effective way to increase HIV testing and the identification of people living with HIV. A Social Impact Bond methodology was chosen to bring new money into the sector and foster innovation, and investors Comic Relief, Big Issue Invest, Viiv Healthcare Ltd and EJAF agreed to support the SIB, which benefitted from a generous grant from the National Lottery Community Fund.

When the Zero HIV SIB launched in Nov 2018, providers were paid on an outcomes-basis for every person linked or reengaged into HIV care. Three hospital Trusts, Kings College Hospital NHS Foundation Trust, Lewisham and Greenwich NHS Trust and Guys and St Thomas NHS Foundation Trust, four GP federations, and six community organisations were contracted to deliver outcomes. By the project's close in Dec 2021, 465 people were linked to care. 209 of these were newly diagnosed with HIV, and 256 had stopped HIV treatment. There were many challenges to implementation, including the impact of COVID-19 on staffing capacity and venues, HIV stigma, lack of knowledge of HIV outside the specialist teams and the many other competing priorities. These challenges were to some extent mitigated by the incentive of the outcomes payments which allowed time to be dedicated to HIV testing or audit and recall work, HIV specialists working to educate and encourage clinical colleagues in good HIV practice, and the increase in communication between primary, secondary and community sectors to improve patient care.

The learning from the SIB has been used to influence government policy, informing the HIV Action Plan, and has been used to inform commissioning. Learning has also been disseminated through written evidence submissions, social media and through conference presentation.

Background

The UK has exceeded the UNAIDS 95-95-95 targets, with 95% of people living with HIV aware of their diagnosis, 99% of these taking treatment, and 97% of these having an undetectable viral load. Although this is a significant achievement, approximately 5,150 people living with HIV in the UK remain undiagnosed[1] , who are therefore unable to access HIV care and are at risk of late diagnosis and potentially transmitting HIV to others.

In 2015, Anne Aslett, our CEO, started talking to NHS clinical colleagues and interested people from Lambeth council and NHS England who were looking at how we might tackle the seemingly intractable problem of continued rates of undiagnosed, and late diagnosed, HIV. The Social Impact Bond (SIB) offered a chance to reach those undiagnosed and late diagnosed individuals by uniting siloed parts of the health system together with the shared goal of bringing people into HIV care. It also brought badly needed new funds by incentivising outcomes yet was flexible enough to try out new approaches with very little risk.

An ethnographic study was commissioned to understand the issues involved from the perspective of commissioners, providers and people living with HIV. It concluded that the biggest impact on untreated HIV would be made through universal HIV testing in Emergency Departments. The Foundation commissioned pilot HIV testing studies at Kings College Hospital Emergency Department (ED) and with Leeds GP practices, with HIV Testing guidance documents from NICE (2016) and BHIVA/BASHH/BIA used to develop good practice.

The Foundation brought both profile as a global organisation with an established record of HIV funding and initiatives, and the reputation of Elton John as an influencer. Having disbursed grant funding to over 3,000 projects across four continents, the Foundation was also driven by the desire to explore social impact investing as an alternative support mechanism that could expand philanthropy and be replicated across other countries; to learn for future SIB models about the impact of this novel funding approach for HIV care, and how a SIB could inform the discussion about invest to save models in HIV prevention, treatment and retention.

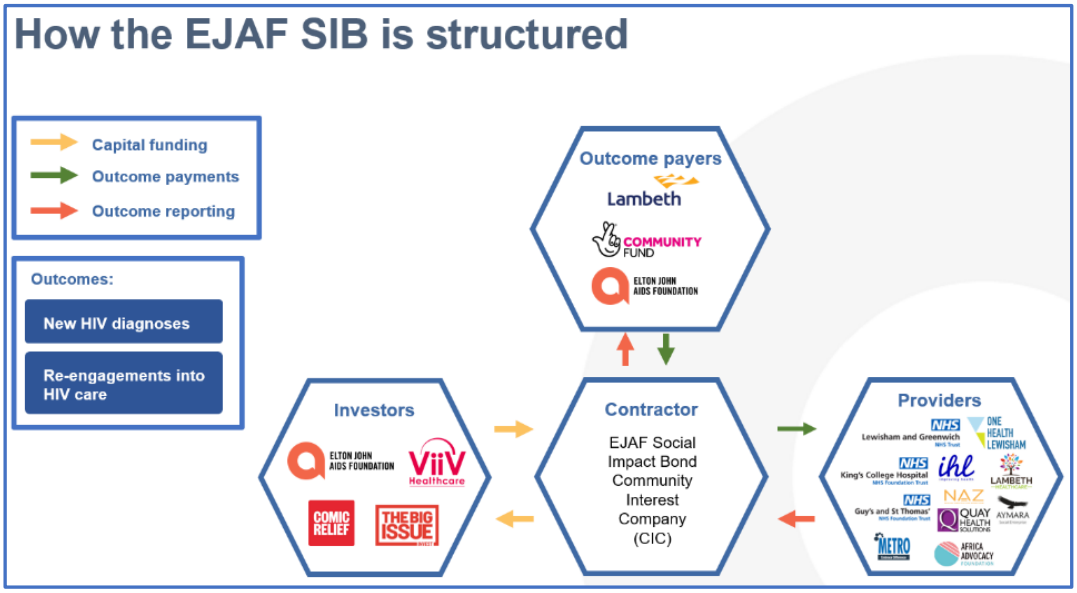
The partnership brought together EJAF and the HIV and sexual health expertise of LB Lambeth, the public health and commissioning teams in London boroughs of Lambeth, Southwark and Lewisham, clinical commissioning groups, the commitment of NHS E/I London region, SIB Project Advisory Board, people living with HIV, the community sector, professional associations such as BHIVA/BASHH and the social impact expertise provided by Social Finance and the Community Interest Company (CIC) Board members. The SIB coincided with a successful opportunity to seek funding from the Commissioning Better Outcomes programme of the National Lottery Community Fund.

The benefits of the SIB included bringing in new investment to the SE London HIV sector, with commissioners only paying for successful outcomes. The funding method also gave incentives for providers to innovate. It enabled the gathering of demonstrable evidence of effectiveness of HIV testing and reengagement work. It brought fragmented and overlapping initiatives by different organisations together in one, coherent and targeted framework, paying for outcomes across providers, thus resolving the disconnection and disincentive between where resources were spent (LAs) and where benefits accrued (NHS).

