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London HIV GP Champions Pilot Project Service Evaluation

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Final report September 2025

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Foreword

Dr Aneesha Noonan
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It gives me great professional pride that as we reflect on the journey of the Fast-Track Cities London HIV GP Champions pilot, this evaluation report captures not only the outcomes but also the commitment, innovation, and collaboration that has defined this new initiative.

It has been really exciting to see GPs in the room alongside HIV Consultants and HIV charities talking about how they can support people living with HIV in their practices, what they can do to improve GP education and awareness of living with HIV in 2025, and how they can offer more joined up care by working with HIV specialist consultants. Most of all the motivation for this has been to ensure people living with HIV are taken care of in a holistic way that supports not only their HIV status but also other long term conditions that occur as we grow older.

General Practice sits at the heart of our healthcare system, and it is here – within everyday consultations – that we have the potential to make some of the most significant impacts on HIV prevention, testing, and care. The GP Champions model was designed to empower primary care professionals to lead this change: reducing stigma, normalising HIV conversations, and improving earlier diagnosis and access to care across our communities.

The insights from this pilot have been both encouraging and instructive. We have seen how leadership within primary care can help normalise routine HIV testing, foster inclusive care environments, and better connect general practice with specialist services and local public health priorities. Crucially, this work demonstrates that tackling health inequalities and improving outcomes for people living with or at risk of HIV is both a clinical and a public health responsibility.

We are deeply grateful to the GP Champions themselves and the incredible network of HIV consultants who volunteered their time to support them, whose passion and dedication brought this initiative to life, and to the charities, patients and practices who embraced this new approach. This pilot has laid a strong foundation for expanding the role of general practice in achieving the goals of the Fast-Track Cities initiative: zero new HIV transmissions, zero AIDS-related deaths, and zero HIV-related stigma.

As London continues its journey toward becoming the first global Fast-Track City to reach and surpass these goals, we hope the findings and recommendations in this report inspire continued investment in primary care leadership and innovation. This is not the end of a project – it is the beginning of a stronger, more connected response to HIV across our city.

Executive Summary

This report presents a service evaluation of the HIV GP Champions Pilot Project, funded by the London Fast-Track Cities Initiative. The project aimed to improve care for people living with HIV in London by integrating services across primary care, secondary care, local authorities, and the voluntary sector. Sixteen GP Champions were recruited to lead this work across London's Integrated Care Systems (ICSs).

The evaluation, conducted by researchers at King's Business School, King's College London, employed a qualitative case study approach informed by the Consolidated Framework for Implementation Research (CFIR). Nineteen semi-structured interviews were conducted with GP Champions, HIV consultants, and health service managers to explore the project's implementation, impact, and sustainability.

Key Findings

Project Impact

The pilot successfully advanced its core objectives, including:

- Increased HIV testing in primary care.
- Enhanced education and awareness among healthcare professionals, contributing to stigma reduction.
- Improved uptake of statin prescriptions for people living with HIV aged over 40, in line with new clinical guidance.
- Strengthened collaboration between primary and secondary care providers.

Motivations and Ethos

GP Champions were highly motivated, often driven by a longstanding interest in HIV care.
The project's distributed leadership model empowered them to tailor interventions to local needs, fostering innovation and ownership.

Operational Strengths

The project's success was underpinned by strong networks, particularly between GP Champions and HIV consultants. Educational outreach and community engagement were central to its delivery.

Challenges

- Lack of protected time and funding for HIV consultants, despite their critical role.
- Limited standardised data collection, which hindered systematic evaluation of outcomes.
- Structural barriers in the healthcare system, including fragmented funding models and limited integration of services.

Sustainability Concerns

While the project has secured funding for a second year, long-term sustainability is uncertain.
The delegation of HIV care funding to ICSs raises concerns about continuity and consistency across London.

Recommendations

1. Extend and Sustain the Programme

Using the learning from this evaluation to fund primary care to deliver on targeted objectives working in partnership with HIV consultants beyond the pilot phase to maintain momentum and build on early successes.

2. Fund Consultant Involvement

Allocate resources to support HIV consultants' participation, recognising their essential role in the project's success.

3. Develop Shared Metrics

Introduce a small set of collaboratively designed, pan-London performance indicators to demonstrate impact while preserving local flexibility.

4. Provide Local Incentives

Establish a central fund to support GP Champions in delivering targeted interventions and incentivising practice-level engagement.

5. Reframe HIV as a Long-Term Condition (LTC)

Advocate for the reclassification of HIV as a LTC to enable better integration into primary care and ensure equitable access.

The HIV GP Champions Pilot Project has successfully improved HIV care in London by fostering collaboration between primary and secondary care, increasing testing, and reducing stigma. While the project has shown strong early results, its long-term success depends on continued funding, better integration with local health systems, and recognising HIV as a long-term condition. Sustaining and expanding this work could significantly advance London's goal of ending new HIV transmissions by 2030.

Introduction

This report provides a service evaluation of the London HIV GP Champion pilot project. This was an innovative public health project which aimed to improve care for people living with HIV in London. It was funded by the London Fast-Track Cities Initiative and operated from February 2024 to May 2025.

The London Fast-Track Cities Initiative is a partnership of organisations dedicated to ending HIV transmissions, reducing HIV-related stigma and discrimination, stopping preventable deaths linked to HIV, and working to improve the lives of those living with HIV across the capital (Fast-Track Cities, 2024). As part of this work, 16 GPs were recruited across London with the specified aims to improve care for people living with HIV by removing the historic barriers between services and offering an integrated approach to long-term health across primary care, secondary care, Local Authorities and voluntary sector organisations for people living with HIV (Fast-Track Cities, 2024).

The HIV GP Champion pilot project had four objectives, as set out on the Fast-Track Cities London webpage:

Table 1: HIV GP Champion pilot project objectives

HIV GP Champion pilot project objectives

1. Improving clinical outcomes for people living with HIV.
2. Primary care workforce education and tackling stigma.
3. Develop a local network between primary and secondary HIV care providers.
4. Ensure visible integration and recognition locally.

These objectives are likely to be achieved in the following ways:

- Community outreach enhancement by developing outreach programmes tailored to specific demographics within the community e.g. homeless, or migrant populations.
- Enhancement of local data collection in collaboration with Data Teams at UK Health Security Agency (UKHSA).
- Development of community-based clinic with secondary care support, e.g. Pre-Exposure Prophylaxis (PrEP) clinics.

16 GP champions spread across the five London integrated care systems, working closely with a HIV Consultant in each ICS area and voluntary and community partners

A qualitative service evaluation was requested by Fast-Track Cities London partnership in 2024 in order to understand more about the nature and effectiveness of the HIV GP Champion pilot project overall and the roles and activities developed by the GP Champions as part of the project. This work builds upon existing HIV service evaluation work in London conducted by members of this research team over recent years (Fraser, Coultas & Karamanos, 2022; Hulse & Fraser, 2024).

