Towards Zero

An action plan towards ending HIV transmission,

HIV Stigma and HIV-related deaths in Brighton & Hove

(2022 to 2025)

PREVENT, TEST, TREAT, RETAIN

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Objective 1: Ensure equitable access and uptake of HIV prevention programmes (PREVENT)

Action 1: we will continue to invest in evidence-based national HIV prevention campaigns and provide additional cross-system support for local HIV prevention activities

Current services/systems in place

1. HIV Prevention England (HPE) national campaigns delivered locally and amplified by local activation partner activity (Terrence Higgins Trust, THT). Two main campaigns per year:
    a. Summer Campaign such as 'Ready for a Hot Summer' June to August. Main activities Trans Pride, Brighton Bear Weekend (July), Brighton Pride (August). HIV prevention and condom promotion focus and wider STI awareness and HIV prophylaxis.
    b. National HIV Testing Week in February. Evaluation reports produced by HPE for this activity. Delivered via social media, websites, and via outdoor advertising, physical and digital outreach, and resource distribution. Partner organisations encouraged to take part in the campaigns and provided with resources.
2. Additional HIV prevention activity:
    a. Appropriate, up to date HIV prevention and sexual health promotion materials available in a variety of formats and accessible in a range of settings e.g. markets, pubs, clubs, places of worship, schools, colleges, universities, businesses, and community centres. Venues & community settings are maintained and replenished on a weekly basis, with more stock being delivered upon request. Priority groups include people living with HIV, Black Africans, Black Caribbean, trans identified people, gay and bisexual men, people who work in the sex industry and young people.
    b. Access to free condoms and lubricants in a range of settings (social venues, commercial premises e.g. barbers, hairdressers and key services, gay venues, sex on premises venues, public sex environment sites, Black & Minority Ethnic Community Partnership (BMECP) etc. Condom distribution scheme for young people (C-Card) app-based on phone, collected via a visit to any C-Card site.
    c. Outreach to priority groups; Black Africans, Black Caribbean, trans identified people, gay and bisexual men, and people who work in the sex industry, providing condoms, lubricant, safer sex, personal safety, pre-exposure prophylaxis (PrEP) & post-exposure prophylaxis (PEP), & risk-taking information and referrals to local services.
    d. Digital Outreach utilising online media, websites and new digital technology to deliver web-based outreach and provide HIV prevention health promotion information, advice and service information to target groups accessing social media apps, dating apps and 'hook-up' sites.

What we need to do to move forward

1. Continue to deliver the Public Health commissioned activities outlined in section 2 above through a scheduled calendar of key performance indicator (KPI) targets as specified in contracted local services with a remit for HIV prevention activity (quarterly on-going).
2. Continue to identify gaps in knowledge and awareness among target groups and in the general population via research findings, data and other available intelligence such as needs assessments and address these in targeted HIV prevention campaigns and activities (reviewed prior to each campaign activity as in pt. 7).
3. Continue to promote and deliver the THT HIV awareness training for the local health and care workforce and voluntary sector (quarterly on-going).
4. Increase the number of organisations who have received HIV awareness training to include businesses/workforces across the City (by Dec 2024).
5. HIV prevention included as part of core delivery of relationship and sex education (RSE) (timing to be confirmed by RSE lead Jan – March 24)
6. Promote the U=U message focussing on those who do not identify as GBMSM via training and campaigns as scheduled throughout the year as per calendar below pt.7.
7. Develop and circulate an annual calendar of campaigns (April 2024 and yearly thereafter)
8. Ensure ongoing funding for prevention activities (main local HIV prevention contract currently funded until March 27)
9. Review the future of the National HIV Prevention Programme post March 25. National HPE contract has been extended for one year from April 24.

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Action 2: we will continue to invest in HIV PrEP (Pre-Exposure Prophylaxis) (funded at £11 million in financial year 2020-21 and £23.4 million in financial year 2021-22) through the Public Health Grant and will support the system to continue to improve access to PrEP for key population groups and monitor progress through a monitoring and evaluation framework.

Current services/systems in place

PrEP freely available via NHS sexual health service to new starters or follow-up patients via designated clinics on Mondays or Fridays at SHAC (Sexual Health and Contraception) East. Also available via specialist clinics, Clinic M, Clinic T, Under 20's. PrEP2U service for PrEP naïve patients via community pathway partnership SHAC and THT twice weekly to silent, marginalised and underserved groups. Demographic data, concurrent STIs, attendances routinely collected.