[1] HIV testing, new HIV diagnoses, outcomes and quality of care for people accessing HIV services: 2021 Report, 1st December 2021 UK HSA

Structure of the Social Impact Bond

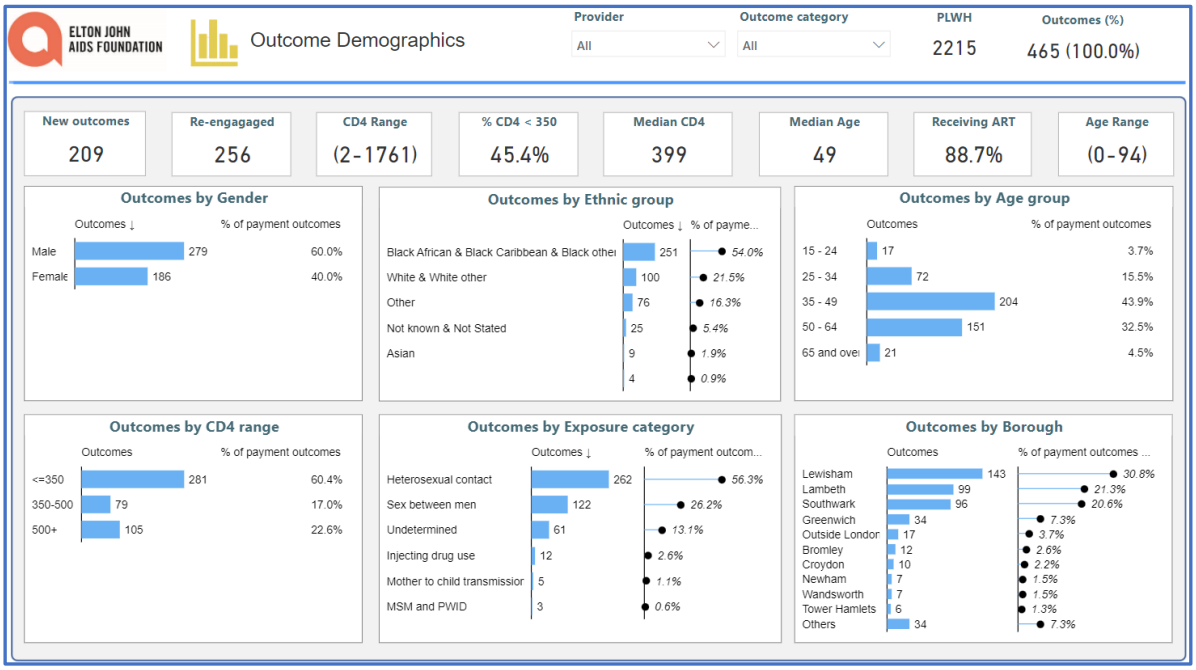
The original concept had been to seek funding for the outcome payments from a combination of NHS England, local authority public health department budgets and clinical commissioning groups. Sadly, their budgets did not allow for support, except for LB Lambeth, who agreed to both act as commissioner, and make a small contribution to the outcomes budget. To ensure that the SIB was able to proceed, the Foundation agreed to be both an investor and an outcomes payer, which is very unusual for a SIB. It was done on the agreement that if sufficiently compelling evidence was found, other organisations would seriously consider commissioning the interventions in future years.



Interventions' Implementation and Impact

Overview

Interventions spanned hospital, primary care, and community settings. By the Social Impact Bond's culmination in December 2022, more than 460 people had been linked to care across all channels. The following set of tables shares aggregated demographic information, which communicates that the SIB was effective in reaching populations frequently missed through previously existing diagnosis and care engagement methods. The sections that follow describe the implementation, learnings, and impact of each distinct intervention type.



HIV diagnosis in Emergency Department

BHIVA/BASHH/BIA HIV testing guidance (2020)[2] recommend HIV testing for everyone undergoing blood tests in EDs where local prevalence exceeds 2 per 1,000, as per NICE guidance (2016), however this is not universally funded or implemented.

The SIB contracted with King's College Hospital (KCH) and University Hospital Lewisham (UHL) to make payments for each person newly diagnosed in their EDs with HIV and linked to care. In the tables below the costs to engage/reengage though each route is shown. To put this in context, avoiding one new HIV transmission has variously been costed as saving between £73,000 - £404,000.[3]

Results:

Table 1: ED HIV Testing			
128 people newly diagnosed	73% had a CD4 count of less than 350	70%+ of people who had blood drawn received an HIV test	Black African, Black Caribbean, Black Other community members 55% of all new diagnoses. People aged 50+ 40% of all new diagnoses.
Average cost to identify someone living with HIV through ED HIV testing: £5,200 - £6,300.			

Challenges

- Staffing capacity constraints due to COVID-19. However, both EDs were able to continue testing and find newly diagnosed people.

[2] BHIVA/BASHH/BIA Adult HIV Testing Guidelines 2020

[3] How much does HIV treatment cost the NHS? | aidsmap

- The level of confidence of ED staff in having discussions with patients and the need for support from HIV specialists to reinforce the practice and answer questions.
- The financial resource to undertake the HIV tests and laboratory capacity to process.
- The pressure of competing ED priorities.
- If a patient is hard to bleed then potentially ED staff only will have enough sample for Full Blood Count and Liver, Renal and CRP tests.

Learning

- ED HIV testing makes the most of every patient contact, identifies people who may not otherwise be tested for HIV, and should be considered part of a routine blood set, normalising it as part of the patient pathway, thus easing professionals' concerns that they may appear to inadvertently stereotype patients, and individuals do not feel singled out.
- It is crucial that the HIV service have complete governance over the response to people who have reactive tests.
- Creating HIV testing champions to give regular updates, training and support to ED staff with HIV testing, improves uptake and engagement and retention in care after a positive result.
- ED HIV testing appears to be effective at addressing health inequalities by reaching black and minority ethnic groups who may be disproportionately affected by stigma, with Black African, Black Caribbean and Black Other community members accounting for 55% of all new HIV diagnoses identified by ED testing. This proportion is larger than that of the newly diagnosed population in London (31%) and in the UK (30%), as reported in Public Health England's 'Spotlight on London' (2018) (8) and UKHSA's 2021 data tables (9) respectively.
- There is a strong correlation with those found through ED HIV testing and those living in areas of multiple deprivation, with over 60% living on the lowest three deciles of the IMD, confirming that ED HIV testing will reduce health inequalities.
- Traditionally, opt out testing was carried out with verbal consent. Although this approach provides confidence that consent is voluntary, uptake has been shown to be poor (6). KCH used 'notional consent' in place of verbal consent. Information regarding ED HIV testing and how to opt out was displayed via banners, posters and leaflets, and translated into other languages. This improves HIV testing uptake, normalises the process and reduces the risk of missed opportunities. UHL verbally checked whether the person wanted to opt out. There was little difference between the rates of refusal, which were small in both EDs.

HIV diagnosis in Primary Care

Like the recommendations in Emergency Department, NICE (2016) guidelines recommend HIV testing at GP surgeries located in areas of high prevalence. The guidelines suggest that testing occur at new patient registration, as well as be offered whenever a patient is undergoing blood tests and has not had a previous HIV test in the past year.