The service evaluation explores the following five research questions:

- What is the nature of the HIV GP Champions pilot project? i.e. what are the key aims, activities, processes and interventions that drive the project, and do these meet the original objectives of the project?
- What are the characteristics of the HIV GP Champions and what motivations do they give to explain their involvement in this work?
- What is the overall strategy and ethos behind the HIV GP Champions pilot project?
- What are the operational elements of the HIV GP Champions pilot project, how have these evolved over time, and how do these facilitate (or not) the aims of the project?
- What should and could come next, after the end of the initial period of funding for the HIV GP Champions pilot project?

The service evaluation is informed by an Implementation Science approach (Damschroder et al, 2009) to explore the aims, underlying logics, impacts, processes, and implications of the HIV GP Champions pilot programme from the perspectives of clinical staff, health service managers, and local authority/health service commissioners through a series of semi-structured interviews over 2024-25. The evaluation also explores questions in relation to the sustainability of the project beyond the end of the initial funding period and offers several recommendations about what should come next informed by the variety of views of the research participants.

Methodological and Theoretical Approach

This service evaluation follows a case study approach (Yin, 2009; Eisenhardt, 1989) to explore the perceptions of key actors in relation to the nature, impacts and sustainability of the HIV GP Champions Pilot Project. A qualitative case study approach is appropriate for exploring issues related to policy implementation (Fraser & Mays, 2020), exploring 'how' and 'why' questions about phenomena through detailed contextualised accounts of a case (Yin, 2009). Interviews were conducted until "data saturation" (Glaser & Strauss, 1967) and were recorded, translated, transcribed, and coded using NVivo 14. The two researchers discussed and reviewed the interview data alongside relevant documentary material to ensure consistency. We followed King's College London Research Governance Office guidance which indicated that because this was a service evaluation, it did not require formal University or NHS ethical review.

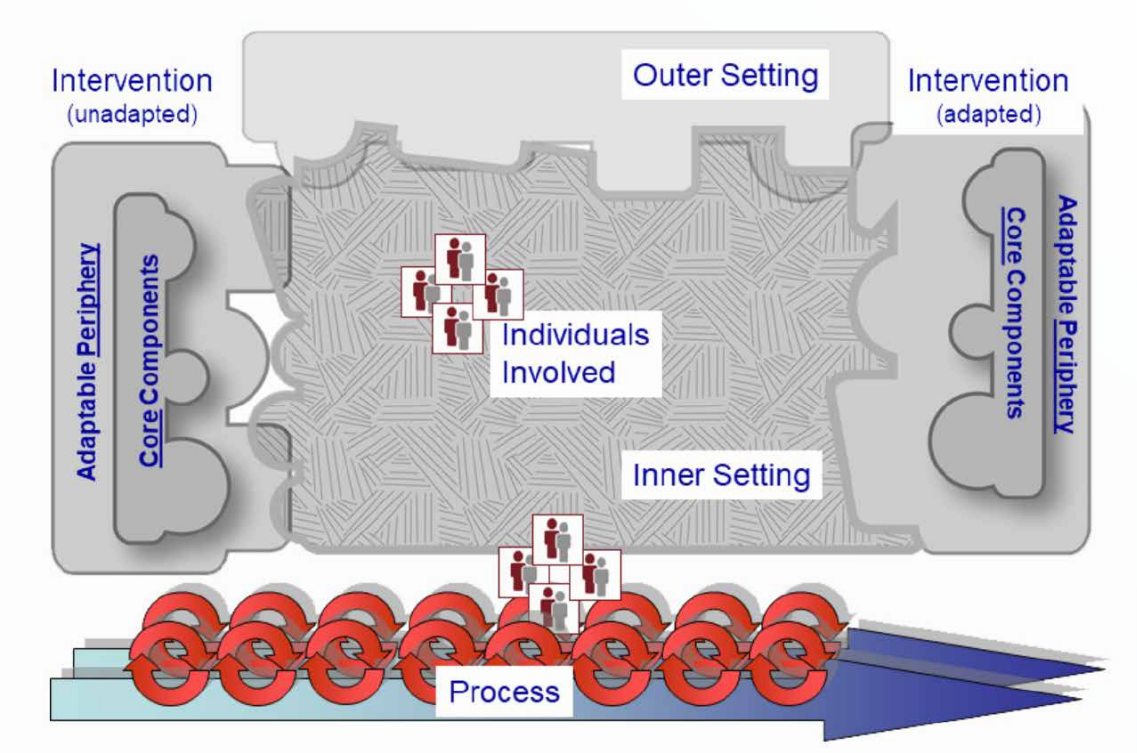
We conducted 19 interviews overall, principally through the Winter of 2024-25. All interviews took place via MS Teams. We purposively sampled informants to ensure a selection of relevant viewpoints and good coverage across all 5 London ICS areas. Most interviews lasted an hour. We used an interview schedule that asked informants about their professional background, work history, and asked them to provide an overview of their understanding of the HIV GP Champions Pilot Project and the barriers and facilitators linked to the implementation of the key facets of the interventions linked to the project. We discussed prospective opportunities and challenges faced in the roll-out and development of the intervention whilst allowing informants the space to express their own narratives (Fontana and Frey, 2000).

Table 2: Interview informant data

Role	Number of informants
HIV champion GPs	11
Managers	4
HIV hospital consultants	4
	19 in total

The data were interrogated repeatedly in order to understand key emergent issues drawing on the principles of 'constant comparison' (Glaser, 1965). The analytical approach drew on both inductive and deductive reasoning (Langley, 1999) – exploring emergent issues alongside insights from wider implementation science theory (Damschroder et al, 2009). The study design is influenced by the Consolidated Framework for Implementation Research (CFIR) framework pioneered by Laura Damschroder and colleagues (Damschroder et al, 2009). The CFIR is structured around five 'constructs'. These are (1) intervention characteristics (2) outer setting (3) inner setting (4) characteristics of individuals (5) implementation processes.

Figure 1: The CFIR



The qualitative data generated by the service evaluation interviews were deductively analysed using key components drawn from the CFIR. This enabled a clear and theoretically informed framework to interrogate:

1. The characteristics of the intervention (or interventions) developed as part of the HIV GP Champions Pilot Project by different actors over time and across different settings
2. The wider financial, strategic, and operational context developed to coordinate the intervention(s)
3. The different relationships and interactions at the micro-level focused on delivery of the intervention(s)
4. The importance of key personal characteristics of individuals designing, delivering, or monitoring the intervention(s)
5. The important processes involved in promoting and/or inhibiting the delivery of the intervention(s).