What we need to do to move forward

1. Continue to promote the understanding and benefits of PrEP to maximise uptake particularly in people who are Black African, sex workers, trans and non-binary people, heterosexual and other non-GBMSM via campaigns, resources and capacity building activities via commissioned activity (quarterly on-going).
2. Disseminate and embed new HIV PrEP BASHH (British Association for Sexual Health & HIV) guidelines when published (due March 24)
3. Ensure monitoring and evaluation of PrEP provision via NHS sexual health service and in community settings including user reported outcomes (quarterly monitoring).
4. Aim to offer all consenting NHS PrEP patients the EmERGE PrEP app digital pathway to increase clinic capacity for complex cases and innovation (approx. 750 as of Dec 23 – target 1,000 by June 24 tbc).
5. Extend PrEP access points to include GPs and pharmacy as this will increase access among non-GBMSM populations – legislative barriers currently – once overcome will require capacity-building activity for primary care and community pharmacies – link with BASHH HIV SIG (Special Interest Group) standards and guidelines once available (est. June 24).
6. Continue with PrEP2u clinic 2 x weekly and pilot 'pop ups' to marginalised groups e.g. sex workers and evaluate (June 24).
7. Continue innovation project proposal for PrEP via Vending Machines in a community setting or pharmacy aiming to provide one month's supply for PrEP EmERGE patients who have run out of supplies (Mar-June24).
8. Incorporate new and emerging on-line PrEP commercial offers to local awareness and capacity building activities and information resources (tbc 2024).
9. Develop estimates in the general population of those eligible for HIV PrEP and in which demographics – awaiting guidance from UKSHA (Apr-Jul 24).
10. Ensure adequate access to TAF (Descovy) for eligible users (**achieved**).
11. Introduce injectable formulation of PrEP when available (SHAC tbc).
12. Audit all new diagnoses and see why they were not on PrEP and identify missed opportunities.

Objective 2: Scale up HIV testing in line with national guidelines (TEST)

Action 3: we will scale up HIV testing, focusing on those populations and settings where testing rates must increase

Current services/systems in place

1. Opt-out HIV testing in Brighton Emergency Department introduced April 2022 – 70% coverage, 10 new cases to end 2023, extra ~25,000 HIV tests per year in the city
2. Opt-out testing in Sexual Health & Contraception
3. Opt-out testing introduced in specific secondary care departments e.g. Clinical Infection Unit
4. On-line testing through SHAC running at ~20,000 kits/ year
5. At home HIV self-testing service for B&H residents at risk (SH:24)
6. Nine community vending machines to raise awareness and reach new groups
7. Primary Care Testing pilot – 7 practices offering opt-out testing since June 2022 – running until Mar 2024
8. Six-monthly download from lab detailing all HIV tests done in Brighton & Hove labs (1^0 and 2^0 care)

What we need to do to move forward

1. Continue and improve opt out HIV testing in Brighton Emergency Department (through to April 2025)
2. Improve testing coverage in Sexual Health & Contraception, particularly in heterosexuals (monthly data collection)
3. Roll out further opt-out testing in specific secondary care departments e.g. Intensive Care (by Mar 2024)
4. Work across the Trust departments to refresh knowledge of clinical indicator diseases e.g. thrombocytopenia in haematology/general medicine (ongoing in 2024)
5. Pilot oral HIV tests in gastroenterology for oesophageal candida post gastroscope (apply for funding by Jun 2024)
6. On-line testing through SHAC – aim to introduce click and collect when new EHR (Electronic Health Record) system in place in 2024
7. Evaluate Primary Care Testing pilot and seek new funding if successful (by March 2024)
8. Continue to measure and analyse number HIV tests done in different B&H settings annually (bi-annually)
9. Promote workplace offer of HIV testing following HIV awareness training (AMEX good example of corporate responsibility – use this elsewhere in the city)
10. Consider future project with custody staff (suggested in SE HIV Action Plan meeting)

Action 4: we will reduce missed opportunities for HIV testing and late diagnosis of HIV

Current services/systems in place

1. Re-launch HIV education sessions for Secondary Care areas aiming to update and re-energise testing in speciality specific indicator conditions or introduce wider opt out testing. Pilot training with dermatology to test the model recently highly evaluated.
2. Training for medical and primary care trainees – 1-day bespoke course (HIV education course run every other year)
3. Some cases of late diagnosis have revealed missed opportunities for earlier testing. Current system needs improving.