Accordingly, we contracted with four GP federations, Lambeth Health Ltd and One Health Lewisham, and then Quay Health Solutions and Improving Health Ltd.

Results

Table 2: Primary Care HIV Testing			
39 people newly diagnosed	60% had a CD4 count of less than 350	62,156 HIV tests were undertaken	Black African, Black Caribbean, Black Other community members 70% of all new diagnoses. People aged 50+ 40% of all new diagnoses.
Average cost to identify someone living with HIV through primary care HIV testing is under £10,000.			

Challenges

- Some GPs felt reluctant to engage in discussions with sexual health implications, especially with those patients they may have known for a long time.
- Some GPs felt they lacked the knowledge to have discussions.
- GPs work within a framework of a ten-minute consultation time, and some were concerned that discussing HIV testing with a patient would be too time consuming.

Learning

- Primary Care HIV testing is very effective at addressing health inequalities through reaching people currently not engaged by services where HIV testing occurs, or who might not take a HIV test because of stigma, such as Black African, Black Caribbean and Black Other community members, who were 70% of all new HIV diagnoses. This figure is higher than the SIB's ED HIV testing (55%), and greatly exceeds the percentages of this community newly diagnosed in either Public Health England's 'Spotlight on London' (2018) figures at 31%, or UKHSA's (2021) national figure of 30%.
- Effective methods include incorporating HIV testing into the new patient registration process, into NHS Health Checks, whenever blood is taken.
- Nearly 50% of people newly diagnosed (16/34) were found through opportunistic HIV testing, including testing at routine health checks and new patient registrations, with the others found by HIV tests undertaken because of clinical indications.
- The provision of HIV stigma training, such as the LGBT Foundation's 'Pride in Practice' or Sexual Health in Practice (SHIP) training, plays an important part in ensuring that people living with HIV are comfortable in engaging with primary care. People diagnosed with HIV in ED often had previous multiple encounters with primary care. In a sample of 24 patients diagnosed with HIV at UHL ED, 17 had seen a GP within the previous two years, with a total of 32 attendance of HIV indicator diseases or seroconversion symptoms, 100 blood tests were ordered, but only 3 HIV tests offered. These 'missed opportunities' for HIV testing are detrimental to patient care and cost the NHS far more as patients are diagnosed late.

HIV diagnosis in Community Settings

Community organizations presented another opportunity to reach people who generally found it difficult to access HIV testing. The SIB contracted with two community organisations in June 2019, Naz Project London and Metro Centre Ltd, on behalf of the GMI Partnership comprising Metro, Positive East and Spectra. In October 2020, we brought on African Advocacy Foundation, and in early 2021, Aymara Social Enterprises.

Results

Table 3: VCSE organisations HIV Testing			
46 people newly diagnosed	60% had a CD4 count of less than 350	5,000+ HIV tests were undertaken	Latin American community members 60% of all new diagnoses. Black African and Black Caribbean people (15%), gay, bisexual and other men who have sex with men (58%), heterosexuals (38%).
Average cost to identify someone living with HIV through VCSE HIV testing is under £10,000.			

Challenges

- The impact of COVID-19 greatly reduced the community sector's ability to engage with communities through their usual venues in the high street via testing buses, barbershops, salons, bars, clubs, saunas, and cafes.
- Attempts to move their testing services online met with relatively little success.

Learning

- VCSEs tested people who did not speak English as their native language, recent migrants who did not understand the UK healthcare system, and people who were reluctant to access clinical services in hospitals.
- Some people were resistant to confirming their reactive results, due to HIV stigma, shock at diagnosis, or other priorities including work, childcare, money concerns, and language.
- Community based support to help access confirmatory results in clinical settings was vital, including language translation, access to peer support, benefits/money advice, and explaining complex medical information.
- HIV Care re-engagement in Hospital Emergency Departments

As well as identifying new HIV diagnoses, testing in ED and primary care proved important in identifying people living with HIV lost to care and supporting them back into treatment. Some people would have been identified as living with HIV through the nature of their presenting condition, although others seen for unrelated conditions would not have been found until presenting with an AIDS defining illness.

Results

Table 4: ED HIV testing as a means for reengagement		
53 people reengaged	81% had a CD4 count of less than 350	
Average cost to reengage someone living with HIV through ED HIV testing is under £10,000.		

HIV Care re-engagement in Hospital Clinics

Another opportunity arose to audit people disengaged from care for more than twelve months, then contact those for whom details were available. UHL started LTFU work in October 2018, with KCH and Guys and St Thomas' starting in June and July 2019 respectively.

Table 5: HIV clinic audit and recall as a means for reengagement		
153 people reengaged	63% had a CD4 count of less than 350	
Average cost to re-engage someone living with HIV through HIV clinic audit is under £3,000.		

HIV Care re-engagement in Primary Care

Different federations employed different methods. One federation had a person in the management team contact people who had disengaged, whilst others filtered the HARS list and then contacted the individual surgery to engage the person. Response rates were broadly similar for each method. This intervention is not currently commissioned within existing contracts.

Table 6: Primary care audit and recall as a means for reengagement		
45 people reengaged	51% had a CD4 count of less than 350	
Average cost to re-engage someone living with HIV through primary care audit was under £10,000.		

HIV Care re-engagement in Community Settings

VCSE organisations influenced people to reengage through their role as trusted contacts.

Table 7: VCSE organisations as a means for reengagement		
5 people reengaged	40% had a CD4 count of less than 350	
Average cost to re-engage someone living with HIV through primary care audit was under £10,000.		

Challenges

- Whilst things have improved since Jose et al's 2018 study[4] showing that 19% of people became LTFU within ten years of diagnosis, there remains a significant need to reengage/link the 7,250 people living with HIV but not in treatment.
- Reasons for disengagement included fear of HIV stigma and very challenging lives.
- Some commissioners had a perception that this activity was already funded through HIV clinic contracts, but the reality is that HIV staff capacity within SIB providers did not allow sufficient resource for this time-consuming intervention, nor was it included in job plans.

[4] Jose et al 2018, Lancet ID 'A continuum of HIV care describing mortality and loss to follow-up- a longitudinal cohort study'

Learning

- In many cases people required intensive repeated contact to establish a rapport, needing support such as food or travel vouchers, and potentially meeting in a community HIV clinic to avoid the possibility of being recognised.
- Clinic audit and recall required dedicated resources, with the activity included in job plans.
- The VCSE group had a median CD4 count of 437 suggesting that even this group, with the highest median CD4 count of all reengagement methods, was still at serious risk of developing AIDS defining illnesses.
- Some people refused to be re- engaged, citing fears of HIV stigma in their community, or denial of their status.

