Developing PrEP care models for diverse needs in Scotland: Report of a multi-sector workshop, March 2023

1. Background

Scotland's HIV transmission elimination strategy, 'Ending HIV Transmission by 2030' (https://www.gov.scot/publications/ending-hiv-transmission-scotland-2030/), recognised that although the national PrEP programme has been highly successful in reducing HIV acquisition (Estcourt et al., 2021; https://journals.lww.com/aidsonline/Fulltext/2021/03150/Population_level_effectiveness_of_a_national_HIV.15.aspx), the benefits of PrEP have not been experienced by all in society. The strategy called for the development of new models of PrEP provision to meet diverse needs.

The workshop

As part of work undertaken by a dedicated short life HIV Transmission Elimination Oversight Group (HiTEOG) a workshop was held in March 2023, co- chaired by Mr Grant Sugden, CEO of Waverley Care, Scotland's leading HIV & Hepatitis C charity, and Prof Claudia Estcourt, a clinical academic in Sexual Health & HIV at Glasgow Caledonian University & NHS Greater Glasgow and Clyde.

Our aim

We aimed to outline possible new models and or settings for PrEP provision, in line with HIV transmission elimination goals:

1) to better meet needs and preferences of people who could benefit from PrEP but who are not doing so currently
2) to provide a basis for future co-production of detailed models, pilots, and research and implementation grant proposals
3) to identify whether / where HIV testing is the key barrier to engagement with PrEP (and other HIV prevention) i.e. testing interventions are needed as a first step to engagement with PrEP – and determine if there are settings in which we are not maximising potential for PrEP in settings already offering HIV testing.

Thirty eight multi-sector, multi-disciplinary attenders from across Scotland represented clinicians providing PrEP services, Public Health Scotland STI BBV team, public health practitioners, NGOs, academics, PrEP users, pharmacists, GPs and other community health care providers. Participants from England provided expertise based on the English PrEP roll out. Invitees who were unable to attend were invited to submit ideas, views and opinions ahead of the event so that they could be included in the small group discussions.

The workshop was structured as an initial context session, followed by evidence-based presentations from experts, which summarised the scientific literature pertaining to five groups / settings. These then formed the starting points for small groups sessions (focus groups) to develop possible care models for each group / health care setting. Finally, each group shared their discussions with all workshop attenders.

The five areas / groups had been identified as priorities by the HIV Transmission Elimination Implementation Group leads (Prof Nicola. Steedman & Dr Dan Clutterbuck), working with Prof Claudia Estcourt & Mr Grant Sugden, ahead of the event. In brief, selection was based on Scottish evidence on i) groups who were felt to be under-utilising PrEP, and ii) groups / areas / settings not being covered by other

committed funding e.g. online PrEP provision, or by specific work in other UK countries e.g. services for women of colour.