What we need to do to move forward

1. Roll out a blood borne testing prompt (BBV-TP) to General Practices across Sussex. The prompt uses indicator conditions as defined by the NICE Guidance to trigger the GP to offer an HIV test. This shifts the focus away from traditional sub-groups within the population considered to be at risk of HIV infection and normalises testing for HIV as part of routine clinical care in non-specialist settings. Piloting this in the Southeast could find new cases and link people living with HIV back into treatment and care. Mar 2024.
2. Opportunity for widespread HIV education / updates linked to this project (2024)
3. Systematic review of missed opportunities regarding late diagnoses across secondary and primary care with presentations to relevant practices / departments (by Mar 2024)
4. Explore ways of re-introducing HIV education for established Primary Care practitioners (GPs & PNs) through Primary Care Network (PCN) updates by March 2024
5. Improve dissemination of education materials across the city (healthcare, dentists, public services etc) by Mar 2024

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Action 5: we will innovate and transform capacity and capability for effective partner notification (including both digitally and for the digitally excluded)

Current services/systems in place

All new patients who receive a new diagnosis of HIV have a 1:1 conversation with a Health Adviser to identify any contacts at risk and discuss preferred method to inform and arrange testing. This can be achieved by the patient; using a national anonymous text system (SXT); or through a direct call or WhatsApp from a Health Adviser. Named contacts are then followed up through our electronic systems to ensure testing. Progress on this is monitored via a database. Current national guidance is that partner notification discussion should take place at time of diagnosis, 4 weeks and 3 months with recorded outcomes, and 97% should have PEP assessments for partners at time of diagnosis.

What we need to do to move forward

1. Develop patient information about the PN process for newly diagnosed (search for existing examples) by Dec 2023 – dedicated page designed for SHAC website (**achieved**)
2. A designated mobile phone for Health Adviser team for WhatsApp which has been proven to be an effective tool in these scenarios by Nov 2023 (**achieved**)
3. Review all HIV PN cases by a named HA at 2 weeks, aiming to **complete PN by 4 weeks** creating a sense of urgency and a target point for completing PN from Oct 2023 (**achieved**).
4. Ensure that PN is a centre point of all new diagnosis and treat as a public health issue where urgent intervention and response required. Continuing to promote an MDT culture within the service around this from Sep 2023.
5. Have a specific digital record for HIV PN for all new H1 cases embedded in new EPR (Electronic Patient Record) system in ONE PLACE that can be easily viewed/ updated and referenced across MDT (by Mar 24)
6. Ensure for complex cases there is a collaborative approach e.g. between in-patient and out-patient care (**achieved by Dec 2023**)

Objective 3: Optimise rapid access to treatment and retention in care (TREAT)

Action 6: we will reduce the number of people newly diagnosed with HIV who are not promptly referred to care

Current figures

In 2023 there were 27 new diagnoses, 19 Brighton & Hove residents. All were promptly referred to care, and of those starting antiretrovirals (24), all had medication commenced in under 30 days (median 11 days). Two patients transferred elsewhere, one was lost to follow-up and one declined HIV treatment. The median time to undetectable viral load was 36 days (range 18-118). It is noted that new HIV diagnoses made through the Emergency Department can be more challenging in terms of follow-up (2 of 10 have not engaged with care).

Current services/systems in place

Since moving outpatient services to the Louisa Martindale Building it was important to maintain links between sexual health and HIV outpatients. To safeguard this a new patient pathway has been developed (see Appendix 1)

What we need to do to move forward

1. Ensure all new diagnoses are linked to care, engaged in their own health, and continue to access services in the medium to long-term (on-going)
2. Monthly MDT to review new diagnoses ensuring PN complete, treatment commenced, viral load reducing and retained in care (in place)
3. Strengthen links with drug and alcohol services to ensure vulnerable individuals are appropriately supported
4. Continued work with the Emergency Department to ensure robust, seamless pathways for newly diagnosed, and mechanism for alerting Health Advisors if/when patients re-attend (new pop-ups now introduced)

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Action 7: we will boost support to people living with HIV to increase the number of people retained in care and receiving effective treatment

Current figures

Local analysis of lost to follow-up figures for Lawson Unit at end of 2021 (using HARS (HIV and AIDS Reporting System) definition) = 1.2% including those staying abroad after COVID. 0.7% of these have subsequently returned to care.