Financing and Investment Management

Payment by outcomes model

Outcome based payments focus providers' attention on achieving specific outcomes and can be useful when targeting hard to reach groups. 'Fee for service' commissioning arrangements do not fully incentivise providers on reaching those people who are hardest to engage and may not include funding to support people to engage with their first treatment. Including the requirement for the person to be linked to care to get an outcome payment is a strong incentive for providers to remove any barriers that may impede people starting their treatment.

LB Lambeth made total outcome payments to the CIC of just under £3.7m. LB Lambeth made an annual £50k contribution (amounting to £150k over three years) to this total, with the balance being reimbursed to them by EJAF. EJAF were in turn supported by The National Lottery Community Fund, who funded over £1.1m from their *Commissioning Better Outcomes* programme.

The investors were Viiv Healthcare UK Ltd, Comic Relief, Big Issue Invest Ltd and the Foundation, who between them made £1m of loan investment. All this investment was drawn down into the CIC. The staggered nature of the start of the SIB meant that the cashflow requirement was not as large as if all providers started at the same time, meaning less than half of the investment was used. Investors were paid back in advance of the deadline, and interest payments made where applicable

Service provider payments

The contracting phase was very time intensive, partly due to the variety of contracts to be negotiated. These included the LB Lambeth commissioning contract between the CIC and LB Lambeth, the funding agreement between EJAF and LB Lambeth, the funding agreement between The National Lottery Community Fund and EJAF, and contracts between the CIC and the providers, many of which were extended.

Significant time was spent with NHS trust data protection teams agreeing appropriate data protection security was in place. Maclaren Consulting was key to persuading the Trusts that the information was anonymised to an appropriate level. Other organisations were confident that if the data protection system had passed the trusts' scrutiny then it was of high standard.

Zero HIV SIB Provider operational start date														
Provider	Oct-18	Jan-19	Apr-19	Jul-19	Oct-19	Jan-20	Apr-20	Jul-20	Oct-20	Jan-21	Apr-21	Jul-21	Oct-21	Dec-21
University Hospital Lewisham (ED and lost to follow up)	Oct-18													
Kings College Hospital (ED)*	Nov-18													
Kings College Hospital (Lost to follow up)								Jul-20						
St Thomas' Hospital (Lost to follow up)							Jun-20							
Lambeth Health Ltd (Lambeth GP Federation)			Jun-19											
One Health Lewisham (Lewisham GP Federation)			Jun-19											
Improving Health Ltd (South Southwark GP Federation)								Sep-20						
Quay Health Services (North Southwark GP Federation)								Sep-20						
Naz Project London			Jun-19											
Metro Centre Ltd (on behalf of GMI Partnership)			Jun-19											
African Advocay Foundation									Oct-20					
Aymara Social Enterprises												Apr-21		
* EJAF funded a pilot of ED testing at KCH in 2016, which was kept going by KCH through restricted funds, but would have ended by start of SIB if no new funding source found.														

Figure 1: Provider Operational start date

Upfront payments were given to all service providers when they began providing services with the Social Impact Bond. This was done with the understanding that the funds would be used to cover costs until payment outcomes had been achieved. When outcomes were achieved, additional payments were not made until total outcomes exceeded the upfront payment amount. Advance payments given to providers by the CIC for anticipated outcomes were largely achieved, with only one GP Federation and one community-based organization missing their targets by one outcome each. This inability to meet prepayment targets was attributed to the lack of face-to-face interactions during the COVID-19 pandemic.

The legal transactional costs are estimated to have been more than £500,000, donated through the generous probono support offered by Freshfields Bruckhaus Deringer LLP.

Contractual continuity amidst COVID-19

The National Lottery Community Fund asked ATQ to undertake an assessment of the impact of COVID-19. The study found that there were no changes to contracts required, that community organisations were particularly affected as the venues for engagement were shut, leading to one delaying renewing the contract. COVID-19 made relatively little impact on ED HIV testing and reengagement, although slightly reducing primary care outcomes. The HIV clinic reengagement activity started during COVID-19 and in some ways replaced outcomes lost to COVID-19.

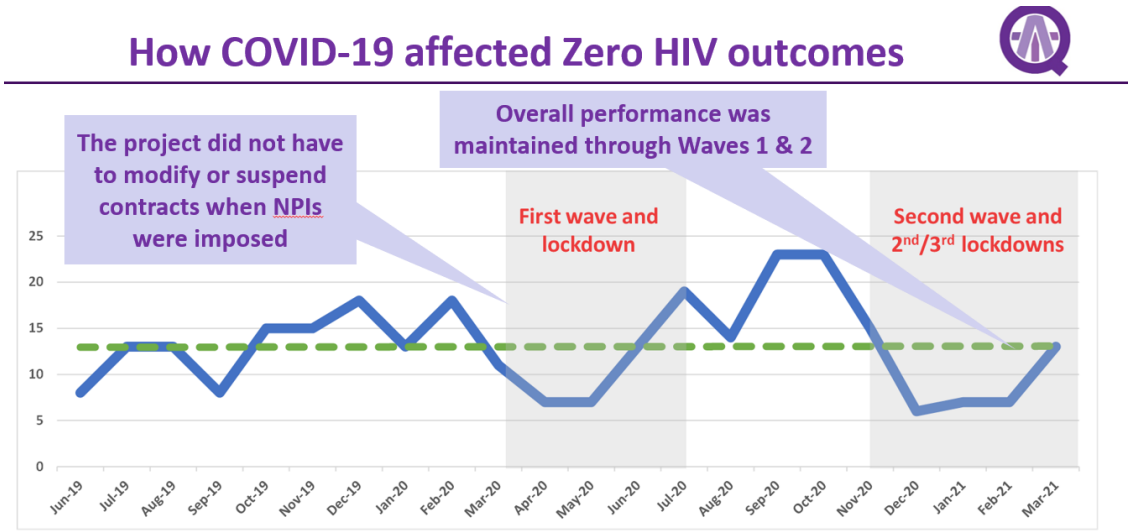


Figure 2: Impact of COVID-19 on outcomes (courtesy of ATQ)

(see Zero HIV SIB Impact of COVID-19 National Lottery Community Fund report).

Long-term healthcare costs avoided

As part of the preparatory work for the SIB, estimates were made of the possible range of costs savings, based on studies of the lifetime costs of someone living with HIV and the possible rates of avoided HIV transmission, focusing on Black African communities and men who have sex with men groups. These estimates were updated following a workshop in 2020, with the revised figure being £220,000 per person linked to care. This would mean that based on 465 people being linked to care, the SIB programme avoided costs to the healthcare system in excess of £90m.

