Pan London HIV Prevention Programme Needs Assessment

Executive Summary

Prepared by Inner North West London Primary Care Trusts on behalf of the Pan London HIV Commissioning Group

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1. Background

- HIV treatment costs approx £500,000,000 per year in London.
- A Pan London Prevention Programme (PLHPP) has been directed by a Pan London Commissioners group and commissioned through Kensington and Chelsea PCT.
- Local evaluation of the programme identifies significant failings with the management of the programme and providers have fallen far short of their activity targets.
- Input to the programme from public health has been very limited.
- A rapid needs assessment has been conducted guided by a steering group with cluster level representation from public health as well as the HPA, clinicians, academia and commissioning.
- The aim and objectives were as follows:

  Aim:
  - To make clear evidence based recommendations for the commissioning of a Pan London HIV Prevention Programme with a view to maximising effectiveness and efficiency of HIV prevention activity (including primary prevention and secondary prevention in so far as it contributes specifically to onward transmission).

  Objectives:
  - Within London to identify and characterise the populations most at risk of ongoing HIV transmission.
  - To summarise the relevant evidence of successful HIV prevention interventions.
  - To examine the extent to which current provision within the Pan London HIV prevention programme is consistent with evidence and best practice.
  - To provide recommendations for commissioning of interventions based on the above.

2. Workstreams

- The work was conducted in 3 separate work streams including epidemiological and evidence reviews and an engagement exercise with providers and service users.
- Separate reports have been produced for each of these work streams together with a discussion document that brings together the highlights of each. This executive summary provides a very brief overview with further consideration to implications and recommendations for future commissioning.

3. Key findings

- There are almost 30,000 people with HIV accessing care in London.

- There is an approximately 5% increase annually, although slowing.
- Approximately 26% of people with HIV are undiagnosed.
- The major risk groups are:
    - Behaviourally: Men who have sex with men (MSM)
    - Demographically: Black African
- Review level evidence for some interventions is either sparse or absent and recent developments in HIV treatment as prevention have not yet been subject to review.
- The most successful interventions incorporate multiple components.
- Testing, prevention and treatment services need to be integrated locally and regionally to maximise access and effectiveness.

4. Assessment of the current programme

4.1 Consistency with evidence base

- The current programme is supported by evidence although in some areas this is very thin.
- There is no definitive evidence that any of the interventions included in the PLHPP programme are themselves ineffective.
- Evidence for condom distribution specific to target populations is very limited.
- There is also a particular paucity of evidence around media campaigns and websites although there is grey literature that indicates local impact on knowledge measures.
- The strongest evidence base supports:
    - For MSM: Voluntary counselling and testing (VCT), individual, group and community level interventions including targeted minorities.
    - Black African: VCT, community specific intervention, linkage to broader determinants of health.
    - PLWHIV: Behavioural intervention and partner notification.

4.2 Evidence based interventions not included in the current programme

- There is good evidence for the effectiveness of intervention with injecting drug users (IDUs). This is not currently commissioned within the PLHPP. The engagement exercise drew attention particularly to injecting sex workers as a small group with very high risk.

4.3 Cost effectiveness

- Cost effectiveness evidence is very limited.
- Targeting of intervention is likely to be a significant driver of cost effectiveness ensuring reach to those at greatest risk.

4.4 Current spend

- Currently approx 1.3 million is spent on MSM, 0.32 million on black African, 0.34 million on PLWHIV.
- Spend targeted at the black African population appears disproportionately low particularly given the deprivation of this population but infections acquired outside of the UK also disproportionately effect black Africans. Historically community level provision has been left to localities.
- The optimal balance of spend of between PLWHIV and risk groups to prevent transmission is unclear.
- Current contributions to the PLHPP from different boroughs are historically based. Consideration of contributions by prevalence across different boroughs shows marked variation.

4.5 Evaluation of the PLHPP

- Our experience in conducting the needs assessment confirms failings identified in the evaluation reports including a lack of clarity over leadership and inconsistent direction from commissioners.
- Having established a steering group to guide the needs assessment and indicating an availability of funds to support work before September, the Pan London Commissioners over rode the steering groups' decision to commission a mapping exercise in favour of a more comprehensive mapping at a later date.

5. Recommendations for further work

- Further work is proposed to examine:
    - risk by:
        - Age
        - Co-infection
        - Behavioural population segmentation
    - UK acquired infection
    - Migration and movement of the black African population
    - Return on investment of current commissioned activity
    - Contributions and benefits by borough
    - Robust target setting for different interventions
    - Treatment as prevention

- Mapping of services is yet to be conducted including:
    - Behavioural change services
    - Testing and partner notification

