HEPHIV2026 · DUBLIN · CLOSING SESSION

Beyond silos

Integrated approaches to HIV and blood-borne virus prevention, testing and care: lessons from England

The final mile in ending HIV transmission will not be reached through HIV services alone.

Professor Kevin Fenton CBE FFPH MD PhD FRCP
Regional Director of Public Health, NHS London
Chief Advisor on HIV to the UK Government



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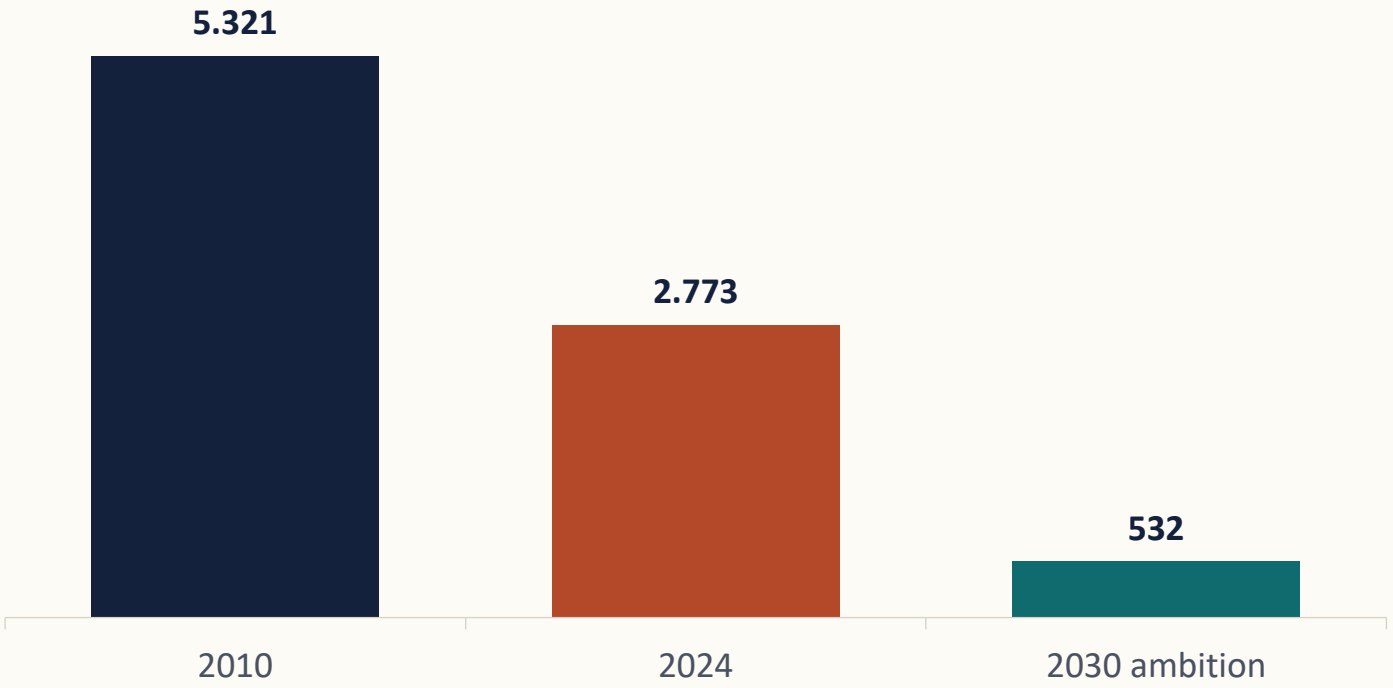
WHERE WE ARE

England has almost halved new HIV diagnoses, but a substantial gap remains to 2030

New HIV diagnoses in England (diagnoses, not infections)



6,000

adults estimated to be living with undiagnosed HIV in 2024

–80%

further fall in diagnoses needed between 2024 and 2030

Context: 95-95-98 in 2024. The treatment figure now includes diagnosed people outside care.

Source: UKHSA. HIV Action Plan monitoring and evaluation framework: 2026 report (2024 data; updated Sept 2026). Diagnoses are first diagnoses in England and a proxy for, not a measure of, incidence; people previously diagnosed abroad are excluded.