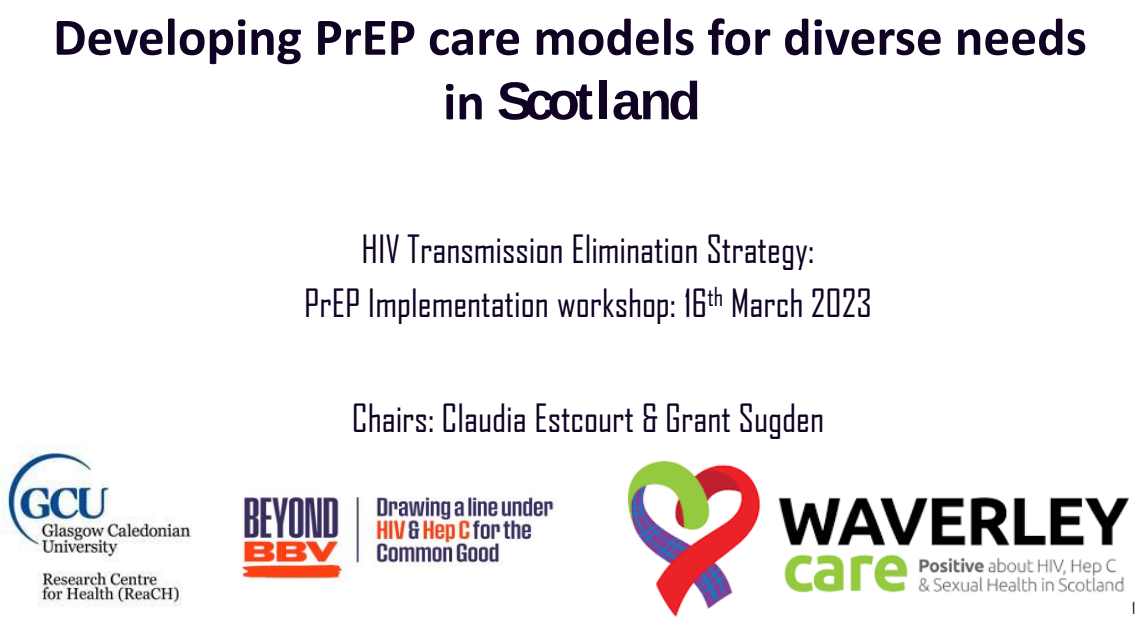
The five groups / settings we focussed on were:

1) Trans people
2) Men who have sex with men (MSM) not attending sexual health services (SHS)
3) PrEP models delivered in whole / part through community pharmacy
4) PrEP models delivered in whole / part through general practice
5) Outreach / reach out models for specific groups experiencing geographic isolation

This report summarises workshop presentations and findings. We hope this is useful for people wishing to develop their services, establish pilots and or research funding proposals.

2. Context for PrEP in Scotland in 2023

To access the slides below, make sure you have saved the document (so not 'read only') and then double click the image below.



3. Summaries of breakout sessions

After the workshop, breakout group leads summarised their discussions. These are provided below, and structured in whichever way the group leads felt was optimal for their content.

a) PrEP services for trans people
b) PrEP services for MSM not attending SHS
c) PrEP models delivered in whole / part through community pharmacy
d) PrEP models delivered in whole / part through general practice
e) Outreach / reach out PrEP models for specific groups experiencing geographic isolation

a) Breakout Discussion PrEP services for Trans People

Lead by Prof Paul Flowers (University of Strathclyde), Oliver Ellis (Waverley Care), and Julie McLeod (Glasgow Caledonian University (GCU)): three participants.

1) What is the aim of the novel PrEP model / care pathway?

The aim of a novel PrEP care pathway would be to improve access to PrEP for trans people. This could be modeled in the following ways (see Figure 1):

- A service available through community-based organisations that is separate from the NHS but has funding and professional support
- A service like London clinic, CliniQ (https://cliniq.org.uk/), that provides holistic wellbeing and sexual health services for the trans community - including PrEP, PEP, peer mentoring, counselling
- A service providing more than just PrEP - gender, sexual health and other health care including support with hormones and surgery; support with name change; PrEP and other SH-related support; drug and alcohol support
- A service by trans people for trans people

It was discussed that a novel PrEP care pathway may involve starting with a peer support model and migrating to a wider service and that there would be a significant benefit of harnessing social and peer support and influence as a route into the service.

2) Who do we want to reach?

We want to reach all trans people. An important group are those waiting on hormones and surgery, who may be self-funding hormones and saving to privately fund surgery - waiting for gender affirming care is a huge barrier to accessing and using any other healthcare. Additionally, we want to reach trans people who are already accessing NHS gender services but do not feel comfortable talking to healthcare professionals about their sexuality, as well as trans people who have had no contact whatsoever with NHS services for gender care or sexual health - we hope a novel pathway would be a way to reach people who will not engage with standard NHS services.

3) What are the barriers and facilitators to accessing PrEP for people in this group?

