TP06: Integrating peer support within NHS clinics, a London Fast-Track Cities Initiative (FTCI) Project

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Background

BHIVA Standards of Care for people living with HIV[1] (PLWH) include quality statements and auditable outcomes for peer-support pathways to improve self-management and engagement in care[2]. FTCI London convened 3-year 'improvement collaborative' projects between HIV charities and NHS clinics. Chelsea and Westminster Hospital (CWHFT) supported the implementation of this initiative to 4 London HIV clinics with a cohort of >10,000 PLWH. We here illustrate the results of this initiative to date.

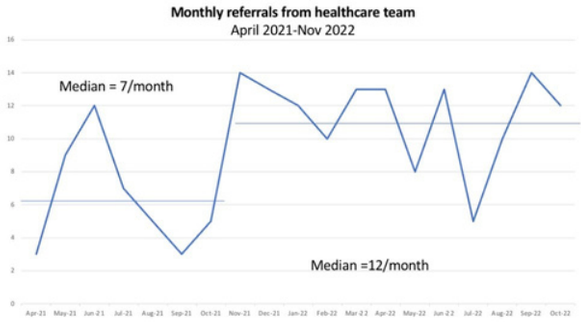
Methods

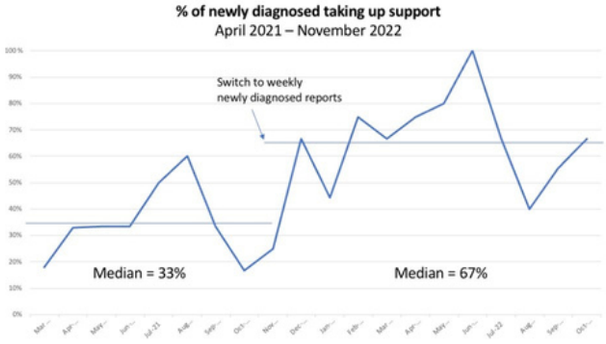
Positively UK, NAZ Project, Plus Health and CWHFT trialled approaches to integrating in-clinic peer-support pathways, with the aim of having >90% of those accessing peer-support retained in care, with a VL<50. Three peer-support workers (two FTE posts) received NHS honorary contracts, emails and the ability to log interventions within the Trust's EPR. Data on uptake of peer support, attendance and outcomes were collected from the EPR into an encrypted NHS database.

Results

Planned to launch as an in-person service in April 2020, the COVID-19 pandemic necessitated a shift to fully remote support and delayed project initiation to July 2020, when email referrals commenced for newly diagnosed patients and those identified as at risk of lost to follow up (LTFU).

Prior to project launch, CWHFT referred an average of one person a month to Positively UK for HIV peer support. In-house referrals to the peer support team reached 4.4/month within the first 3 months. Initiatives such as inclusion in the MDT, focus group participation, staff teaching and physical presence in clinics increased referrals to 7/month by April 2021 and 12/month by November 2021.





The proportion of newly diagnosed patients taking up the offer of peer support increased from 18% (via opt-in HCP referrals) to 33% in April 2021 after switching to an opt-out offer (peer support team making direct contact with patient). This figure increased further to 67% by 12/2021, with the sharing of weekly rather than monthly newly diagnosed reports.

Median patient age was 45 years (range 16-74) and 13% were female, compared to CWHFT HIV cohort median age 48, 15% female. 47% were from BAME backgrounds (vs 34.5% in the cohort) and median diagnosis length was 2 years (<1-31). Overall, 287 people (66% of referrals) engaged with peer-support between 7/2020 and 11/2022, with 164 (57%) receiving ongoing support. Virtual appointments moved from 100% to 54% over time, but virological outcomes were similar for patients being supported remotely as those accessing face to face support. Rates of having a VL<50 increased from 71% at referral to 90% following peer-support, including new diagnoses. 86% are still engaged in care, either having attended an appointment within 6 months or having one booked.

Conclusions

Implementing in-clinic peer-support pathways significantly increased referrals and uptake of support for those at risk of LTFU. Direct and early peer-to-peer contact for the newly diagnosed significantly increases uptake of support. We now plan to introduce newly diagnosed patients to peer workers in the first clinic appointment to gauge potential additional uptake of support. Integrating targeted peer support within the HIV clinic illustrates the potential of improving clinical outcomes and quality of life of PLWH.

References

[1] https://www.bhiva.org/file/KrfaFqLZRlBhg/BHIVA-Standards-of-Care-2018.pdf
[2] Berg RC, Page S, Øgård-Repål A PLoS ONE 2021;16(6): e0252623