

1. Summary

Title	Re-engage people with HIV who are lost to care, back into clinical care and treatment
Kick off meeting	March 2026

2. Context and outline

Purpose of grant programme	<p>Aim To deliver a coordinated programme of work designed to re-engage Londoner's living with HIV back into care, on their medication and with an improved quality of life.</p> <p>Objectives</p> <ol style="list-style-type: none"> 1. Trace and contact people living with HIV and not in care. 2. Provide personalised support to people living with HIV and out of care. 3. Re-engage people with HIV who are lost to care, back into clinical care and treatment. 4. Improve quality of life for people living with HIV alongside re-engagement support.
Context for funding	<p>UKHSA defines the lower threshold of people not in HIV care as those not seen in the last 15 months. The upper threshold is people not seen in the last 5 years.</p> <p>Latest UKHSA data estimates that that in England, the lower threshold is 4,307 people and the upper threshold is 12,068 people.</p> <p>In London these figures are 1,541 people and 5,568 people. This means that London represents between 36% and 46% of the total number of people in England that are not engaged in care.</p> <p>See slides included with pack for a further breakdown of data by gender identity, age, route of exposure, ethnicity and ICB of residence.</p>

Approach and dependencies	<p>Expected approach</p> <p>We are looking for applications from one or two consortiums/ partnerships that want to work in collaboration with the Fast Track Cities Leadership Group.</p> <p>This work must be delivered to people who have been identified by UKHSA as out of care and whose details have been shared with clinics via the HARS database, and who are living in one of the London boroughs or who are or were accessing care in London.</p> <p>The model or approach to delivering this work should include the following aspects:</p> <ul style="list-style-type: none"> • Cleaning the data provided by UKHSA to remove people who are in care elsewhere, out of the country or deceased. • Tracing and contacting people who remain on the list. • Providing a referral pathway for people identified via the opt out testing in emergency departments programme. • Providing appropriate support to meet the specific needs of individuals to improve the quality of their life and re-engage them with care, whether in-clinic or via remote access. • A fund to provide practical support such as help with travel expenses, emergency food and childcare. • A ‘learn and share’ approach to working with re-engagement leads across the city to shape and inform future service provision <p>To be successful the consortium/partnership should include:</p> <ul style="list-style-type: none"> • HIV clinics (NHS Trusts) and staff, both in-clinic and outreach roles. • Other NHS partners specialising in inclusion health or track and trace activities, for example NHS Find and Treat. • Voluntary and community organisations to deliver peer support and to tackle identified barriers to re-engagement (such as stigma, mental health, drug/alcohol use, housing, poverty and immigration). <p>The approach can be tailored by the consortium/partnership, working closely with the Fast-Track Cities London programme team, using quality improvement methodologies to trial, test and adapt methods to get the best results.</p>
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The grant application will need to cover funding to include:

- Project management or admin support.
- NHS staff costs, extra shifts, buying back NHS time/resource.
- Paying the voluntary and community sector (HIV and non-HIV).
- Expenses for people living with HIV involved in the project and expenses for patients, e.g. mobile phone data, food/travel expenses, incentives and hardships funds.

Fast-Track Cities London will separately fund:

- London's HIV GP Champions
- Overarching programme evaluation
- Quality improvement support
- Any other admin and programme management that supports strategic delivery of the re-engagement programme, convening and sharing knowledge outside of London and with other Fast-Track Cities.

Interdependencies

The consortium must collaborate with:

1. Other Fast-Track Cities London workstreams like; Getting to zero collaborative (peer support and wraparound VCSO support), stigma programmes, London's HIV GP Champions and with the NHS England opt-out BBV ED testing programme.
2. Other re-engagement in care programmes of work in London.
3. UKHSA to ensure you're working with the most up to date lost to follow up data.
4. Link in with the new national HIV action plan December 2025 and any re-engagement implementation group.
5. Work in line with any new BHIVA standards of care on re-engagement.
6. ICBs now responsible for commissioning HIV services.
7. Engage with work led by Fast Track Cities London to achieve a sector wide consensus on confidentiality within HIV care, in the current context.

Expected outcomes and evaluation

Applicants should be open to a quality improvement methodology and an ongoing evaluation designed to learn lessons to share more widely. Fast-Track Cities London will commission an evaluation and work with the consortium to ensure robust data collection and internal project evaluation.

	<p>All projects should set aims for number of patients reengaged in the first year. Years 2 and 3 of funding will be contingent on meeting these milestones.</p> <p>All projects will complete the same standardised data collection sheet and return anonymised data to Fast Track Cities London for analysis.</p> <p>All projects will also have to return updated information on patients out of care on the clinic dashboard to UKHSA so that UKHSA can update national HARS database.</p> <p>Definitions: The definition of patients not in care is not seen for > 15 months (other option is no VL blood test for 15 months) or off treatment and not seen > 8 months.</p> <p>Definitions will be discussed and agreed together at the start of the project.</p> <p>Some of the key outcomes you'll be expected to measure and provide are the following:</p> <ul style="list-style-type: none"> • Numbers of patients re-engaged • Demographics of patients • CD4 count and VL at reengagement • Viral load date and value every 6 months for 2 years post engagement • Wellbeing assessment results, e.g. use the Fast-Track Cities <i>Getting to zero wellbeing</i> survey. • Reasons for being out of care • Hospital admissions
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3. Finance and monitoring

Context	<p>The total grant pot is £450,000 for year one.</p> <p>There will be funding for years 2 and 3 dependent on agreed outcomes.</p> <p>The funding will come in the form of a grant from the Fast-Track Cities London Leadership Group.</p> <p>The proposal from a consortium/partnership should include the proposed management of the grant money in terms of payments and distribution among the VCSO and NHS partners.</p> <p>This initiative will be monitored by the Fast-Track Cities London Leadership Group and report on a quarterly basis.</p> <p>Transformation Partners in Health and Care (TPHC) is hosted by the Royal Free London NHS Foundation Trust. The Royal Free London NHS Foundation Trust will hold this contract on behalf of Fast-Track Cities London.</p>
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	<p>As well as additional years funding, there is a potential of up to 50% extension in contract value/timescales, subject to additional funds becoming available to Fast-Track Cities London in future budgets. This would be awarded at the discretion of the Leadership Group, based on the outcomes delivered by the programme.</p>
4. Provider requirements	
Key skills and experience	<ul style="list-style-type: none"> • Excellent knowledge of HIV, incorporating strong understanding of prevention, diagnosis, treatment and care, quality of life, stigma and discrimination. • Excellent understanding and experience of supporting people around the wider determinants of health and inequalities related to HIV and sexual health through the life-course. • A clear understanding of the current HIV NHS and voluntary sector services across London, from prevention to treatment, care and support services. • Experience of positively influencing outcomes for and working with people living with HIV with complex intersecting needs. • Ability to work collaboratively with multiple stakeholders from diverse communities. • Strong project management skills. • Experience of working in supporting the mental health and wellbeing of people accessing their services. • Experience of linking/partnering with NHS organisations, voluntary sector partners and primary care. • Experience of improvement methodologies, or willingness to learn. • Political sensitivity and ability to maintain neutral, evidence-based approach to the programme. • Experience of delivering large programmes of work with maximum impact. • Capacity and ability to undertake the proposed initiative. • Ability to collect and analyse data to gain insight, inform decisions and improvements, and build data-led reports • Participate in delivery of evaluation of the programme to share learning.