Future academic outputs will explore these five constructs in greater detail than we do in this current report – however the analyses included here are driven by key CFIR ideas. It is also worth noting some important inductive codes not covered by the CFIR. These included the definition of the HIV GP Champions Pilot Project, HIV testing, HIV stigma, the prescribing of statins for people living with HIV, HIV as a Long-Term Condition, and ideas for HIV GP Champion work following the end of the pilot project period.

The qualitative findings are supplemented with quantitative data throughout the report generated by HIV GP Champions themselves in conjunction with Fast Track Cities London.

Qualitative Findings

A total of 43 codes emerged from the content analysis of the 19 interviews across the five CFIR components in addition to the sixth inductive component. Table 3 below illustrates the distribution of references from interviews to these components across the sample of 19 informants.

Table 3: Coding references

Components	References
Characteristics of individuals	55
Inner setting	247
Outer setting	82
Intervention characteristics	112
Process	96
Inductive codes	219

Upon further analysis we were able to group these components into five broad themes of:

1. Defining the HIV Champions pilot project
2. HIV GP Champion motivations.
3. The strategy and ethos of the project.
4. The operational elements of the project.
5. Next steps.

It is on these five broad themes that we report upon below.

1. Defining the HIV GP Champions Pilot Project

Table 1 outlines the central aims of the GP Champions project, however, the informants tended to articulate these aims through addressing three key issues, which were tackling stigma, increasing HIV testing and advocating the prescription of statins to people living with HIV who are over 40 years of age. These three issues will be taken in turn in this section.

1.1 Tackling Stigma

The issue of stigma for people living with HIV is still prevalent in society and the informants felt it remained a problem within healthcare settings as this HIV consultant explains:

> 'When we do hospital based surveys now of healthcare workers to look at stigmatising attitudes to HIV, we still see loads. So you know, if we can't even sort out HIV related stigma in hospital and healthcare settings... We just know that there's loads of HIV related stigma in the general population, so without some better education, some better educational campaigns, you know, I just do not see that end of stigma goal being met.'
> **HIV consultant 4**

Stigma amongst healthcare staff and the wider public was seen as a significant factor impacting upon the willingness of some people living with HIV accessing their GP practice. If there is to be greater integration of primary and secondary services, then this access issue must be tackled and so addressing this issue was seen as an important task for the HIV GP Champion work as this HIV consultant argued:

> '[The] elephant in the room, of course is the patients that don't want to engage with the GPs and that is a real you know a tangible problem. It's definitely not majority, but it's a significant minority. People who really don't want to engage with GPs and we've actually discussed that quite a lot with the GPs, about how we can try and improve that and the perception of going into a GP practice. I suspect there is still some stigma from some GPs I'm afraid. I hear dreadful stories from my patients... they can literally make you tearful because they have such terrible experiences in other healthcare settings from Practice Nurses and GPs. I've been working now [since 1992] seeing people with HIV and the one thing that hasn't changed very much is the stigma. It's got better and certain groups, it's got better. But you know, there's still a huge amount of stigma out there. So I don't know, I couldn't hand on heart say that all GP, don't have stigma. I think some probably do, which is why the work around that [stigma] is so important.'
> **HIV Consultant 1**

It is important to note that participants felt that tackling stigma remains a difficult issue, and one in which progress is hard to measure as this GP champion explains:

> 'I would certainly say I need help with [challenging] stigma because I don't know where to kind of go with that. It feels a lot more woolly than [other objectives]. Don't get me wrong, it is very, very important, and I'm a big advocate for it. But it's much harder as a champion to champion that, whereas the other ones were a bit more measurable, I guess.'
> **GP Champion 4**

Over 2,025 primary care professionals across London received HIV stigma-focused teaching sessions

Education of primary care staff was seen as a good way of tackling the problem of stigma in primary care and this is an activity that many of the GP Champions were actively engaged in. The HIV Confident initiative (https://www.hivconfident.org.uk/) was cited as an effective way of challenging stigma in organisations. The HIV Confident initiative is supported by Fast-Track Cities and was developed in partnership with the National AIDS Trust, aidsmap and Positively UK. It is free for all GP practices and NHS Trusts, which aims to increase staff knowledge of about HIV and improve their attitudes towards people living with HIV to tackle HIV related stigma. All the respondents advocated this as an effective way of tackling stigma in organisations as this HIV consultant states:

> 'It's just really difficult and I think we should at very least start with healthcare settings, HIV Confident as a way to start achieving that. So you know we should see all NHS organisations, local government organisations etcetera signed up to HIV Confident.'
> **HIV Consultant 4**

Many of the GP Champions stated that they had engaged with this initiative:

> 'We're pushing for the HIV Confidence Charter, 60% of practices have signed up. We're literally so close in my own practice to becoming HIV Confident. So again that was getting all practises on board or as many on board as possible.'
> **GP champion 1**

This HIV Confidence Charter work which was pursued through the wider HIV GP Champions project demonstrates a clear and effective contribution towards challenging stigma in healthcare organisations in general and GP practices in particular, which will make a positive impact upon the lives of Londoners living with HIV.

1.2 HIV testing

Another activity that the GP Champions were engaged in and discussed in these interviews focused on increasing the amount of HIV testing that was carried out in primary care. The following HIV consultant explains why this is so important:

> '[W]hat we really need I think, is primary care colleagues to be testing more people, whether they have indicated conditions or not. So that we can try and identify earlier those people who are missed by other approaches to HIV testing. There are estimated to be 5000 or so undiagnosed people in the UK with HIV. We need to get those into care if we're to achieve the UN aids targets of no new HIV transmissions by 2030.'
> **HIV consultant 4**

HIV testing in southwest London increased from 7,910 HIV tests in 2023 to 10,232 tests in 2024 – a 29% increase

Some of the GP Champions had achieved quite impressive success in this aspect of their work as this GP Champion indicated:

> 'The exact [figures] I think it was a 56% increase in the number of testing that we've done from my year as the Champion to the year before. So it was a huge increase in testing.'
> **GP Champion 4**

The GP Champions employed several strategies to increase testing in primary care, such as introducing HIV testing for new patient registrations, including it in annual mental health reviews and providing financial incentives for testing in GP practices. This is another tangible and measurable improvement that the GP HIV Champions pilot project was having on HIV services in primary care. As will be discussed later in the report, one potential missed opportunity lies in developing more standardised measurement of these percentage increases across all GP Champion patches, to really underline the progress made in HIV testing.