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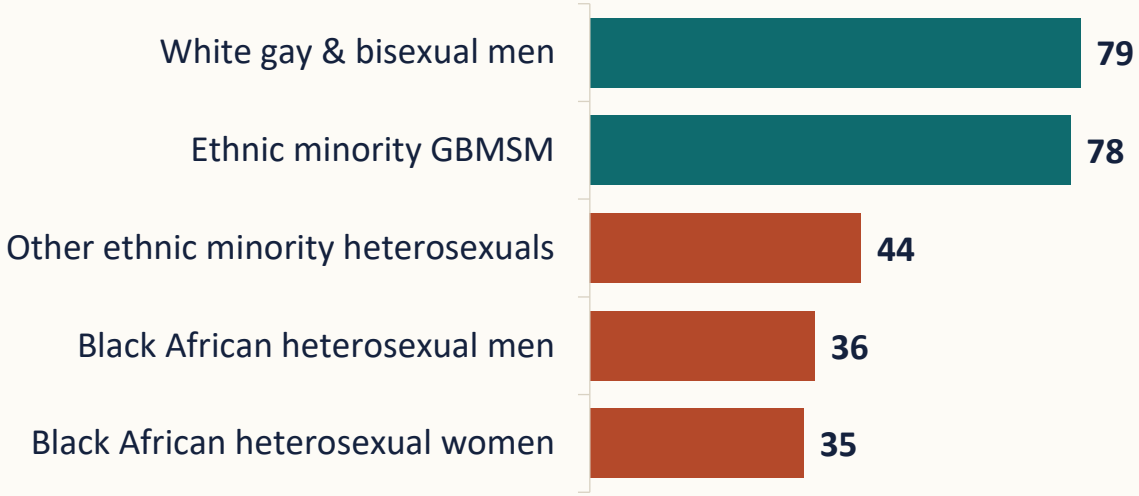
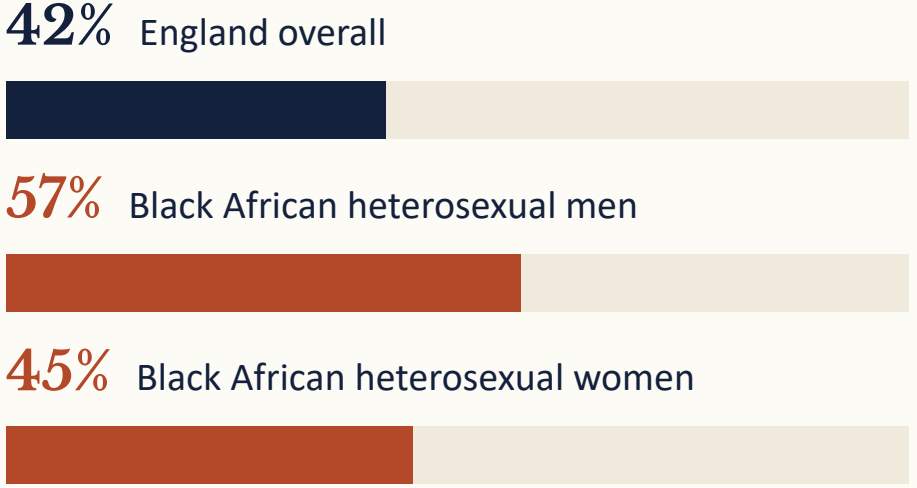
WHO IS BEING MISSED

Unequal access to prevention and timely diagnosis threatens equitable progress

PrEP need met, 2024 (%)



Diagnosed late, 2024 (%)



As diagnoses fall, progress depends on reaching people existing pathways serve less well.

Source: UKHSA. HIV Action Plan monitoring and evaluation framework: 2026 report (2024 data; updated Sept 2026). PrEP need met = initiated or continued PrEP among attendees with identified need. Late = CD4 <350 at diagnosis; proportions within each group.