Current services/systems in place

1. Proactive approach to those who Do Not Attend
2. Lead Role for lost to follow-up and a Nurse Consultant designated clinic for those lost to care or semi-engaged
3. Clinical Nurse Specialist with 20-30% of caseload focussed on poor engagement
4. Electronic alerts and a walk-in facility for people poorly engaged
5. Two-way text and WhatsApp messaging service
6. Named nurses for people who have difficulty engaging
7. High level intensive case management approach to those at substantial risk of disengaging
8. Ongoing prescribing for patients who have not been seen in person or not had blood monitoring, but remain in communication with services
9. Multi-agency working with HIV services across Brighton, GPs, homeless teams, drug and alcohol services
10. Monthly report and twice-yearly data analysis identifying those lost to follow-up
11. Databases for people with detectable HIV viral load
12. Menu of face to face and virtual services to appeal to a range of health and attendance needs
13. Individualised care plans where attendance is an issue for patients
14. Option to have long-acting injectable therapy if appropriate/preferred

What we need to do to move forward

1. Develop further databases for
    a. those at potential risk of transmitting
    b. those at substantial risk of disengaging
    c. those who have disengaged already and not returned to care (**all achieved**)
2. Monthly review of all these databases with development of an individual plan for each patient (Jan 2024)
3. Look back at those lost to follow-up from 2017 onwards to establish if they have died, have engaged in care elsewhere (involving collaboration with UKHSA (UK Health Security Agency)) and review of the individual strategies to re-engage each person (Mar 2024)
4. Co-produced model of care with patients to sustain attendance in the longer term (Autumn 2024)

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Objective 4: Improving the quality of life for people living with HIV and addressing stigma (RETAIN)

Action 8: we will optimise the quality of life of those living with HIV

Current services/systems in place

Improving the quality of life for people living with HIV involves a comprehensive approach that addresses their physical, emotional, social, and psychological needs.

1. Proactive approach by nurses during annual health check to promote healthy living and identify physical, emotional, social and psychological needs
2. Regular use of patient reported outcome tools to identify physical, emotional, social, phycological issues
3. Multi-agency working with HIV services across Brighton & Hove, GPs and community organisations
4. Specialist clinics to address specific physical needs such as ageing, memory and cardiology clinics
5. Use of data from Positive Voices survey to improve services

What we need to do to move forward

1. Improve data collection to better understand the burden of comorbid disease affecting people living with HIV in B&H (data available in people over 50 years old attending the Lawson Unit)
2. Utilise local data to identify key priority areas to improve health related quality of life (by June 2024)
3. Work with the Integrated Care Board to develop service models to improve joined-up care and support patient centred care delivery
4. Promote linkage to primary care
5. Co-produce models of care with patients to empower them to take an active role in managing their health and wellbeing (by December 2024)
6. Co-produce materials specifically aimed at people living with HIV in B&H to promote understanding of their individual risks and to empower them to take an active role in managing their health and wellbeing (ongoing). Materials from Silver Clinic, Orange Clinic and hypertension program available, website for people with cognitive impairment available October 2024
7. Implement a staff education and training program to provide clinical staff with the knowledge and skills needed to discuss healthy lifestyle interventions with patients, ongoing as part of the NICHE study involving health coaching for HCP, other work plan for end 2024 and early 2025 focused on frailty.
8. Improve access to existing social prescribing interventions available to residents in the city. Develop a list of available services aimed at improving quality of life and healthy living for patients and HCPs (Dec 24). Services should include:
    a. mental health support
    b. exercise programs
    c. social connectedness and social support
    d. peer support
9. Build on existing relationships with providers in the city to share learning and promote joined-up care, collaborative work already taking place with several charities across the city including Lunch Positive, THT, LGBT Switchboard and the Sussex Beacon
10. Explore support for older people living with HIV in social care settings, aiming for safe and inclusive spaces following comprehensive education of care-home staff across the city (Oct 2023 -Mar 2024)
11. Use baseline measurement (PROM/PREMs) to explore outcomes for comorbidities, access to support services, peer support (started Sep 2023, pilot results July 2024, another project starting by end of 2024)

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Action 9: we will tackle stigma, improve knowledge and understanding across the health and care system about transmission of HIV and the role of treatment as prevention