6. Issues for consideration

- Given that there is varying strength of evidence for particular interventions within the PLHPP, this could be used as a basis for prioritisation. On the other hand the PLHPP is one of the largest of its kind in the world and it could be regarded as appropriate or even essential that it incorporates innovative interventions that lack an existing evidence base. Clarity is required as to the local appetite for innovation and the ability to ensure appropriate research and evaluation of any such programmes.
- We have not been able to identify any clear rationale for the composition of the programme as it currently stands or the activity targets set for providers. It appears that these have evolved over time without any explicit strategic direction. This needs to be urgently addressed.
- Similarly the contributions of different boroughs to the programme have not been revisited since the programme began in light of prevalence trends of any assessment of benefit at the borough level.
- Whilst we have identified that interventions aimed at IDUs have a clear evidence base but are not commissioned within the current programme, we understand that interventions aimed at IDUs have purposely been excluded from the programme. The rationale and the appropriateness of this decision need consideration and should be made explicit.
- The epidemiology report is potentially useful in considering the equity of current provision but for any meaningful analysis the purpose of the current programme needs to be clearly articulated and placed in the context of knowledge of provision elsewhere.
- The epidemiology report is also potentially useful in considering whether present interventions are delivered at an appropriate scale but again without mapping of services more broadly our ability to comment is limited.
- Whilst there have been a number of recent papers advocating a treatment based prevention model, its potential remains uncertain and review level evidence is lacking. The appropriate thresholds for, and decision making mechanisms that might lead to, a fundamental reorientation of HIV prevention should be clarified ensuring appropriate consistency with developments in other areas where the role of NICE would be crucial.
- Although not considered within this needs assessment, queries were raised within the steering group of the extent to which it is advantageous to separate HIV prevention from broader sexually transmitted infection (STI) and blood borne virus (BBV) programmes of work. It is unclear whether this would be in the scope of the London Sexual Health Board or where leadership across these areas might come.

- The status of the PLHPP in terms of regional leadership of HIV prevention should be specified.
- Whilst there are areas where there is a clear rationale for London wide commissioning because of economies of scale and/or the mobility of populations, the optimal balance of local verses London level commissioning and coordination urgently requires further attention:
    - Engagement returns show that consistency and coordination are valued.
    - Whilst epidemiology shows marked variation in prevalence, 26 of 31 PCTs are above the threshold for universal testing of adults entering primary or secondary care.
    - The significance of local provision may vary across different aspects of HIV prevention and to different target groups.

7. Governance of the programme

- Local evaluation has drawn attention to significant failings in the commissioning and programme management of the PLHPP programme.
- Public health leadership is required through the engagement of London DsPH and perhaps through the identification of a lead consultant to support the programme.
- The implications of the movement of public health to local authorities and the proposals included in the Fowler report need consideration including:
    - DH is to place a duty on those commissioning HIV services to support the integration of HIV services in commissioning decisions.
    - In areas of high prevalence, Health and Wellbeing Boards are to be required to undertake an annual review of the management, coordination and integration of HIV and sexual health services.
    - HIV Commissioners will be put under a duty to secure health and Wellbeing Board approval.

8. Summary actions

The need and case for HIV prevention is clear, particularly in the light of treatment costs (currently £500,000,000 per year in London with lifetime treatment costs of £280,000 to £360,000 per patient). Therefore:

- Strategic priorities of the PLHPP need to be clearly identified
- The management and governance of the PLHPP require urgent review. Robust mechanisms for monitoring, quality assurance and decommissioning of failing providers must be assured. Leadership of the PLHPP and of HIV prevention more broadly needs clarification.
- Prioritisation within the current programme needs to be considered in the light of strategic priorities (in particular the desire and capacity for innovation).

- The existing HIV prevention infra structure needs to be mapped at the borough level and reviewed in light of a clear strategic direction for HIV prevention.
- Cost effectiveness must be a priority concern for HIV prevention activity. Targeting of intervention is a key driver of cost effectiveness. Further epidemiological work has been proposed to examine risk by age and co-infection and to ensure appropriate utilisation of behavioural research and population segmentation.
- A research and evidence generating strategy should be developed to ensure the gaps in knowledge are addressed both by future provision of work but also by national commissioning of research by appropriate bodies.

9. Further recommendations

Although beyond the scope of the needs assessment work conducted, a view on the future direction of the programme has been requested. We suggest:

- That the need for Pan London level leadership of HIV prevention is more significant than the particulars of exactly what interventions are funded within a PLHPP.
- Appropriate ownership and leadership of HIV prevention needs to be identified and we would look to the London DsPH to ensure this.
- A PLHPP incorporating interventions where there are economies of scale, serving populations that are highly mobile, and which is strategically focused based on regular needs assessment has the potential to make a significant contribution to HIV prevention and perhaps to the reduction of BBVs and STIs.
- Innovative intervention should be incorporated in the PLHPP only where robust research and evaluation can be assured.
- The potential for research on HIV prevention from outside of London is very limited for some target groups, particularly black Africans.
- A prioritisation exercise needs to be conducted urgently to inform commissioning intentions.
- A response from the Pan London Commissioning Group and a meeting between the needs assessment lead, sponsoring DPH and the London DPH are requested. It is envisaged that a meeting of senior commissioning and public health representatives will be required shortly to ensure momentum.