The SIB did not use a counterfactual methodology, which meant that there would be some difficulty in establishing for some interventions what might have happened had the SIB not been in place, such as HIV testing in primary care. In practice, the impact of PrEP during the SIB's operational period, COVID-19 and the declining pool of undiagnosed as the work progressed, meant that this would not have been a reliable measure of the SIB's impact.

There were difficulties in accessing data and costs from other sources for comparative purposes, largely due to either contract confidentiality clauses or the requirement to not release information before conference presentation or publication in journals. This is unhelpful, and a potential solution may be to create a London shared data building on a platform such as Fingertips.

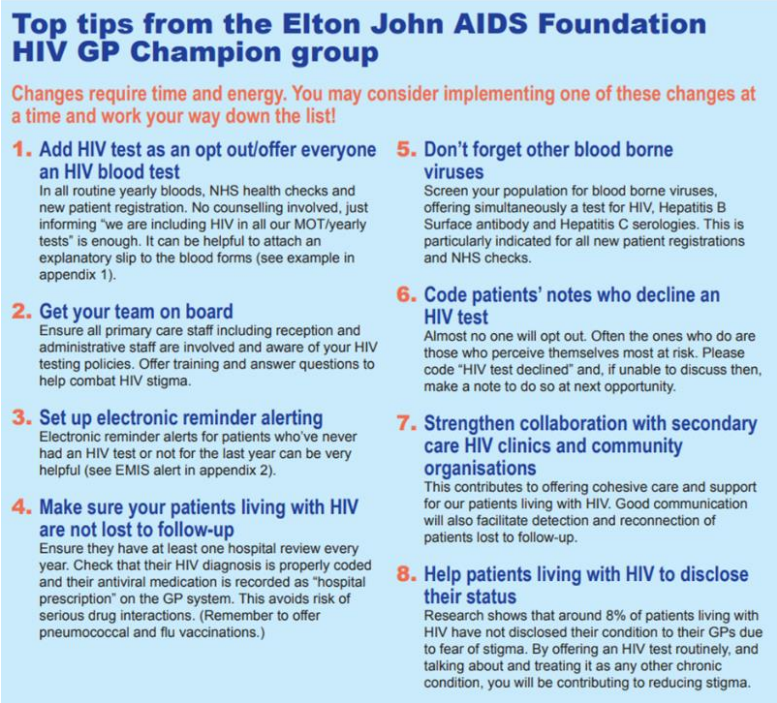
Clinician Behaviour Change

The importance of clinician and staff behaviour change is frequently overlooked in health system improvements. Within the SIB, behaviour change was an important element for ED nurses maintaining high levels of HIV testing, for GPs, practice nurses and health care assistants undertaking opportunistic HIV testing in practices, and community organisation staff supporting during the 'handholding' period between reactive test and first HIV clinic appointment. ED nurses were greatly supported by HIV clinic nurses spending time in ED, training about HIV, and acting as a support.

Changing clinical behaviour requires a focussed approach of leadership, knowledge acquisition, peer support and highlighting successes. Visible commitment by senior consultants and nursing leaders to opt out HIV testing is crucial, as is offering training with methods most likely to have an impact. These include short sessions that count to Continued Professional Development accreditation for GPs that can be accessed at lunchtime through online learning, peer support through HIV specialists to inform the practice of ED staff, or HIV GP Champions who work to influence the practice of peers and share tools/templates/IT developments that make it easier for others to change behaviours.

HIV clinical leadership within primary care is vital to enhance the collaboration across the patient pathway, and to offer support and guidance to those practices wishing to optimise their HIV testing and patient care. The CIC recruited six HIV GP Champions on one session a month whose role was to improve communication, share learning, and improve HIV practice across primary care. They improved communication between primary and secondary care through establishing a group with HIV clinic consultants to discuss quality improvements, shared GP registration pathways for vulnerable patients with secondary care, strengthened relationships with the HIV Community CNS team and supporting charities, and linked with asylum seeker hotels for HIV testing as part of health screening. They improved systems through sharing an electronic prompt that indicates when someone may benefit from an HIV test.

They undertook education activity, promoted National HIV Testing Week, delivered lunchtime HIV training sessions, and gave HIV sessions to over one hundred trainee GPS to enthuse them about good practice. The HIV GP Champions worked with HIV Prevention England to develop practical guidance for implementing HIV testing and reengagement[5].



Top tips from the Elton John AIDS Foundation HIV GP Champion group

Changes require time and energy. You may consider implementing one of these changes at a time and work your way down the list!

1. **Add HIV test as an opt out/offer everyone an HIV blood test**
   In all routine yearly bloods, NHS health checks and new patient registration. No counselling involved, just informing "we are including HIV in all our MOT/yearly tests" is enough. It can be helpful to attach an explanatory slip to the blood forms (see example in appendix 1).
2. **Get your team on board**
   Ensure all primary care staff including reception and administrative staff are involved and aware of your HIV testing policies. Offer training and answer questions to help combat HIV stigma.
3. **Set up electronic reminder alerting**
   Electronic reminder alerts for patients who've never had an HIV test or not for the last year can be very helpful (see EMIS alert in appendix 2).
4. **Make sure your patients living with HIV are not lost to follow-up**
   Ensure they have at least one hospital review every year. Check that their HIV diagnosis is properly coded and their antiviral medication is recorded as "hospital prescription" on the GP system. This avoids risk of serious drug interactions. (Remember to offer pneumococcal and flu vaccinations.)
5. **Don't forget other blood borne viruses**
   Screen your population for blood borne viruses, offering simultaneously a test for HIV, Hepatitis B Surface antibody and Hepatitis C serologies. This is particularly indicated for all new patient registrations and NHS checks.
6. **Code patients' notes who decline an HIV test**
   Almost no one will opt out. Often the ones who do are those who perceive themselves most at risk. Please code "HIV test declined" and, if unable to discuss then, make a note to do so at next opportunity.
7. **Strengthen collaboration with secondary care HIV clinics and community organisations**
   This contributes to offering cohesive care and support for our patients living with HIV. Good communication will also facilitate detection and reconnection of patients lost to follow-up.
8. **Help patients living with HIV to disclose their status**
   Research shows that around 8% of patients living with HIV have not disclosed their condition to their GPs due to fear of stigma. By offering an HIV test routinely, and talking about and treating it as any other chronic condition, you will be contributing to reducing stigma.

Policy Influence and Commissioning Change

A key element of the SIB was to develop compelling evidence and to leverage that into effective change. This was enhanced through influencing partnerships with Terrence Higgins Trust and National AIDS Trust.