A range of barriers and facilitators to trans people accessing PrEP were identified (see Table 1). Of these, the key barriers were waiting for gender care and a lack of trust in sexual health services. It was discussed that those waiting for gender care, on up to 5 year waiting lists, would likely not be thinking about sexual healthcare, nor be receptive to receiving it when they could not yet receive hormones or surgery. Additionally, historic negative experiences with sexual healthcare has led to an overall mistrust of sexual health services. As such, the key facilitators were being able to access PrEP through community-based organisations which are trusted and have professional support as well as ensuring trans people are in paid positions of power and influence in sexual health services and PrEP services are co-produced with trans people.

4) What is the evidence that the proposed new setting / pathway is appealing to people from that group?

It was discussed that community-based organisations are much more trusted by trans people than sexual health services and are provided and used far more often by trans communities. Further, the success of CliniQ is also evidence that a holistic service is appealing for trans people, as the service offers a wide range of sexual health services (e.g. PrEP, PEP, cervical screenings), mental health services (e.g. counselling, mentoring, peer support), and other forms of practical support (e.g. blood tests for hormone monitoring). Additionally, pharmacies were discussed as a possible PrEP care pathway. Although there is no documented evidence of their effectiveness for trans health care, pharmacies are perceived to be more anonymous than

sexual health services, are in numerous locations, and are already being accessed by trans people who do not use healthcare services. While there is no definitive pathway due to a lack of research, the evidence suggests a trans-led, holistic, community-based service is appealing to trans people.

5) Exactly how will the care pathway work e.g., PrEP initiation, follow up or both?

A PrEP care pathway through a community-based organisation pharmacy and/or holistic sexual health service would be inclusive of initiation and follow-up.