1.3 Prescribing statins

Recent British HIV Association and NICE guidance recommends that all people who are over 40 and living with HIV should be prescribed statins. This new guidance has prompted HIV consultants to work with GP Champions in their area to roll out the prescription of statins to the target population through primary care, as this HIV consultant describes:

> 'There's new guidance stating that people living with HIV should be on a statin after the age of 40. And one part of this project has been rolling that out across London. The GPs and the secondary care clinicians have been working together quite closely in terms of, we've had to have a statin working group to look at the best way to do that. And so the communication regarding standard letter wording for GP letters, if we want to start sending out texts to patients in terms of that communication.'
> **HIV consultant 3**

GP Champions have also worked with pharmacists to increase statin prescriptions for people living with HIV in accordance with the new guidance as this GP champion explains:

> 'I actually did a project with our pharmacists about statin prescribing. So there was some new guidance about a year ago about statin initiation for people living with HIV. So I did some education on it with them and actually got some funding, and we did a project to basically remunerate practices to do a search to see who was eligible from their population and then do consultations with patients to get them started on statins.'
> **GP champion 7**

Seven practices in Islington, offered 150 patients a consultation on starting statins – of those, one-third of eligible patients not previously on statins successfully started treatment

Although this would seem a sensible initiative, it is not straightforward to implement or standardise this across the board because of the stigma issue, which has led to the reluctance of some people living with HIV to visit their GP, as this GP Champion explains:

> 'The statins are expected to be prescribed by the GP. But if the patients don't really want to come in and see the GP, then they won't get the satins and actually, when we had those meetings with some of the HIV teams, they did say that they've had patients who were quite reluctant because they just didn't really want to go and see the GP and they wanted the HIV team to prescribe the statins. And they didn't really understand why they couldn't get that from the HIV team.'
> **GP champion 9**

So, whilst statin prescribing emerges as another key practical initiative that the GP Champion pilot project supported, the data illustrate how interconnected and deep-rooted the challenges are and that stigma remains a fundamental obstacle for some people living with HIV accessing primary care services. This would suggest that the broader cultural changes needed to reduce stigma and encourage greater normalisation of HIV as a long-term condition that can be managed in primary care is likely to need continuing targeted support. We will return to the issue of treating HIV as a long term condition towards the end of this report.

2. HIV GP Champions Motivations

In this section we explore the motivations of HIV GP Champions. Overall, we find that many of the GP Champions express a significant commitment to furthering and improving HIV services and often have a long-term interest in HIV care and service development. At the same time, there are some GP Champions who took up the role more opportunistically. For some GPs, the role involved quite a steep learning curve. The GPs report that they enjoy the degree of autonomy they have to adapt the role to their localities and skill sets. The role requires effective interactions with HIV consultants based across London hospitals. We explore the views of these consultants in this section – whilst they also share a passion for HIV services with many of the HIV GP Champions and are motivated to improve services, an important finding is that many HIV consultants report that involvement in the project had impacts in terms of increasing their workloads – however, in contrast to the GP Champions, they did not receive any protected time for this work – this is something that may need to be rectified in future iterations of the project. We also highlight a counter view in relation to the positive implications of the motivational commitment of the GP Champions for improving HIV services.

Many of the GP Champions that we interviewed expressed a longstanding interest in sexual health and/or HIV service improvement, and highlighted how the GP Champion role enabled them to build on their existing experience and further their goals:

> 'I would say that my area of special interest is sexual health. I did a sexual health job as a trainee, as a GP trainee, so I did six months working in sexual health that's always been the sort of thing that I was more interested in... And so when the job came up and three people I know sent it to me and said, you should, you might be interested in this... I've always wanted to try and have more of a special interest in sexual health and HIV and try and have a role that goes alongside my normal salary job. So it was definitely the sort of thing I'd sort of been wanting.
> **GP Champion 7**

This level of personal and clinical interest in HIV, alongside a significant commitment and enthusiasm for service quality improvement were seen as key strengths of the project by non-GP Champion participants:

> 'I mean we've got a super enthusiastic bunch of GP Champions which just makes it very nice.'
> **HIV Consultant 1**

Several GP Champions had been involved in the Elton John AIDS Foundation (EJAF) Social Impact Bond (SIB) project and had developed good links and networks – particularly in South East London, so the GP Champion pilot project was able to build on these. As noted, whilst most GP Champions had relatively long-term interests in and commitments to HIV services, a smaller number of GP Champions said that they got involved in the project not so much because of a passion for HIV service improvement per se, but for other personal motivations such as a desire to be involved in change management work, to apply their local leadership skills, or to utilise a passion for educational outreach and wider teaching in primary care settings.

It might be interesting to explore the different motivations and skills of individual GP Champions and how to optimise these dynamics in future years. The GP Champion below highlights how their own perceived rather junior status made the role challenging, and also the importance of support based on existing HIV consultant relationships:

> 'A lot of it was a little steep learning curve for me because I'd never done a leadership role and I didn't know a lot of people within [this patch] and the bigger ICB and the structure of how an Integrated Care Board (ICB) works actually was all very new to me. So I think it was always going to be challenging anyway, but actually there were four key areas that they wanted us to kind of look into. And so it made it quite obvious what I was trying to achieve. But also, I had an incredibly supportive consultant at the [hospital] who I knew anyway, who gave me the job in sexual health three years prior. And I said these are the aims. What can we do? What's going on? What work are we doing [here] that I can get involved in? Hook in and you know, make some change. I think they were quite clear aims. I think the problem was is that a lot of people didn't know who you were obviously because it was this strange pilot. You know, this is this person who is this new young doctor youngish. Coming in and you know, going on and on about HIV.'
> **GP Champion 4**

The importance of the relationships that the project encouraged between GP Champions and HIV hospital consultants emerges strongly – with positive examples described elsewhere in this report. Whilst all the HIV consultants we interviewed were very positive about the project overall, several noted that the project increased their workload in some ways, and that they did not receive any payment or protected time for this work, which was considered unsustainable as these two HIV consultants explain:

> 'I am a consultant in HIV medicine at the [hospital], and I am the GP London HIV GP Champion link coordinator for [a part of] London. So I'm the touch point for the three HIV GP champions in [this area] and also part of the wider London HIV GP Champions Oversight Group... without any remuneration or time allocated... [none of my time/involvement] was funded in the part of the fast track cities [project].'
> **HIV Consultant 4**

> 'And one thing that's been a real problem with is the funding. It's like the secondary care time. Like my time, [X's] time, [Y's] time has all been unfunded. So this is all out of our own time, which has been slightly frustrating from our perspective because actually we kind of agreed to do this project, but, essentially, if this was something going forward, then I think the secondary care clinician time needs to be funded as well, because actually it's been a significant output from our perspective in terms of the number of meetings and the amount of support that we've needed to provide. And the clinical input as well. [...] at least a session a month that I would say if not more.'
> **HIV consultant 3**

There was indeed a consistent message from informants that HIV hospital consultants may appreciate and need some protected time in future iterations of the GP Champions project to enable them to provide the kind of support so valued by GPs with whom they interact so effectively.