The HIV Commission

The HIV Commission was created by the Terrence Higgins Trust, National AIDS Trust, and our Foundation as an independent body to find the path to ending new HIV transmissions and HIV-attributed deaths in England by 2030. They explored the issues, considered written contributions, and visited local HIV clinics, sexual health and support services, and public meetings. Our Foundation submitted evidence about HIV testing and reengagement, which formed the basis for the Commission Report's emphasis on 'test, test, test', published in December 2020. It made 20 recommendations, and three key priorities:

- England should take the necessary steps to be the first country to end new HIV transmissions by 2030, with an 80% reduction by 2025.
- Government must drive and be accountable for reaching this goal through publishing a national HIV Action Plan in 2021.
- HIV testing must become routine – opt-out, not opt-in, across the health service.

(See HIV Commission Report and Recommendations).

[5] HPE Practical Guidance for implementing HIV testing and reengagement in primary care

Submissions to All Party Parliamentary Group on HIV/AIDS

We provided evidence as part of joint submissions with THT and NAT to two APPG inquiries. We focussed on the themes of ED and primary care testing reaching those communities who would not normally come into contact with HIV testing, the importance of the community sector in reaching those who are particularly vulnerable, and the ways to offer support to those lost to follow up so that they will reengage.

See APPG submission on HIV testing and APPG submission on Impact of HIV on BAME communities .

HIV Oversight Group and evidence for Department of Health and Social Care

The UK Government adopted many of the HIV Commission report recommendations as the foundation of a HIV Action Plan. We contributed evidence to the HIV Oversight Group, including an Evidence Paper which highlighted how ED and primary HIV testing was very effective in reaching Black African, Black Caribbean and Black other community members, women and older people. (See Evidence Plan).

We also took part in lobbying of MPs and government officials with THT, NAT and other HIV sector members.

HIV Action Plan

The HIV Action Plan was launched December 2021 and aims to:

- prevent new infections by expanding and improving HIV combination prevention activities and ensuring that expansion of access to PrEP for key groups continues.
- scale up HIV testing in high-risk populations - including expanding opt-out testing in EDs in highest prevalence areas of HIV, backed by £20 million.
- ensure people once diagnosed, rapidly receive treatment and support everyone living with HIV to stay in treatment.

(see HIV Action Plan 2021)

The HIV Action Plan ED committed to HIV Testing roll out in all areas of very high HIV incidence. The programme will be overseen by Ian Jackson, Director of Specialised Commissioning at NHS E/I London region, and led by Steve Hindle, formerly EJAF's SIB Performance Manager, which ensures that learning from the SIB will be continued into the roll out. The HIV clinic LTFU will be funded in 2022/23 and is potentially now embedded into routine commissioning for SE London. The HIV GP Champions role was extended to March 2022, with LSL local authorities likely to continue the roles in some format.

Policy paper

Towards Zero - An action plan towards ending HIV transmission, AIDS and HIV-related deaths in England - 2022 to 2025

Updated 21 December 2021

Contents

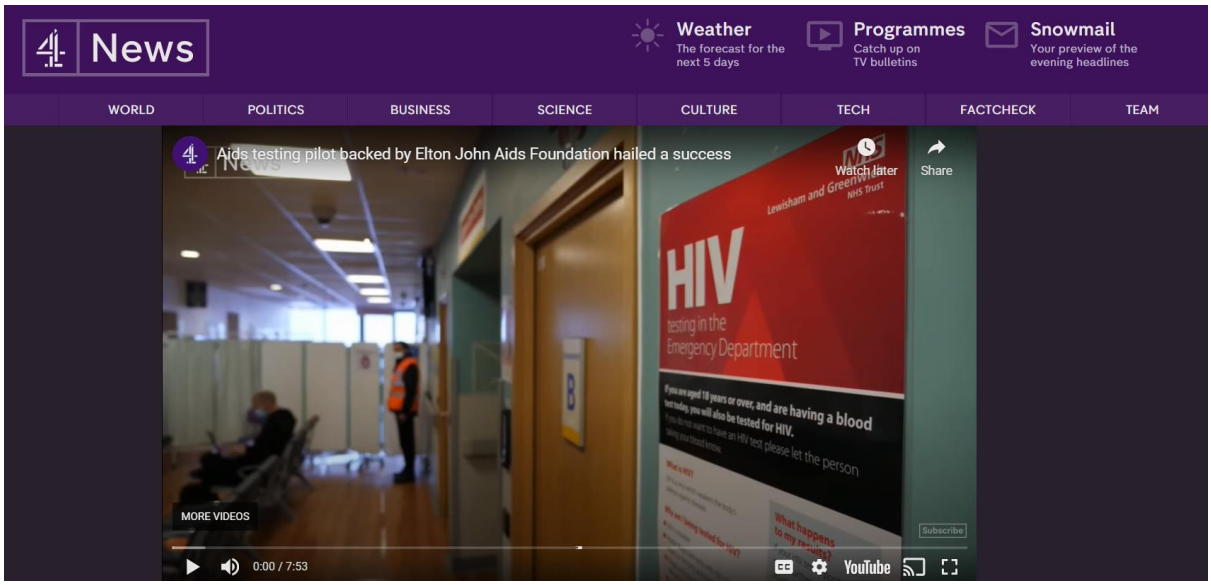
Ministerial foreword

I'm so proud of how far we've come as a country on HIV. It's a consequence of some incredible work across our health and care system, local government, the voluntary and community sector and so many more. Now, if diagnosed early and with the right treatment, people with HIV can expect to live a normal life. Not only does this HIV Action Plan set out our commitment to zero new transmissions of HIV by 2030, it sets out a plan for how we achieve it.

To realise our ambitious commitments – including our interim commitment to an 80% reduction in transmissions by 2025 – we should take enormous encouragement from the progress we've already made. We've met the UNAIDS 90-90-90 target for 3 years in a row. This means we're diagnosing over 90% of people who live with HIV, over 90% of those who are diagnosed are getting treatment, and over 90% of those who are treated have quantities of HIV so small that it is undetectable. Should we achieve our