Figure 1: *A PrEP model of care for trans people including possible routes in*

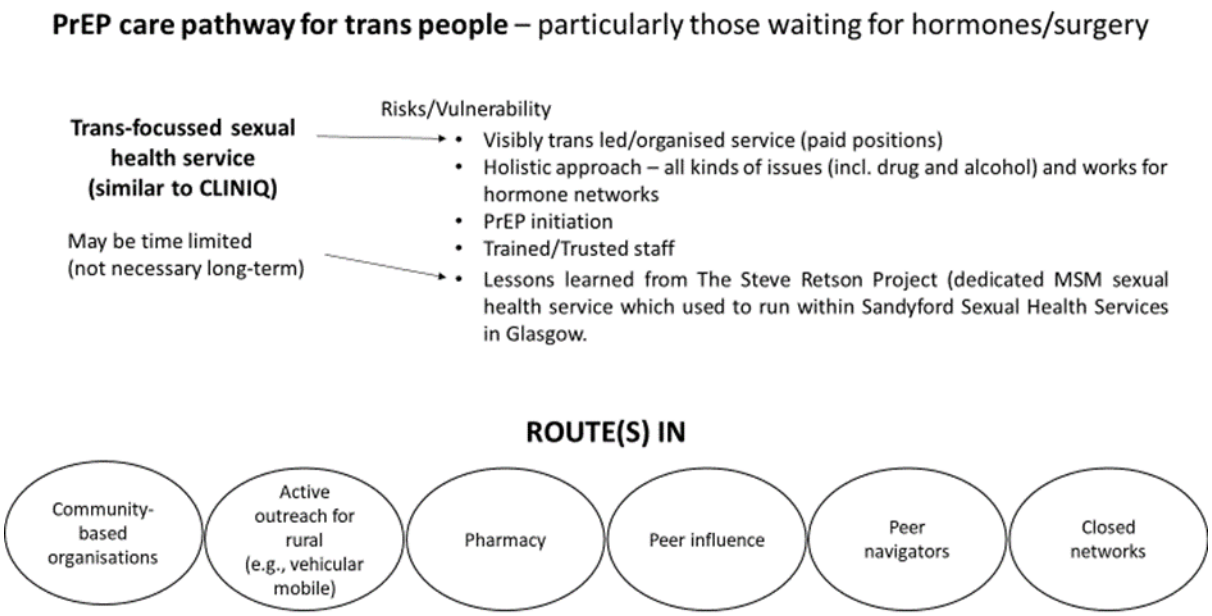


Table 1: *Barriers and facilitators to trans people accessing PrEP*

Barriers	Facilitators
– Waiting for gender affirming hormones and surgery (5+ year waiting times) - not thinking about HIV care/PrEP until they've had surgery: "without hormones, life is not worth living" - trans communities being frustrated with being able to access prep but not hormones from the same clinic – Current gender and sexual health services being linked - there's a lack of trust due to previous experience of trans people's sexual health history being used to justify denying gender care - need to know if it's confidential and private. – Fear of doing or saying anything that may impact receiving gender affirming care. – Lack of awareness of PrEP and knowledge about whether or not they need it - need to rapidly increase awareness – Many trans people don't access any healthcare services because it's too much trouble - more likely to use community-based organisations – Variation in services - trans people know where the services are competent and friendly and where they are not and talk to each other about negative and positive experiences – Concern about confidentiality with postal packages	+ HCP training on trans-specific needs + Build trust between sexual and gender health o Paid positions for trans people o Co-production with trans people - nothing for us without us o No judgment, misgendering, discrimination + Telehealth/ telemedicine, online and postal services; mobile/vehicular service that reaches rural and geographically isolated areas + Professional support for peer-led and community-based groups such as HCPs visiting the services and supporting with information e.g., about the formal ways for trans people to access PrEP + Harnessing social influence as a way to reach people who don't access/use sexual health services + Pharmacies providing PrEP - many locations, more anonymous and more likely to be engaged with by people who don't use healthcare services

b) Breakout Discussion PrEP services for Gay, Bisexual, and other Men who have Sex with Men (GBMSM) not currently attending sexual health services (SHS)

Lead by Prof Alison Rodger (University College London (UCL) and Beyond BBV (BBV)), Dr Jen MacDonald (GCU), and Christopher Ward (Waverley Care): four participants.

What are the key characteristics of GBMSM not currently attending SHS? Whom do we want to reach?

GBMSM not currently attending SHS are a challenging group to define, though are likely diverse with broad characteristics. Limited existing Scottish national PrEP and HIV surveillance data,[1] HIV testing data (SMMASH2 and SELPHIE),[2,3] and sexual health service attendance and risk behaviour data from NATSAL-3[4,5] suggest that GBMSM with unmet need are older, younger (i.e. the very youngest), and non-GBMSM identifying. We considered lack of identity as GBMSM of particular significance, so a clear way to improve population knowledge and the reach of PrEP would be to focus more on the behavioural aspect i.e., anal sex with a man/risk and need rather than identity. It is also important to recognise intersectionality, for example, with geographical and/or social isolation, if living in a rural location or within a smaller/disadvantaged community within urban settings, including migrants or those with other marginalised characteristics i.e., multiple forms of inequality or disadvantage.

What are the barriers and facilitators to accessing PrEP for GBMSM not currently attending SHS?

In Table 2, we summarise our discussion of the barriers and facilitators that may affect access to PrEP among GBMSM not currently attending SHS.

Table 2. *Barriers and facilitators to accessing PrEP among GBMSM not currently attending SHS*[6]