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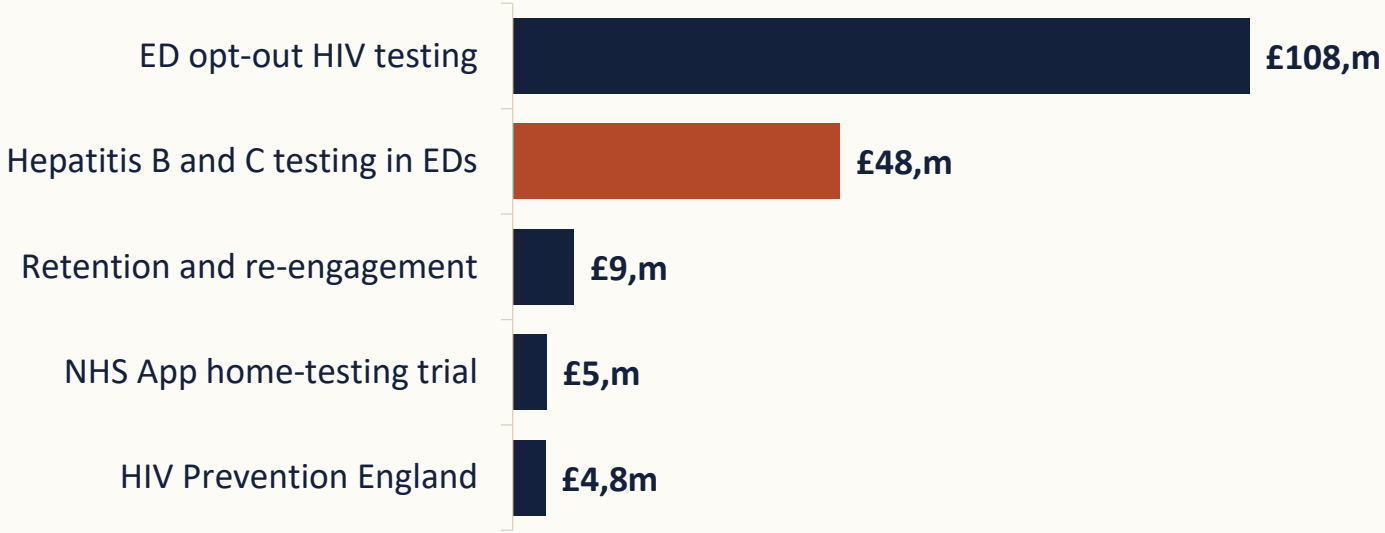
THE POLICY PLATFORM

England's 2025–2030 plan is HIV-specific in ambition, integrated in delivery

Prevent	Test	Treat	Thrive	Collaborate

New national commitments, 2026–29 (£ million)



£170m

additional national investment, April 2026 to March 2029

5

population groups monitored separately, not just the national average

Sources: DHSC. HIV Action Plan for England 2025 to 2030 (Dec 2025); UKHSA. HIV Action Plan monitoring and evaluation framework: 2026 report (2024 data; updated Sept 2026). Additional national investment, April 2026 to March 2029.



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WHAT INTEGRATION MEANS

Integration means removing unnecessary fragmentation, not merging every service

BY POPULATION

Who has overlapping risks and needs?

Design services around them, not around a single infection.

BY PLACE

Where do people already present?

Emergency departments, pharmacies, prisons, drug and homelessness services.

ACROSS THE PATHWAY

Where do people fall through?

Prevention, testing, linkage, treatment, retention, re-engagement.

ACROSS CONDITIONS

Where does combining add value?

HIV with hepatitis B and C; STIs, TB, mental health and vaccination where it fits.

Protect specialist expertise. Remove unnecessary fragmentation.

Sources: WHO. Global health sector strategies on HIV, viral hepatitis and STIs 2022–2030; ECDC. Public health guidance on HIV, hepatitis B and C testing in the EU/EEA: an integrated approach (2018).



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THE CASE FOR INTEGRATION

Five reasons integration matters for prevention and control, with evidence of different strength

REASON	RATIONALE	EVIDENCE ●●● trial ●●○ observational ●○○ modelling
Infections cluster in the same people and places	Shared routes of transmission and shared social drivers	ED testing built for HIV: 3,667 new HBV vs 719 HIV diagnoses. TB killed 150,000 people with HIV in 2024 ●●○
Every handoff loses people	Each referral adds appointments, journeys and disclosures	HCV treatment in PWID: 73% same-site vs 35% hospital-only (meta-analysis); 77% → 98% (RCT) ●●●
Multi-disease platforms improve several outcomes	One patient-centred contact can address several conditions	SEARCH RCT: viral suppression 79% vs 68%; hypertension control 47% vs 37%; HIV incidence unchanged ●●●
Routine offers reach people risk-based services miss	No need to disclose, or be judged to be, at risk	ED opt-out: 63% had no previous test; women were 35% of new HIV diagnoses vs 30% elsewhere ●●○
Shared infrastructure stretches shrinking budgets	Shared blood draw, labs and staff; donor HIV funding fell 18% in 2025	UK model: ED HCV and HBV testing about £8,000–£9,900 per QALY. HCV cure at homeless sites: £257 per case ●○○

Not automatically better: hepatitis B treatment starts were 49% in primary care vs 78% in specialist care (2025 meta-analysis).