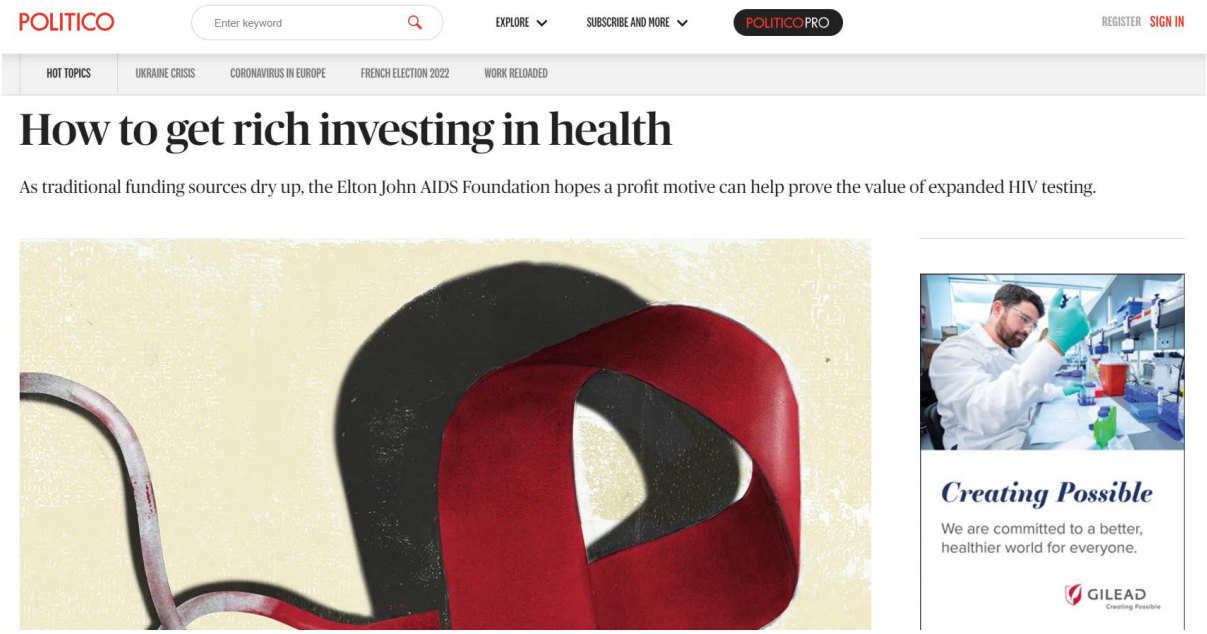
Media Coverage and Formal Reports

As part of the SIB's influencing strategy, insights from the SIB have been widely shared through traditional and social media. Selected news coverage is shared below.



[Channel 4 News story on ED HIV testing at University Hospital Lewisham]

[ITN programme on ‘HIV at 40’ focussing on ED HIV testing and reengagement at Kings College London]



[Article in POLITICO Europe]

2030 end to England HIV deaths 'within reach', Elton John's Aids Foundation says

An HIV Action Plan, backed by over £23 million of government funding, aims to cut new infections by 80% by 2025 and end infections and deaths by 2030.

[Article in Evening Standard]

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ejaf Over the past three years, opt-out HIV testing across Lewisham, Lambeth and Southwark has been supported by the Foundation's #HIV Social Impact Bond with a goal to connect more people to care.

@janetdaby, MP for Lewisham East, visited University Hospital Lewisham to see the success of opt-out HIV testing in Emergency Departments and encourages everyone to order a free HIV

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FEBRUARY 10

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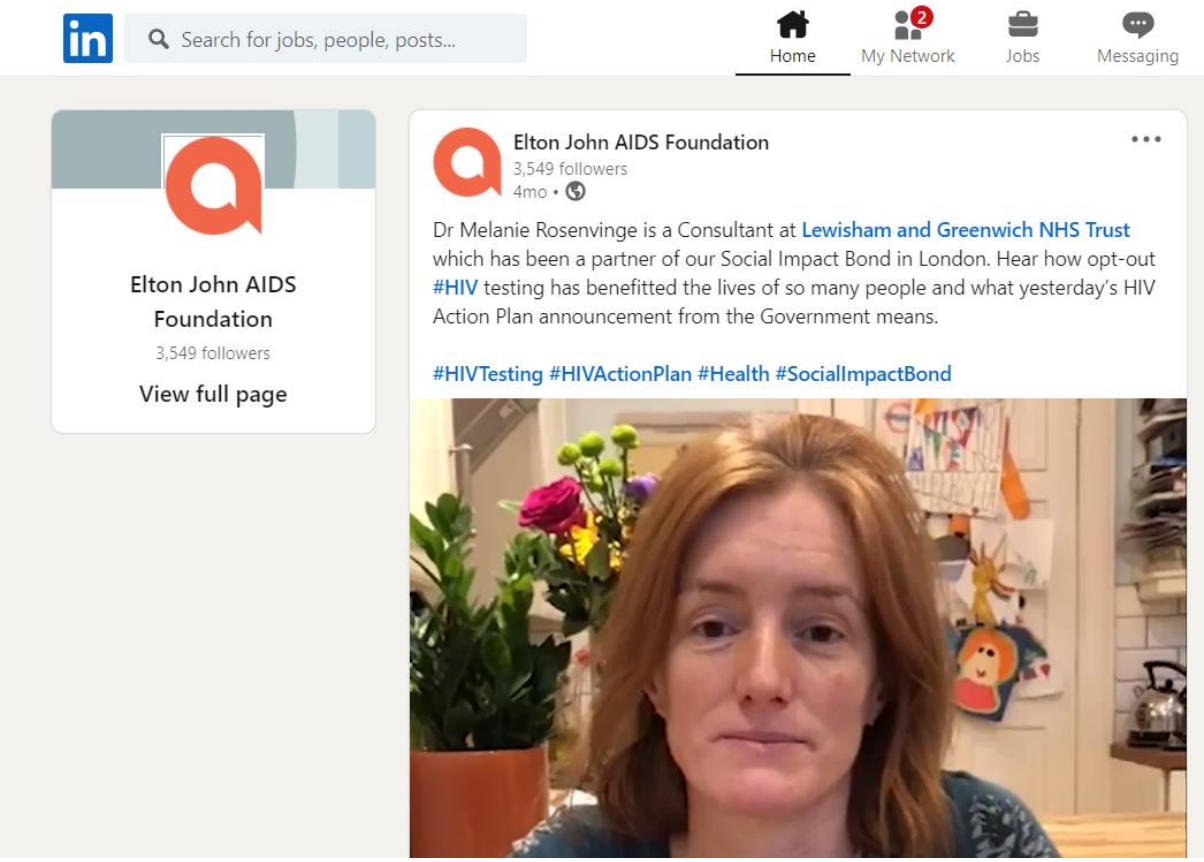
Elton John AIDS Foundation
@ejaf

The learnings from this SIB have provided compelling evidence which has informed the #HIVCommission's recommendations to reach #0HIVby30.

We couldn't do this without the incredible teams on the ground so today we'd like to introduce our HIV GP Champions 👇



Social media activity across LinkedIn, Twitter, and Instagram

To promote academic and clinical evidence, we emphasised the importance of conference presentations and papers to provider colleagues, resulting in 16 presentations to conferences including IAS, BHIVA/BASHH, Adherence, RCGP and GO LAB. Full list in Appendix 1.

We also conducted formal evaluations of the SIB itself. As part of the National Lottery Community Fund Commissioning Better Outcomes programme, three in-depth evaluations were agreed. The first related to the set up and implementation phase, the second to the impact of COVID-19, and the final is the overall assessment of the programme, which will report in July 2022.