Barriers	Facilitators
– Self-stigma. – Fear of stigma, exposure, and shame re: disclosure of sexual behaviours, a positive HIV test/taking HIV medication, and PrEP. – Positions of power held by clinicians and confidentiality concerns. – Historical adverse health service experience. – Traditional access points within overstretched services, difficult to get an appointment. – Numerous levels of engagement with services required before getting PrEP. – May not be exposed to norms around frequent HIV/STI testing or know about PrEP – education not conducted within their social spaces. Likely need to be involved in LGBT community, venture into the healthcare arena, or engage with the third sector to receive relevant information. – Awareness-raising resources may not 'speak' to them (e.g. off-putting terminology or communication channels, messaging targets identity not behaviour). – Desire not to be associated with 'gay' services or resources – PrEP viewed as for gay men/ownership of PrEP by gay men. – HIV not a concern (e.g. more worried about STIs, personal evaluations of low HIV risk – 'othering') – Concerns about taking a pill for prevention and possible side effects.	+ Peer influence/relationships/ navigators (e.g. empower those comfortable with their GBMSM identity or behaviours via community and clinic to share knowledge and lived PrEP experience with closeted sex partners – "tell a friend"). + Approachable healthcare workforce – feeling safe to disclose sexuality/sexual behaviours, will require wider workforce training and development: knowledge, competencies, non-judgemental attitude. + Multiple points of access, including non-traditional settings and engagement into HIV testing, PrEP, and education (e.g. more flexible model, less onerous on patients, at venues of displaced interest, via health and/or social services that they are already accessing). + Rebadge and rebrand PrEP, using positive message framing and language focussed on behaviours not identity – change understandings of what it means to be a PrEP user. + Bundle PrEP information with general health information.

What are possible novel PrEP care models for GBMSM not currently attending SHS?

We need to provide differentiated PrEP services to address health inequalities, based on risk and current low uptake in this key population. We discussed a range of possible novel PrEP care models that could provide multiple forms of access for PrEP initiation and monitoring for GBMSM not currently attending SHS, as outlined below.

- Peer models of engagement to engage and inform potential PrEP users re: the reality of and how to navigate the service.
- Within existing drop-in STI/HIV testing services at community venues, resource healthcare support workers to do HIV testing and free up nurses to undertake more PrEP engagement, risk assessment, and prescribing.
- Provide PrEP via alternative settings within the healthcare system e.g. pharmacy, GP where more general health care and services are provided (offers discretion and anonymity and PrEP provision as part of an overall health management assessment).
- Lower intensity and facilitated pathways at the community level that feel more user-friendly and accessible i.e. education and access in non-traditional spaces, such as saunas, sports environments, music venues. Should purposely be low key.
- HIV self-testing services (point of access for PrEP): availability of sufficiently sensitive HIV self-test kits would allow for PrEP to be potentially obtained via post. Resource third sector to do some follow-up and PrEP engagement especially with those doing their first HIV test.

How could GBMSM not currently attending SHS be involved in designing a new PrEP care model?
We considered it important to work both forwards and backwards when designing any new PrEP care model. Working forwards, we identified a clear need for some mixed methods research to engage non-identifying GBMSM and understand more about their needs and preferences. Working backwords, Grimshaw's analysis indicated that only a small % of HIV diagnoses pre- and post-PrEP implementation were 'PrEP preventable'.[7] What could have helped the non-PrEP preventable to HIV test earlier and access PrEP? Working with HIV services, who build long-term relationships with patients, a qualitative study could sample non-PrEP preventable non-identifying GBMSM who have been recently diagnosed with HIV and ask them to reflect on their journey to diagnosis, considering barriers and facilitators to testing and PrEP uptake (e.g. knowledge, stigma, attitudes, access etc.).

Exactly how will a PrEP care pathway work e.g. PrEP initiation, follow-up, or both?
New PrEP care pathways should be inclusive of initiation and follow-up. However, since GBMSM not currently attending SHS are typically seen at diagnosis and crisis point rather than at the prevention stage, we should prioritise initial engagements i.e. PrEP uptake over maintenance, to begin with.

How could you monitor and evaluate if the proposed new setting/pathway is appealing to GBMSM not currently attending SHS?
We conceptualised the success of any new setting/pathway in several ways, including:

- *Retention in care* – while you would expect some drop-out due to modified behaviours / seasons of risk, active follow-up of those who stop attending can clarify reasons for disengagement.
- *Attitudinal changes* – how people feel about PrEP.
- *How people find the service* – what they like/dislike and any areas for improvement.