UKHSA ED evaluation 2025; WHO Global TB Report 2025; Oru, Lancet Glob Health 2021; Fadnes, PLoS Med 2021; Havlir, NEJM 2019; Williams, Value Health 2020; Stockdale, Lancet Gastroenterol Hepatol 2025. Full references in backup.



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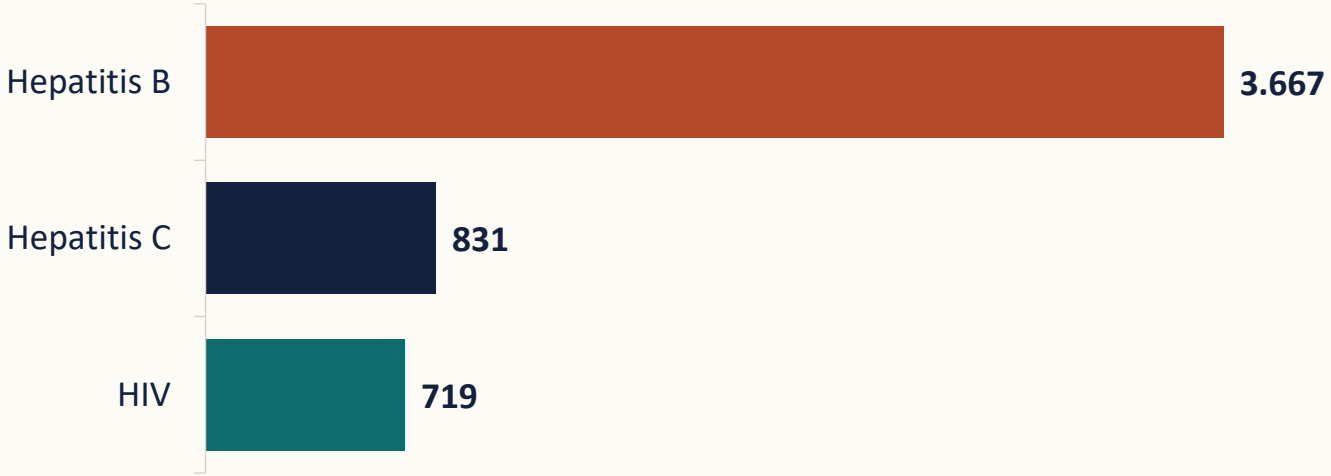
EMERGENCY DEPARTMENT OPT-OUT TESTING

Testing built for HIV found five times as many new hepatitis B diagnoses as HIV

New diagnoses by virus, 24 sites (categories overlap)



240

people tested per new hepatitis B diagnosis

1,276

people tested per new hepatitis C diagnosis

1,916

people tested per new HIV diagnosis

7.1m

virus tests in 34 EDs: tests, not people

5,185

people newly diagnosed in 24 sites

63%

of eligible attendees had no previous BBV test on record

Source: UKHSA. Public health evaluation of BBV opt-out testing in EDs in England: 33-month final report (Apr 2022–Dec 2024; published Oct 2025). Tests: 34 EDs. Diagnoses: 24 sites with complete data; virus counts overlap.