Zero HIV SIB first National Lottery Community Fund

Zero HIV SIB Impact of COVID-19 National Lottery Community Fund report

We partnered with Kings College London who undertook a service evaluation of the SIB using an implementation science approach. They interviewed over thirty stakeholders and people living with HIV to gain their understanding of what had been successful.

KCL Service Evaluation of the Elton John AIDS Foundation Zero HIV Social Impact Bond

Finally, there have been discussions with University of Greenwich, London School of Economics, Kings College London and KCH to undertake an academic health economics analysis, which would seek funding through a National Institute of Health Research grant. This will be discussed between the partners in autumn 2022 when they have capacity to write a proposal.

Stephen Hindle and Jennifer Warner 28/03/2022

Appendix 1: Conference Submissions

Conference	Date	Status	Author(s)	Title	Focus area(s)
AIDS 2020	7 July 2020	Delivered as moderated panel.	Jen Warner	HIV Social Impact Bond brings Londoners into care, with international applications and replicability.	• SIB structure, outcomes, and results • SIB lessons learned
Government Outcomes Lab: Social Outcomes	1-4 Sept 2020	Delivered as moderated panel.	Jen Warner, Steve Hindle	My way or the highway: Accessibility and responsiveness of services for vulnerable groups.	• Responsiveness to service user needs • Responsiveness during COVID-19
Fast Track Cities	8-10 Sept 2020	Developed presentation, not delivered.	Jen Warner, Steve Hindle	Zero HIV Social Impact Bond: Tackling the HIV epidemic in London amidst the COVID-19 pandemic**.**	• Responsiveness during COVID-19
BASHH	19-21 Oct 2020	Delivered as poster.	Dr Mel Rosenvinge, Lucy Wood, Steve Hindle	Exploring impact of a Social Impact Bond on a hospital's ability to engage PLHIV in treatment and care.	• Hospital results to date in ED testing & LTFU work
Adherence	2-3 Nov 2020	Delivered as poster.	Steve Hindle, Jen Warner, Dr Killian Quinn, Jigna Pandit, Aimee Beckett	World's first Social Impact Bond with HIV outcomes brings 244 PLHIV into treatment and care and builds evidence for long-term service provision.	• Results to date • SIB as funding mechanism
APPG HIV and AIDS (non-conference)	4 Feb 2021	Delivered as presentation.	Steve Hindle, Jen Warner, Dr Kate Childs, Dr Hannah Alexander, Dr Grace Bottoni	The Zero HIV Social Impact Bond.	• Results to date • Implications for governmental funding decisions

RCGP Fresh Approach to General Practice	10-11 Feb 2021	Delivered as poster.	Dr Grace Bottoni	'Zero HIV': a primary care population-based project to increase HIV diagnosis and improve engagement of patients living with HIV.	• Results to date for primary care testing and re-engagement work
BHIVA/BASHH joint conference	18-21 April 2021	Delivered as poster discussion; commended.	Dr Zoe Ottaway, Dr Hannah Alexander, Julie Barker, Noeleen Bennett, Steve Hindle, Cuong Chau, Dr Kate Childs	Going backwards on the treatment cascade? Identifying and reengaging people who are lost to follow up.	• Results to date for clinic re-engagement work • Process of identifying LTFU patients • Demographics of LTFU patients
IAS Conference on HIV Science	18-21 July 2021	Delivered as poster and supporting video.	Jen Warner, Steve Hindle	The path to universal testing policy: leveraging testing and treatment evidence from a HIV social impact bond to influence national service commissioning.	• SIB structure, outcomes, and results • SIB's influence on policy development
GO Lab: Social Outcomes Conference	9–10 Sept 2021	Delivered as moderated panel.	Jen Warner, Steve Hindle	Improving long-term outcomes for vulnerable adults: How do differing models affect service users?	• How the user voice contributed to SIB structure, outcomes, and results
RCGP Annual conference	14-15 Oct 2021	Delivered as poster.	Dr Ruth Harris, Dr Georgina Thomas and Dr Grace Bottoni, Steve Hindle	Offering mass HIV blood testing to Primary Care patients via (MJOG) text message: What we learnt and did it work?	• The extent to which text messaging impacts uptake of primary care HIV testing

Fast Track Cities	20-22 Oct 2021	Delivered as poster and presentation	Steve Hindle, Jen Warner	The EJAF Zero HIV Social Impact Bond	• SIB description, results, learning • SIB's influence on policy development
Fast Track Cities	20-22 Oct 2021	Delivered as poster and presentation	Dr Grace Bottoni, Dr Georgina Thomas	Diagnosing HIV in the Emergency Department – missed opportunities in primary care?	• Exploring HIV positive patient journeys through primary care
18th European AIDS Conference (EACS)	27-30 Oct 2021	Delivered as poster and video presentation	Dr Larissa Mulka	ED HIV testing	• Effectiveness of ED HIV testing
BHIVA/BASHH	20-22nd April 2022	To be delivered as poster	Dr Ruth Harris, Dr Cristina Guallar, Dr Jessica Philipps, Dr Grace Bottoni, Dr Rebecca Hall, Alex Adams, Steve Hindle	How HIV GP champions can contribute to promoting HIV testing and improving patient outcomes.	• How Primary care champions can enhance coordination across primary care, secondary care and community organisations.
BHIVA/BASHH	20-22nd April 2022	To be delivered as poster	Dr Ruth Harris, Dr Cristina Guallar, Dr Jessica Philipps, Dr Grace Bottoni, Dr Rebecca Hall, Steve Hindle	Enhancing diagnosis of HIV in primary care in South London.	• Showing the role of opportunistic testing in increasing HIV testing in primary care

BHIVA/BASHH	20-22nd April 2022	Delivered as poster.	Dr Ruth Harris, Dr Georgina Thomas and Dr Grace Bottoni, Steve Hindle	Offering mass HIV blood testing to Primary Care patients via (MJOG) text message: What we learnt and did it work?	• The extent to which text messaging impacts uptake of primary care HIV testing
BHIVA/BASHH	20-22nd April 2022	Oral presentation	Hannah Alexander Kate Childs, Golaleh Haidari, Zoe Ottaway, Ayoma Ratnappuli, Bennett Noeleen, Julie Barker, Steve Hindle	Addressing a significant health inequality: a project to re-engage patients lost to HIV follow up	• Evidence of effectiveness of LTFU work in two SIB hospitals
IAS Conference on HIV Science	July 29 - August 1st 2022	Abstract submitted.	Hannah Alexander Kate Childs, Golaleh Haidari, Zoe Ottaway, Ayoma Ratnappuli, Bennett Noeleen, Julie Barker, Steve Hindle	Addressing a significant health inequality: a project to re-engage patients lost to HIV follow up	• Evidence of effectiveness of LTFU work in two SIB hospitals