Current services/systems in place

1. Towards Zero Taskforce Stigma Working Group incorporating key stakeholders, clinicians, academics and service users in Brighton and Hove including THT and Lunch Positive. The working group has three active workstreams focussing on reducing stigma in healthcare, empowering people living with HIV and public awareness. The role of the group is to co-ordinate and support innovative stigma reduction activities across the city.
2. Positive Voices volunteers (people living with HIV) are supported to access appropriate forums where they can share their experiences and challenge stigma by delivering talks of their personal experiences of living with HIV. A minimum of 24 talks per year to 2,000 people (THT).
3. PEP & PrEP are discussed in all training sessions and all training events address stigma including a specific HIV & stigma training module which includes a Positive Voices talk. Minimum of 25 course delivered per annum (THT).
4. Anti-stigma campaigns such as International Zero HIV Stigma Day, My Life Really Changed. Fighting HIV Stigma and Proud: march, vigil, and rally - an ever-growing coalition committed to ending HIV stigma (THT).
5. Work with voluntary sector stakeholders to reach, engage and support representation of groups and communities that are under-represented, and those who experience health inequalities (Lunch Positive and Brighton & Hove Community Works).
6. Event management of Brighton & Hove Zero Stigma Day Rally (Lunch Positive)
7. Participate organisationally in relevant community activities working towards zero HIV stigma goals, actively widening reach of audience and attracting additional asset-based resources towards delivery of community activities (Lunch Positive).

What we need to do to move forward

1. Through the **Towards Zero Stigma Taskforce:**

   a. Healthcare: December 2023 at University Hospitals Sussex – further rollout of HIV Stigma module and measuring uptake 3 monthly. Continue to campaign for mandatory training in HIV and to recruit HIV Allies to address and tackle stigma. Develop advanced module in HIV Stigma by September 2024. Engage partnership healthcare organisations in Brighton and Hove in HIV education initiatives. Continue with medical student research projects in HIV Stigma.
   b. Local businesses: Identifying and challenging discriminatory policies and practices in services, e.g. cosmetic, beauty, tattoo: resource and work package to be defined / explored
   c. Empower people living with HIV: January 2024 – re-apply for funding to support resilience and self-management for people living with HIV where stigma is affecting their quality of life. Ensure that information, support and advice is freely available to people affected by HIV stigma via local and national organisations.
   d. Public Awareness: From January 2024 – co-ordinate planning for HIV Zero Stigma Day on 21st July. Promote HIV Allies across the city through co-ordinated public relations messages by June 2024. Continue to work alongside arts organisations in Brighton and Hove to raise awareness through music and art events.

e. Stakeholders: Current and ongoing – maintain engagement with key stakeholders across the city, with regular updates and involvement in events. This will be monitored through Stigma Group meetings.
f. We will use nationally developed tools such as the HIV Friendly Charter Mark to enhance local stigma work. Organisations participating in the new charter mark programme will work towards an accredited status and become more inclusive, safe spaces, for people living with HIV, as well as promoting HIV testing. We have applied for two medical students 2024/5 to take forward addressing stigma through workforce development training and education.
g. We will ensure all language used in research and publications consistent with the People First charter https://peoplefirstcharter.org/
h. We will aim to broaden membership of the group to include public relations expertise, equalities, faith organisations. Embed leads for each workstream. January 2024

2. Through specific organisations we will build capacity by delivering HIV prevention and sexual health training programmes. We will promote training to organisations identified with a learning / development need including care homes, dentists, health and social care providers aiming to:

   a. Increase understanding of HIV stigma and its impact on the lives of people living with HIV
   b. Increase awareness that HIV stigma affects people in different ways
   c. Increase understanding of how HIV stigma can create barriers to HIV testing and prevention (THT - contracted activity reported quarterly)

3. We will challenge and tackle HIV stigma and discrimination through recruiting, training & deployment of volunteers / community champions (THT - contracted activity reported quarterly)

4. We will actively contribute lived experiences, promote and enable diverse PLWHIV voice as part of community representation and activities by:
   a. Contributing knowledge of need, service provision, and intelligence of HIV in discussions within VCSE (Voluntary, Community and Social Enterprise) and in focussed health and community discussions / forums
   b. Promoting and advocate for HIV awareness and stigma reduction training / activities / providers across VCSE
   c. Ensuring we cascade relevant information and guidance across the local VCSE (Voluntary, Community and Social Enterprise) through digital information and discussion lists (‘e-lists’) (Lunch Positive)