A final, counterpoint in relation to the overwhelmingly positive overall implications of the motivational commitment to HIV services expressed by most participants was that sometimes, this passion can lead to naivety:

> 'I've definitely encountered people who are really passionate [about HIV], but maybe don't [grasp] that there's going to be cuts everywhere and we need to be savvy about that because everyone else is being savvy about that as well. You know, so if you're the one programme who's saying, well, it really makes a difference for patients. But... you know, everything makes a difference to patients, to be honest. So it's about making sure that you're an evidence based programme [so that commissioners] know what they're paying for.'
> **Interview 11, Manager 3**

In other words, as well as being an incredible strength in terms of dedication to patients, it can also sometimes be perceived that the levels of personal commitment to the cause of HIV, if not aligned with the generation of evidence of effectiveness, may also be a weakness.

3. The Strategy and Ethos of the Project

In this section we discuss the strategic approach taken to the HIV GP Champions pilot project. The ethos pioneered by the leaders of the project emphasises adaptability in relation to how GP Champions were encouraged to pursue the priorities of the project. This aligns closely with a collaborative, network governance approach (Newman, 2001; Osborne, 2010), drawing upon professional knowledge, skills and autonomy. GP Champions were encouraged to be flexible in terms of how they interpreted the overall aims of the pilot project, and to adapt the project to their diverse settings. This also aligns with a distributed leadership approach (Gronn, 2009). Most interview participants welcomed this approach – as will be outlined below. However, many participants also articulated a sense of ambivalence, in that the emphasis on adaptability and autonomy for GP Champions arrived at the expense of 'hard' metrics – or data that could demonstrate the effectiveness of the interventions linked to the project in a coherent pan-London way. These tensions are explained and analysed below.

The HIV GP Champion model has a legacy from the EJAF SIB in London, and there are wider examples of the model being used in other areas, including in relation to blood borne viruses (BBVs) such as hepatitis C. One of the key leaders of the HIV GP Champion pilot project had good experience of rolling the model out nationally in the hepatitis C context and drew on their experience to lead this work:

> 'So we kind of got to test [the GP Champion model] out [in hepatitis C work earlier] and it was about a properly resourced, properly connected [role with] time and money – a person with good connections in primary care who's willing to work really collaboratively and a bit imaginatively. To improve outcomes and increase awareness. But the key is that it they have to have some very clear objectives. It's not just be a "champion."'
>
> **Manager 1**

The aim was to work collaboratively between all care settings to support people living with HIV, reducing obstacles to treatment and care, and improving health and quality of life

These objectives included reducing stigma, increasing testing, improved links between primary and secondary care, as well as education and information exchange within primary care alongside particular clinical projects such as increased statin prescribing (as discussed elsewhere in this report). Beyond this starting point, and these objectives, the GP Champions were trusted to take a lead and develop their own, professionally and contextually informed approaches to deliver on these objectives.

> 'So, for example, for the GP Champions [we say]... here's four very loose things we want you to do... then come back and let's see how we can work on that together and then share with each other and everything. So they are then empowered just to go and do that and find the people and work together and do it. And they've done such amazing things. But then on the flip side is [that] a couple of times that people have come back and said: "Other people don't want to work like me" or, especially when they've gone into NHS spaces and people are like, "well, who said you could do that and who you know and where's that come from?" So like, so with that, with that kind of creativity and transformation ethos and collaborative ethos, where you're going, well, I want to work with you. You work with me and let's do this together... They'll come up against people sometimes that say but you don't have authority to do this.'
>
> **Manager 2**

As articulated at the end of this quote – the GP Champions do not have formal, or line management positions through which they can compel other staff to work with them – so this collaborative ethos makes sense particularly given the lack of hierarchical power embedded in the role. At the same time – the importance of trusting GPs to make the right decisions based upon their preferred approaches and local knowledge also sat behind the leadership approach of the managers of the pilot project.

> 'I mean absolutely like, why on earth would myself or [other managerial colleagues] tell them what to do in their job, in their patch, in their town that they work in with their patients and their colleagues? They know what's going to work. So for example [Dr Q] in [his London borough] got all of his, you know, I don't think he ever would have done this if we'd given him five targets with five lots of numbers to count, but he knew that the thing that he could do and have the most impact in one session a week in one year was to train up as many primary care staff as possible, give them up to date HIV training. You know, get them along to an event and he did an event for them. He got the HIV Confidence Charter, which is our big stigma workstream. We got them along. He got everybody signing up to this Charter, you know, that's incredible... it's a really great bit of work and he knew it would work because he knows his area. He knows his staff, he knows what they need. So he did that, and other patches didn't do that. They did other things, you know, that worked for their area... So it's definitely something about trusting them. We'd recruited good champions, we knew they would do a good job and then just supporting them to find the thing that would work in their area and do it to the best of their abilities really.'
>
> **Manager 2**

The quote below, from a GP Champion offers some justification for the approach:

> 'I think personally GPs are very, very open to change. There were a couple of projects that were already kind of starting to bubble. But no one had really taken the [initiative to run these]. I kind of almost became like the link or the glue to try and get those things going and moving... And one of them was a sort of a shared care pilot. So we were piloting where the GP would review the HIV patient every six months and the consultant every year. And that idea was to kind of test to build this relationship up and to check their medication, check their blood pressure, do all the kind of stuff that GPs should be doing for HIV patients. So I spent the whole year, and it [was] wonderfully [started] by my colleague in secondary care but hadn't really got any further into [other] people participating. Then we managed to secure £5,000 pilot funding for it... as an incentive to do it... So I personally chose projects that were already kind of sitting within the borough that needed a bit more kind of oomph, I guess, and get things going because I was paid and have the time to do that... so that kind of worked well for me.'
>
> **GP Champion 4**

This quote highlights the practical nature of the decision making logic reflected by many other GP Champions – they were able to use their protected time to pursue mini-projects of value in their own boroughs or ICS areas – often guided by existing projects or the furtherance of secondary care clinician relationships. This participant noted that they were aware that they only had 12 months funding – given the nature of the pilot project – so to pursue a new, or 'bigger' project would have been counter-productive. Many other GPs also noted this same point in relation to timeframes counting against the logic of extensively measured, top down led projects. Others spoke of the incompatibility of data sharing systems – which made data collection difficult. Others spoke of the difficulty in objectively measuring the relational nature of much of their work as GP Champions:

> 'We should be focusing on objective measures and data. And I think that is important, but actually, you know, the other day I got a message from someone in north London saying can you tell me more about the opt out stuff you're doing, you know? [they were] like, oh, I've actually tweaked the HIV alerts because I know about EMIS [electronic patient record system used in General Practice]. Can I send you the latest version? And there is such value with having an e-mail list of other GP Champions and other areas and asking each other how did it work? How did you ask that question? What did the ICB say? There is such value in that and it's really difficult to measure, but I think it's really important.'
>
> **GP Champion 2**