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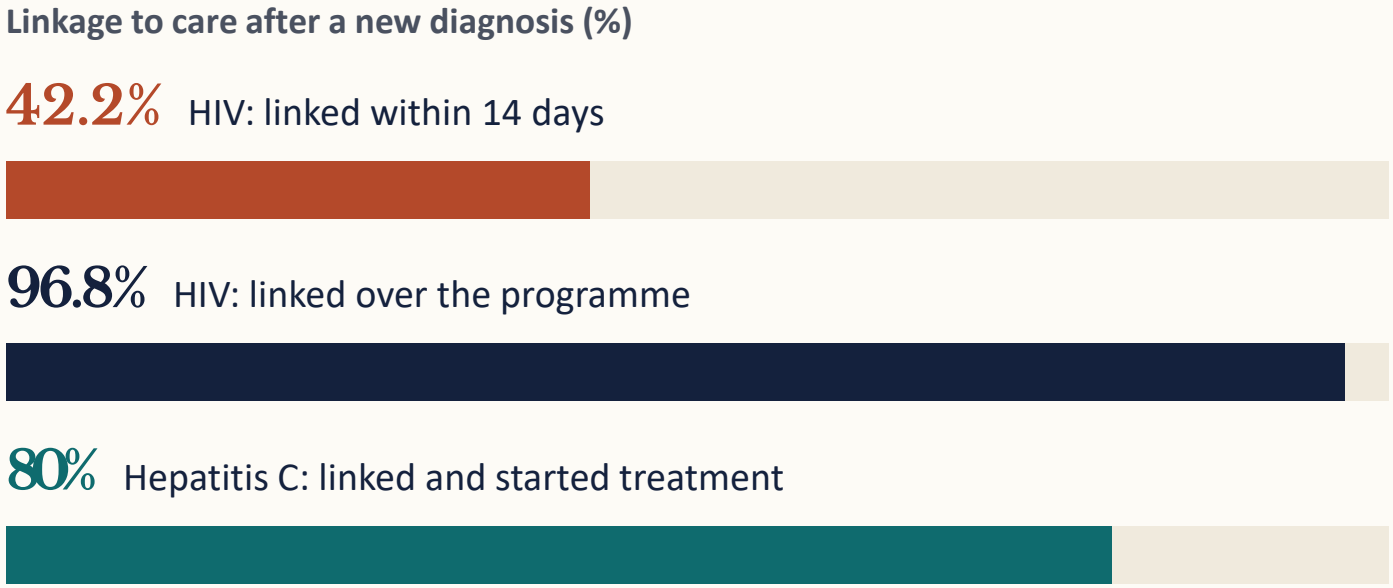
EMERGENCY DEPARTMENT OPT-OUT TESTING

Routine testing finds unmet need. Timely linkage remains the next challenge

Linkage to care after a new diagnosis (%)



86%

of people newly diagnosed with HIV had attended an ED in the previous year

A likely earlier testing opportunity, not proof of earlier infection

Hepatitis B: no national registry, so the care cascade cannot be assessed nationally

Integrated testing creates the opportunity. Funded follow-up decides how fast people benefit.

Source: UKHSA. Public health evaluation of BBV opt-out testing in EDs in England: 33-month final report (Apr 2022–Dec 2024; published Oct 2025). HBV: no national care registry; local data from 7 London sites.



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INTEGRATION BY POPULATION

Integrated delivery can improve access and outcomes, with different levels of evidence

PEOPLE WHO INJECT DRUGS

INTRO-HCV · Norway

●●● Randomised trial · 298 people

77% → 98%

started hepatitis C treatment (hospital vs integrated)

Cure among all randomised rose from 64% to 83%: more people started treatment

PEOPLE EXPERIENCING HOMELESSNESS

END C · southeast England

●●○ Prospective evaluation · 418 people · no comparator

105 of 116

with active hepatitis C started treatment; 81% cured

High uptake and cure at modest cost, but no comparator group

GBMSM AFFECTED BY CHEMSEX

M3THOD · Sydney

●○○ Formative evaluation · 33 interviews

Acceptable, feasible

peer support and service navigation valued by clients

Clinical outcomes not yet shown. Needs trained, supervised peers and referral routes

Fadnes LT et al. PLoS Med 2021;18:e1003653 (INTRO-HCV). Mourad A et al. JHEP Rep 2024;6:101183 (END C). Freestone J et al. Harm Reduct J 2025;22:181 (M3THOD). Details in backup slides.



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MAKING IT HAPPEN

Five implementation lessons for integrated delivery

1

Shared purpose and leadership

One population outcome, owned with communities

2

Aligned investment

Align incentives where costs and benefits cross boundaries

3

Governance and accountability

Named leaders, clear roles, escalation routes

4

Shared data and metrics

One pathway view, stratified by population

5

Workforce, peers and learning

People, not just protocols; test, adapt, spread

MEASURE THE WHOLE PATHWAY, STRATIFIED BY POPULATION





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WHAT WE ARE LEARNING

Integrated delivery can improve access and treatment uptake. Its success depends on completing the pathway.