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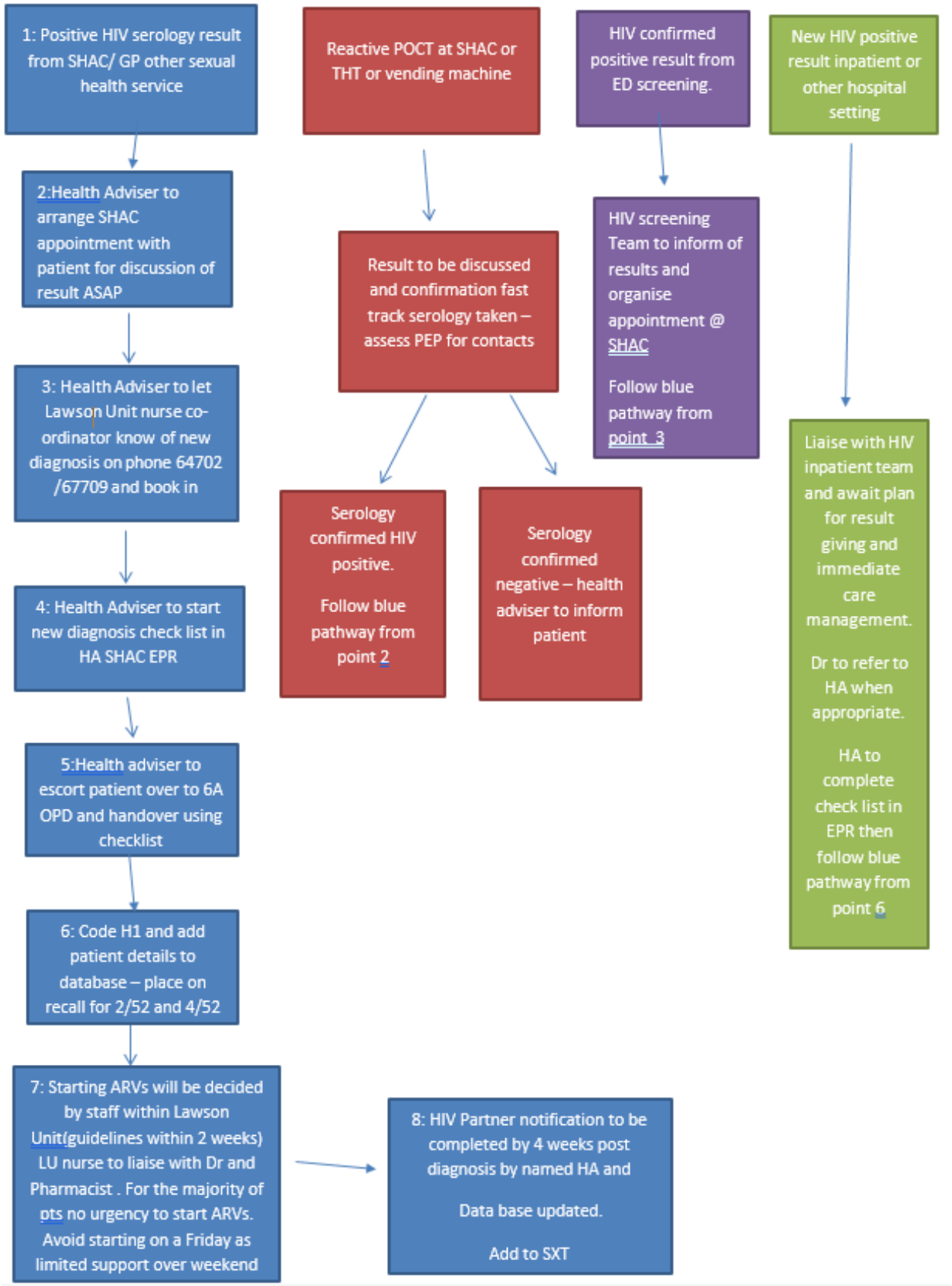
Appendix 1: New HIV Diagnosis Pathway



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New diagnosis checklist

Pt informed of positive HIV result.

Psychological well-being following diagnosis: risk assessment of immediate response/mental health/suicide risk and check support is in place for next 24 hrs.

Partner Notification commenced (look back as pragmatic, or to last HIV negative result).

PEP required for sexual partners?

Explanation of HIV test and transmission. Understanding of result checked, discuss criminalization.

Explanation of how HIV affects immune system. ARV Therapy discussed.

Check support: support services, Peer Mentors, exploration of sharing of HIV results/ status to friends and family.

Referral to senior Dr if suspect patient is seroconverting or if unwell.

Recall placed to ensure follow up and partner notification.

Explanation of care pathway. Lawson Unit appointment /leaflet given / Info sent.