References

1. https://publichealthscotland.scot/publications/hiv-in-scotland/hiv-in-scotland-update-to-31-december-2021/
2. https://www.lothiansexualhealth.scot/wp-content/uploads/2020/03/SMMASH2-Final-Report-March-2018.pdf
3. https://www.selphi.org/publications
4. https://www.natsal.ac.uk/natsal-survey/natsal-3
5. https://gtr.ukri.org/projects?ref=studentship-1764939
6. https://blogs.ucl.ac.uk/igh-blog/2019/05/17/heterosexual-identifying-men-who-have-sex-with-men-an-understudied-population/
7. https://sti.bmj.com/content/98/1/53.long

c) Breakout Discussion PrEP models delivered in whole / part through community pharmacy

Led by: Katherine Davidson (NHS Lothian), Dr Andrew Radley (NHS Tayside), and Dr Ross Kincaid (GCU): five participants.

What is the intended role(s) of community pharmacies?
Community pharmacies (herein 'pharmacies') could support PrEP provision in several ways ranging from relatively straightforward approaches of a supply function to pathways that are more complex. Before deciding what approach to take, we need to have a clear understanding of the role expected of pharmacies. For example, do we want pharmacies to provide care to less medically/socially complex PrEP users to give sexual health services greater capacity to focus on PrEP users who require care that is more complex? Do we want to use the pharmacies' reach and ease of access to identify people who could benefit from PrEP and raise awareness of PrEP/link to PrEP care we are currently missing? Or, do we want to initiate people

on PrEP/deliver a complete pathway through pharmacies to overcome the barrier of people not wanting to attend a sexual health service (e.g. https://www.rpharms.com/blog/details/make-pre-exposure-prophylaxis-available-through-community-pharmacies)? There are no definitive answers to these questions. However, it was clear in our discussion that pharmacies could take on a variety of roles depending on the needs of the population, given the right support. In Table 3, we summarise our discussion around barriers and facilitators that may affect PrEP provision through pharmacies.

Table 3. Barriers and facilitators to community pharmacy-delivered PrEP

Barriers	Facilitators
– Pharmacies are at capacity in terms of workload, especially due to an increase in the number additional services delivered from pharmacies. Additional workload is unfeasible unless adequately funded. – The higher cost of PrEP medication (compared to sexual health services), logistics of procurement and the need for pharmacies to carry stock of PrEP, which could go unused. – The existing relationship between pharmacies and service users may dissuade those who do not want to disclose certain information to someone they know.	+ There is an eagerness from pharmacy teams to support PrEP provision as long as there is support. The want/willingness is already there. + People view pharmacies as discrete – they could be going in for anything – which could be appealing to people who do not want to be seen going into a sexual health service. + Pharmacies tend to be conveniently located, able to overcome some geographic/access barriers given that people are likely closer to a community pharmacy than a sexual health service. + There is often an existing rapport and trust between community pharmacies and service users. + Existing service models (e.g. HCV/bloodletting clinics) that could provide a blueprint for PrEP-related care. + The option of having a central/hub pharmacy (e.g. Umbrella model, see below) that specialises in PrEP with surrounding pharmacies relieving burden by acting as 'hubs' for other pharmacy-delivered services.

What are potential pathways that could involve community pharmacies?

We could provide PrEP and PrEP-related care (e.g. education and HIV testing) through pharmacies in several ways. In our discussion, we considered the following:

1. Raising PrEP awareness through posters (e.g. as done in NHSGGC for emergency hormonal contraception https://twitter.com/NathanBurley4/status/1595033030024101888) and by using the purchasing of HIV self-testing kits as an opportunity offer information about PrEP.
2. Providing PrEP 'drop-in' sessions operated by sexual health service staff, phlebotomist and/or peers. This utilises the pharmacy's accessibility while limiting the impact on the pharmacy staffs' workloads.
3. Dispensing PrEP medication following a prescription issued from sexual health services/primary care/ePrEP clinic. This could utilise the pharmacy's accessibility while limiting the impact on workloads.
4. Providing PrEP supply at the pharmacy based on the results of testing conducted elsewhere (e.g. sexual health service/online postal self-sampling) and dispensing the medication using PGD or independent prescribing where available.
5. Having an integrated approach (e.g. Umbrella (https://umbrellahealth.co.uk/) where the pharmacy manages users' journeys alongside sexual health services and primary care.
6. The community pharmacist, as an independent prescriber, assesses the appropriateness of PrEP, issues a prescription, and dispenses the medication; similar to a model used for hepatitis C. Note at present not all pharmacists have an independent prescriber qualification.

Main messages

Pharmacy teams are keen to be involved in PrEP provision but, as in other areas of healthcare, they are at capacity. The role of pharmacies in PrEP provision will depend greatly on our ability to overcome the structural barriers relating to workload, procurement of stock, and financial support for pharmacies. We also need to have a clear understanding of the role that we want pharmacies/pharmacists to play when developing future pathways given the numerous ways pharmacies could support PrEP provision. A

nationally agreed framework for service delivery would provide uniformity and clarity of service provision and could include a suite of choices to allow Health Boards to adapt to local needs and capacities.

d) Breakout Discussion PrEP models delivered in whole / part through general practice

Leads: Dr Daniela Brawley (NHS Grampian), Dr Marguerite Ferrier (NHS Greater Glasgow & Clyde), and Dr Lewis Clarke (HIV Scotland): three participants.

Current practice in Scotland

Vast majority of HIV PrEP is prescribed through specialist sexual health (SH) services. Shared care models exist in NHS Grampian and NHS Highland with primary care and non PrEP SH prescribing services/island boards for a very small number of patients. These models involve a virtual consult by the NHS Grampian/Highland, local testing and NHS Grampian/Highland prescribing with local dispensing. This process avoids the issue of community prescribing costs but is not streamlined and recognised not ideal model for large numbers.

Current practice outside Scotland

Across Europe and central Asia 11% of PrEP is provided in primary care with an increased proportion in Australia, Canada and USA. The current evidence base shows success but highlights the importance of education and engagement with primary care, resourcing and ongoing support/need to maintain patient base/skill set.

Australia

- Feasibility: Good continuation rates when care transferred from study sites to primary care but some drop in provision especially in areas with low prescribing rates and high deprivation
    - *Utilisation of pre-exposure prophylaxis (PrEP) for HIV prevention in the Australian general practice setting: a longitudinal observational study 2022 (Chidwick et al)*
- Practitioner feedback: Infrequent prescribing an issue in areas with small case loads, need for succinct guidance and education and ability to provide in short consult time
- Study recommendations: Improved economic and support conditions to support primary care provision
    - *PrEP in Practice: A Qualitative Study Investigating the Perspectives of Clinicians who Prescribe PrEP in Australia, 2022 (Smith at al)*

Canada

- Feasibility/patient feedback: Patient initiated PrEP request to primary care. Worked but barriers regarding lack of knowledge in primary care, lack of health insurance, issues discussing eligibility/sexuality
    - *Decentralizing PrEP delivery: Implementation and dissemination strategies to increase PrEP uptake among MSM in Toronto, Canada, 2021 (Charest et al)*
- Practitioner feedback: Aware but not comfortable prescribing citing need for more education or joint model/e-consult with HIV physician
    - *HIV Pre-exposure Prophylaxis (PrEP) Adoption in Primary Care: An Online Survey of Ontario Physicians, 2020 (Vincent et al)*

USA

- Feasibility: 790 patients in San Francisco, worked but some reluctance initially/referral back from providers. Cited lack of recall system contributed to drop in continuation and issues regarding financial reimbursement for f/u
    - *Successful Implementation of HIV Preexposure Prophylaxis: Lessons Learned From Three Clinical Settings, 2016 (Marcus et al)*