Start with people, not diseases

Integrate where epidemiology and pathways overlap, not for its own sake

Fund the follow-up, not just the test

Measure who benefits, not how many services were combined

Integration is not a distraction from the goal. It is the route to achieving it.



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BACKUP · INTRO-HCV

INTRO-HCV: integration improved cure mainly by getting more people into treatment

Design	Multicentre randomised controlled trial (1:1), not fully blinded; recruitment 2017–2019
Setting	Opioid agonist therapy and community care clinics, Norway
Participants	298 people who inject drugs with chronic HCV (148 integrated, 150 standard)
Intervention	On-site testing, fibrosis assessment, counselling, DAA treatment and follow-up by multidisciplinary teams vs hospital outpatient care
Results	Initiation 98% vs 77% (HR 2.2, 1.7–2.9). SVR all randomised 83% vs 64% (OR 2.8, 1.6–4.8); among treated 85% vs 83%
Limitations	Single country; not fully blinded; follow-up to SVR12

Fadnes LT, Aas CF, Vold JH et al. Integrated treatment of hepatitis C virus infection among people who inject drugs: a multicenter randomized controlled trial (INTRO-HCV). PLoS Med 2021;18(6):e1003653. doi:10.1371/journal.pmed.1003653



BACKUP · END C

END C: decentralised care at homeless sites achieved high treatment uptake

Design	Prospective service evaluation; no randomised or concurrent comparator
Setting	Multiple homeless sites, southeast England (Sussex), with novel linkage-to-care strategies
Participants	418 people (74% currently homeless; 25% current injecting; 65% current alcohol use)
Results	116 (28%) HCV RNA positive; 105 started DAAs. ITT SVR12 81% (72–88%). Reinfection 6.82/100 person-years
Cost and quality of life	£359 per case detected, £257 per case cured (2022 £). Quality of life improved after cure
Limitations	No comparator; single region; adherence was the only predictor of cure

Mourad A, McGeer R, Gray E et al. A novel multisite model to facilitate hepatitis C virus elimination in people experiencing homelessness. JHEP Rep 2024;6(11):101183. doi:10.1016/j.jhepr.2024.101183



BACKUP · M3THOD

M3THOD: peer-led chemsex support is acceptable; clinical effectiveness is untested

Design	Implementation and formative evaluation; thematic analysis of field notes and 33 interviews
Setting	Peer-led service for GBMSM using crystal methamphetamine and GHB in sexual contexts, Sydney
Intervention	Harm reduction education, motivational interviewing and service navigation by peer workers
Interviews	15 clients, 9 eligible non-recipients, 3 peer workers, 2 managers, 4 partnering clinicians
Findings	Acceptable, appropriate and feasible; peers built rapid rapport and reduced shame; clients wanted ongoing support
Requirements and limits	Training, supervision, pastoral care and referral pathways needed. No HIV, HCV or overdose outcomes measured

Freestone J, Storer D, Siefried KJ et al. Implementation and formative evaluation of a peer-led chemsex intervention targeting sexualised crystal methamphetamine and GHB use: the M3THOD study. Harm Reduct J 2025;22:181. doi:10.1186/s12954-025-01329-2



BACKUP · ED OPT-OUT TESTING

ED opt-out testing: what the evaluation can and cannot tell us

Scope	34 EDs in wave 1 (London, Manchester, Blackpool, Brighton); 1 April 2022 to 31 December 2024
Tests vs people	7.1 million virus tests (2.78m HIV, 2.36m HCV, 1.99m HBV); one attendance can include all three
Diagnoses	24 sites with complete data: 5,185 people newly diagnosed; virus counts (3,667 / 831 / 719) sum to 5,217
Linkage	HIV 42.2% within 14 days, 96.8% over the programme; HCV 80% linked and treated; HBV no national registry
Re-engagement	6.1% (483) of previously diagnosed people with HIV and 86% (659) with HCV were not engaged in care
Interpretation	Observational; prior ED attendance suggests missed opportunity but not earlier infection or eligibility

UKHSA. Public health evaluation of BBV opt-out testing in EDs in England: 33-month final report. Published 29 October 2025; updated 3 February 2026.