That said, numerous participants did express the opinion that on reflection, perhaps some more thought could have been given to strategies or requirements to collect standardised data from across London to help demonstrate the effectiveness of the GP Champion pilot project work:

> '[Measuring performance] is something I've been banging on since the start because it's just pointless if we don't. If we can't demonstrate that we're improving. So we did suggest one outcome at the beginning, which was a very specific outcome around statin prescribing. So it's offer of a statin to individuals who are over the age of 40. You know, as perhaps recommended by the clinic. And that's been part of the reason that we've done educational events. And there are various audits going on... I have to say I think it's a little bit variable across the patch and that's always been my slight gripe, if you like with this project is that, you know, are we measuring testing? Not as far I'm aware because, you know, I think it's a bit diverse in terms of, you know, which borough is pushing for, you know, there are clear guidance out there that GPs should be doing, testing for interventions etcetera, etcetera, etcetera, new registrants but migrants etcetera. But as I'm not aware that is being measured per se.'
>
> **HIV Consultant 1**

Overall, there is a recognition that top-down target setting from the centre is not really appropriate for a 12-month pilot programme being led by GPs operating in highly diverse settings across the capital. The overall, collaborative governance approach characterised by a facilitative, distributed leadership ethos is highly valued by participants. However, a learning point for future HIV GP Champion work in London work, might be that a more ambitious attempt to embed some common measures could be beneficial to help justify the value of the pilot project to wider stakeholders and other funders.

4. The Operational Elements of the Project

The analysis of the data identified several operational elements to this project, operating through the overarching ethos of the initiative which was grounded in networking and relationship building. It was through developing networks that the GP Champions were able to deliver on the principal aims of the project. The GP champion initiative itself was founded on collaborative working which is central to the way Fast Track Cities operates in all its work, as a senior manager explained:

> 'Academia, doctors, nurses, people living with HIV, NGOs, local authorities, government, et cetera. And then we also work connect up with the other cities in England. We connect up with the other cities across the Four Nations, UK and Ireland, and then with European partners as well. We've got lots of collaborations.'
> **Manager 2**

Most GP Champions felt comfortable with this collaborative ethos and overall way of working and felt that networking was the best way of achieving their broad aims:

> 'Now that we are working towards no new diagnoses, by 2030, you know we're working towards a completely changing population of patients living with HIV. And I think that the Champion's role has really helped build those links and we've got much better links now in [our patch] than we did a year ago. People know who we [the local GP Champions] are and the HIV clinicians will reach out to us, and we can talk to them. So I think it's been really beneficial.'
> **GP champion 7**

Another GP Champion explained how networking and wider encouragement of interactions between different stakeholders can achieve the end results they are aiming for, albeit, over time:

> 'Trying to get testing in suspected cancer clinics. We have gone around to separate people individually in our areas, but we know that they all talk to each other. So, you know, we know that things are probably being shared amongst their networks and we're kind of probably the more they see, the more they think of it. And then eventually there's an action.'
> **GP champion 5**

This same GP champion also described in some detail how they built and developed their network:

> 'People would reach out to me and say, oh, what have you got for us today? What can we circulate? So yeah, [the project has] infiltrated a lot of networks also like WhatsApp groups for the different boroughs... So, you know, you could just post stuff on there now, which is great. I mean some of it is literally cold calling, figuring out who does the job and just, you know, writing slightly grovelling emails. I've worked in quite a few places, so a lot of the people I know have also spread around, so just contacting all you know, all my ex colleagues and things like that where you working now or could you, who can we, who can I contact? You just have to be a very good kind of schmoozer, basically.'
> **GP champion 5**

The various informants stated that the key relationship in this project was between primary care and secondary care, and the key people in facilitating this relationship are the GP Champions and the HIV consultants. The statin example discussed earlier clearly illustrated this key relationship in action and the following HIV consultant points to some other positive outcomes of this relationship:

> 'In terms of our network, we've had GP representation from primary care and really good primary care representation at those network meetings. So then again, it gives us an opportunity for secondary care, primary care, third sector organisations and commissioners to be in the same room. We've had the GP input for things like making sure that the testing pathways are uniform across London and the feedback to GPs after a positive test and what to do next, which was causing a lot of stress because there were different pathways depending on which GP practice previously.'
> **HIV consultant 3**

The GP Champions recognised that establishing better communication between secondary and primary care was critical for improving the care for people living with HIV:

> 'In terms of engaging, I think as a GP it really is about improving that engagement with secondary care and specifically between us and HIV. And I think that there's a lot of friction, a lot of sometimes misunderstanding which gets in the way of people's care.'
> **GP Champion 8**

The HIV consultants similarly echoed the GP Champions' sentiments, as this HIV consultant articulates:

> 'But the real aim is kind of increasing communication and education and knowledge amongst the primary care and also sort of having those links between primary care and secondary care. Which has been particularly beneficial in terms of sharing clinical care and improving outcomes for patients. So that's the kind of crux of it.'
> **HIV consultant 3**

However, building networks, particularly over a short period of time was often seen as a challenge for the GP Champions and something that some of them found difficult and time consuming as this GP Champion explains:

> 'There's some things that are really just sort of changing people's behaviours that are quite slow. A lot of the time so, and I think you're building rapport. These things can take years. Also collecting data, so there's some things that you just don't really know until you do it for more than more than 15 months.'
> **GP Champion 5**

Many of the other activities that the GP Champions carried out were then sustained and delivered through the networks they had managed to develop. Most of the GP Champions carried out a number of different types of educational initiatives in their role, as these two GP Champions describe:

> 'I guess a lot of it very simply was education. We did quite a lot of education sessions, some collectively within [my patch] and then also I went to the pharmacist, so things like new guidance on statins and medications and stuff went specifically to kind of target the people that would be initiating that. I went to the GP training scheme. There's, like a group, meetings for each borough and did kind of online teaching to those as well.'
> **GP Champion 6**

> 'We did a lot of education sessions. I think we added it up - we think we've trained over 500 people across [my part of London]. So there was, there's definitely people came away with improved knowledge from those sessions, which is really like, which is what we were aiming for.'
> **GP Champion 7**

Running costs were £275,000 for the 15-month period including funding for project support and some small grants for targeted projects in addition to the agreed work programme

Although education could achieve a lot of positive change within HIV services, many informants felt that there were significant structural challenges that needed to be addressed to achieve more lasting improvements. The way that the current payment system for HIV works discourages collaboration which means that people living with HIV too often may not get optimal care, as this HIV consultant explains:

> 'The way that we've been paid in HIV is via block contracts, so that means that we're all very keen to keep our own cohorts rather than looking for opportunities to collaborate, [generate] economies of scale, you know, share our joint services etcetera. People are very feudal because they don't want their patients transferring out because they'll lose the block amount of money that they're paid for them. So you get a fixed amount of money per year per patient. So who wants to let their patient go to a frailty service at another centre? Because what if they never come back? We'll have lost the money attached to that patient. I mean, one of the main barriers is being that we need to be paid differently, which may or may not happen when we get funding devolved to ICB level. Because it should be right that people are seen in the right place by the right person at the right time.'
> **HIV consultant 4**

Further structural change in services is needed so that the needs of people living with HIV can be prioritised. The person living with HIV is not currently at the centre of how services function, the integration of services is what is needed as this GP champion explains:

> 'Why does someone have to travel halfway across the capital to have their bloods done? Why can't it be done in their general practice? Why do medications need to go to a hospital pharmacy to give? It doesn't make any sense. That kind of integrated thinking hasn't happened yet.'
> **GP Champion 8**

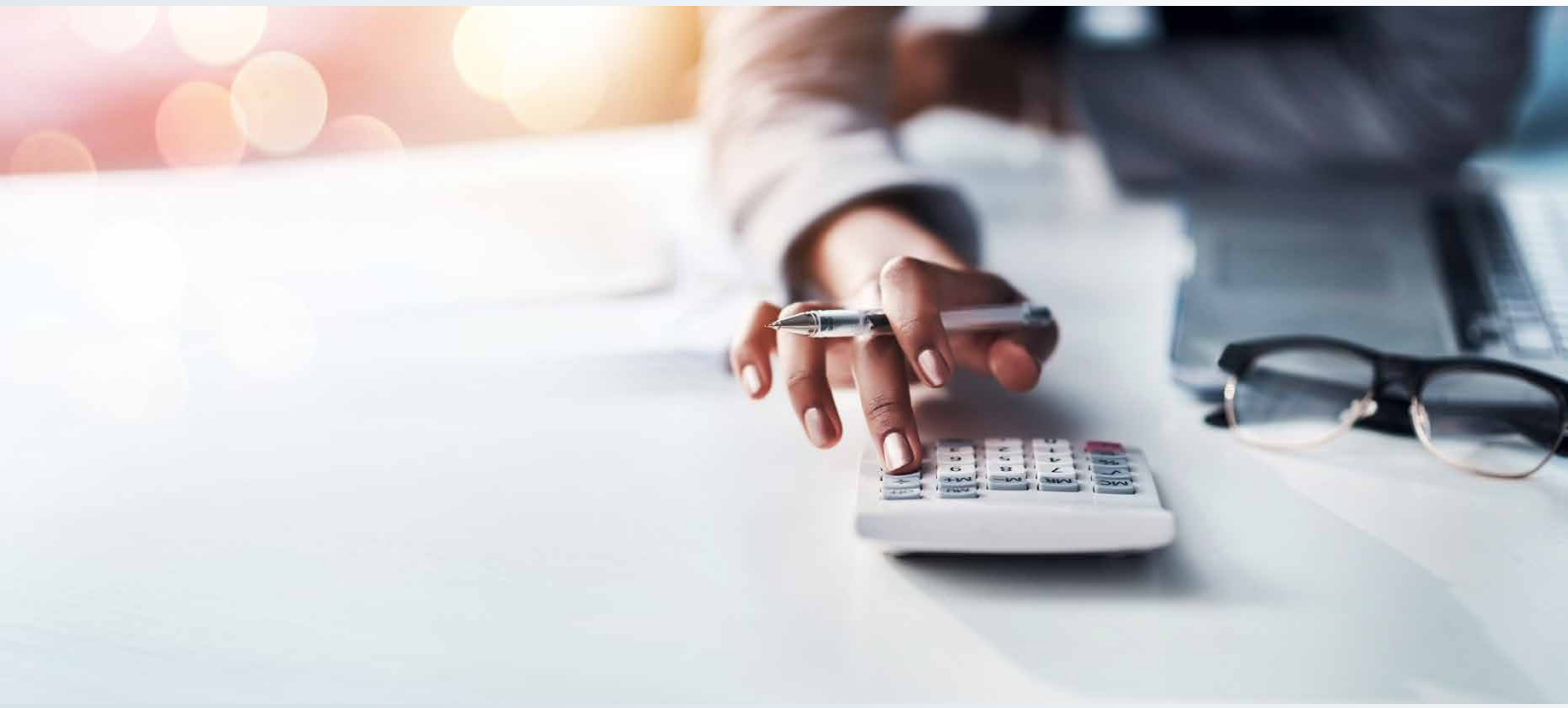
Although all the respondents felt that the GP Champions initiative had achieved many positive outcomes they did identify some problems with the initiative, these difficulties centred around issues to do with cost. These tended to fall into two different categories, the first was the lack of funds to cover the work that the HIV consultants provided for this project (which we documented earlier in the report) and the second was the general lack of resources that could be given to GP Champions to incentivise various changes that they were trying to initiate in general practice.

Although all the GP Champions felt that they were adequately funded for the time they spent on the project they did highlight that it was difficult to instigate changes in general practice without being able to offer financial incentives to practices as these two GP Champions illustrate:

> 'I think we're just at a difficult place if we haven't got the funding for it, people won't be very receptive in primary care to being given loads of stuff to do without funding, which is fair enough. I think the challenge is funding a lot of the time it's, you know, people want to do things and people will listen to me and say yeah, no, that sounds a good idea. It sounds in the patient's best interest, but where's the money?'
> **GP Champion 7**

> 'I've got no [financial] incentive to offer anyone, [so I can only encourage others by] understanding that things are good, good clinical practice or just, you know, because it's a good thing to do basically. And yes, I think that that's been quite hard. So you know the first question, oh, you know, is there any money behind this? I say no, you know, we're just we're just trying to encourage it and stuff.'
> **GP Champion 6**

These findings suggest firstly then that more thought may need to be put into how the project could be funded as a whole so that HIV consultants are costed for as described earlier in the report, and secondly that the GP Champions may need be given relatively small budgets that they can access for incentivising positive activities across general practice.



5. Next Steps

The GP Champions project will be funded for another year, into 2026 which will be welcomed by all those connected to the programme, however, the longer term funding of the initiatives that the GP Champions have instigated is less certain. If HIV services are no longer to be funded as a specialised central service, then it will be up to individual ICBs to decide on their budgets as this strategic manager explained:

> 'When HIV care gets delegated and is no longer a specialised service, the risk now is that each ICB doesn't continue the work. And that's the danger, because there is no central accountability for HIV services.'
> **Manager 1**

All the GP Champions felt that this type of initiative relies on momentum, and they felt that many of the improvements they have achieved might be lost if the project was to end as this GP Champion explains:

> 'I think the shame will be that there's a lot of good things going on and that when you stop that loses a lot of momentum. I think there are certain things that we've put in place and a lot of them will be carried on. But if without the sort of support from me and my colleagues, I can see things easily getting dropped or lost in the system.'
> **GP Champion 7**

The lack of clarity in relation to the strategic roles to be played by ICBs was frequently mentioned by GP Champions as a critical factor in terms of next steps and most GP Champions felt that ICBs had been somewhat disconnected from this initiative up to now and they found it difficult to access information about the ICB's role and responsibilities:

> 'But yeah, now, especially now the funding's about to move those links with the ICB would be really useful. I have tried to find out who's going to be in charge of the funding as of the 1st of April [2025] and nobody knows.'
> **GP Champion 7**

This would suggest that going forward significant efforts need to be made to develop links and engagement from the various ICBs in London as this strategic manager recognised:

> 'But the only thing I think was missing, but I think maybe it just didn't feel like they were in the right place when we set it up, were probably ICB people. So if we could go back and do it again, maybe that would have been a thing to do to try and do some engagement in each of the ICBs.'
> **Manager 2**

Several GP Champions felt that in the future that their role could be located within ICBs as this would give their work more credibility as this GP Champion explains:

> 'The alternative is you could have an HIV person for each borough, but within an ICB role. And then you can still meet regularly with the other ICB leads. With or without Fast Track Cities support. But you know, in order to be taken seriously by your colleagues, if it's an ICB role. You've got a reason to be emailing the practice saying, I'm the southeast London HIV lead, I need to know your new cases. Please can you let me know how many positives you have rather than I'm an HIV Champion for Fast Track Cities. So that would make it sustainable.'
> **GP Champion 3**

However, the overwhelming feeling amongst all the respondents was that the best way to keep improving services for people living with HIV was to work towards the reclassification of HIV as a long term condition, rather than as a specialised service as it currently is. Both the GP Champions and the HIV consultants argued that this was the best way forward for the service and for people living with HIV:

> 'Make HIV a chronic long term condition, just like diabetes is, just like asthma. And I think that's where I kind of over the year became very passionate about kind of the take home message, I would love to see HIV [care] being paid [for by] GPs, as if it was an asthma, as if it was a diabetes, because that's what it should be, a long term condition. It's a long term chronic condition.'
> **GP Champion 4**

Such a change in classification would bring benefits to people living with HIV as this GP Champion explains:

> 'Let's say like a long term condition review. You know, just to kind of sit down with the HIV patient and consider these things, [this kind of thing is] funded for diabetes, it's funded for heart disease, it's not funded for HIV. So you know, if someone remembers while they're sitting with them, you know, ad hoc, you might get something, but to get any kind of consistent, meaningful change, it just feels like you need a lot more behind you than we have. I do think things like funding it as a long term condition would be huge.'
> **GP Champion 6**

Such a change would additionally mean that people living with HIV would be exempt from prescription changes which an HIV consultant felt would help many of his patients who were struggling financially.

In summary, the overwhelming desire from participants was that the HIV GP Champion work should continue into a second year and possibly beyond, so that the gains already delivered could be extended and sustained over time. In the longer term, the drive to reframe HIV as a LTC is a key aim that unified all the stakeholders we interviewed.

Conclusions and Recommendations

As set out earlier, this service evaluation explores the following five research questions:

- What is the nature of the HIV GP Champions pilot project? i.e. what are the key aims, activities, processes and interventions that drive the project, and do these meet the original objectives of the project?
- What are the characteristics of the HIV GP Champions and what motivations do they give to explain their involvement in this work?
- What is the overall strategy and ethos behind the HIV GP Champions pilot project?
- What are the operational elements of the HIV GP Champions pilot project, how have these evolved over time, and how do these facilitate (or not) the aims of the project?
- What should and could come next, after the end of the initial period of funding for the HIV GP Champions pilot project?

In this final section, we return to these questions, offering some conclusions on the effectiveness of the HIV GP Champions pilot project and discuss the strategic thinking and practical processes and activities behind the effectiveness before offering some recommendations for future work in this area.

Overall, we conclude that the HIV GP Champions pilot project has been successful in meeting its original objectives. As detailed in this report, the GP Champions have generated good evidence of increased HIV testing across many London ICSs. There is also good evidence of work to improve HIV awareness, not just amongst other GPs, but wider NHS and community stakeholders through training and outreach programmes. These education and awareness raising sessions are reducing HIV stigma across primary care in London as attested to in general positive feedback on these sessions and the number of NHS organisations that are engaging with the HIV Confident programme. Beyond increased HIV testing figures, there is evidence of improved health and well-being for people living with HIV in London, for example through increased statin uptake for those eligible.

It is clear through the qualitative research findings that all participants have a good grasp of the key aims of the HIV GP Champions pilot project and that the GPs recruited to work as Champions are highly motivated, dedicated and capable. The overall strategic approach to the delivery of these aims is set by the project leadership team and is characterised by a distributed leadership approach which encourages individual GP Champions to draw on their own clinical and professional judgement to collaboratively (with other local GP Champions and HIV hospital consultants, as well as the wider pan-London GP Champion team) assess local problems and priorities, and to tailor the activities and interventions to meet the project aims as best suited to their own ICS areas. This gives the GP Champions a level of freedom and responsibility that they highly value.

The links between the GP Champions and local hospital HIV consultants emerges as crucially important in the qualitative findings. It is appreciated by both GPs and HIV consultants and delivers on the central aim which is to improve primary-secondary care relations in HIV care.

It seems that it is often through the operational elements of the project (HIV testing, statin prescribing, educational outreach) that the wider aims of HIV stigma reduction and the efforts to reframe HIV as a long-term-condition are taking place on a day by day basis with repeated interactions. However, we know from other recent work that significant barriers remain in this regard and that continued and sustained work is needed to overcome these (Unheard Voices, 2025).

Moving on to recommendations, we would underline the following points for consideration:

- The HIV GP Champion project pilot has proven itself to be valuable – both in terms of impacts and processes. It would therefore be worth extending the project beyond the initially funded time period so that the gains made by the project can be sustained and extended.
- The work of the HIV consultants is crucial to the effectiveness of the work that the GP Champions do. It is important that the HIV consultants are appropriately funded for their involvement in this work in the future.
- Without wishing to damage the overall ethos of the pilot project, which encouraged locally led, contextually informed approaches to meeting the aims of the project, it would be worth considering a small set of pan-London performance metrics to be collected and published to highlight the effectiveness of the project in a more systematic way. To maintain the initiative's devolved approach, the metrics could be collaboratively developed by the GP Champions themselves rather than be mandated from the centre.
- Although the GP Champions have made great progress in advancing HIV care, this could be further enhanced if they had access to a central budget from which they could bid for small funds for specific projects.

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