- Practitioner feedback: Increased knowledge associated with increased prescribing rates and also related to contraception prescribing
    - *Human Immunodeficiency Virus Pre-Exposure Prophylaxis Knowledge, Attitudes, and Self-Efficacy Among Family Planning Providers in the Southern United States: Bridging the Gap in Provider Training 2022, (Ramakrishnan et al)*

France

- Practitioner feedback: 72% not aware, of this 23%% thought PrEP wasn't effective, however eagerness for more training
    - *HIV pre-exposure prophylaxis (PrEP) knowledge among general practitioners in 2020: A French survey, 2022 (Gilles et al)*

Belgium

- Practitioner feedback: Limited awareness but high eagerness. 4 areas- identifying, referral, initiating and follow up. Concerns how to integrate into practice, lack of anti-retroviral knowledge and presumed lack of contact with eligible individuals
    - *How do family physicians perceive their role in providing pre-exposure prophylaxis for HIV prevention? An online qualitative study in Flanders, Belgium,2022 (Van Hamel et al)*

Group discussion feedback

1) **What is the aim of the novel PrEP model / care pathway?**

The group felt the aim of primary care involvement was to increase reach of PrEP to underserved communities. Some evidence in NHS England to support trust and preference of people from ethnic minority groups, especially women, have for primary care and the importance of this route for PrEP provision.

There was some discussion around primary care provision for "routine PrEP care" and/or follow up which was felt to be possible from skill set perspective but difficult regarding challenges in primary care capacity and issues re cost of community prescribing. Some suggestions that e-prep model may better for routine care, releasing capacity in specialist services and primary care to engage with complex care or less well served populations/groups.

2) **Who do we want to reach?**

Groups not well engaged with PrEP and/or who find it difficult to attend SH services- heterosexual populations, women, people from ethnic minority groups and rural populations.

3) **What are the barriers and facilitators to accessing PrEP for people in this group?**

Multiple barriers including but not limited to awareness of PrEP, use/trust of services, service awareness and comfort prescribing PrEP to wider group (need for new guidance to be distributed), possible role of stigma, education for wider services including but not limited to primary care.

4) **What is the evidence that the proposed new setting / pathway is appealing to people from that group?**

Some evidence from UCL colleagues that women from ethnic minority groups prefer to access sexual health care in general from GP due to trust and confidentiality of reason for attendance. Data presented on primary care models out with Scotland doesn't specify specific demographics.

5) **Exactly how will the care pathway work e.g. PrEP initiation, follow up or both?**

From discussions and background evidence groups sees a stepped process, which may:

1. Need for engagement, education and awareness in primary care
2. Referral pathways for practices who feel cannot provide/follow up

3. Follow up and/or shared care with SH with SH prescribing
4. Initiation from practices (would need resolution to community prescribing)

Primary care pilot would be useful to look at how a full provision pathway would look in practice.

6) **How have / would the target group been involved in designing the care pathway?**

Recognised need for target group involvement as soon as possible in designing pathway, however also key stakeholder/primary care buy in.

7) ***How will / have relevant health care professionals / PrEP prescribers been involved?***

Limited discussions with primary care at present nationally and needs to be further discussed ideally with results from local pilot. Initial feedback that this would need funded/LES model.

8) ***Which organisation has clinical governance?***

If shared pathway then results governance on service doing this and likewise for prescribing. If wholly primary care then governance within primary care but ultimately depends on local SLA

9) ***Who will prescribe?***

Will depend on model as above- within primary care could be GPs or non-medical prescribers i.e. practice nurse, ANP, PA and/or pharmacy

10) ***Who is responsible for results provision, follow up & chasing of people who miss appointments/tests/prescriptions?***

Depends on pathway- if all in primary care would be primary care, if shared care depending on SLA.

11) ***How / where are records kept & in what form?***

NASH or primary care system

12) ***What is the estimated cost of set up & then cost per patient?***

Will depend on primary care model and staff providing.

13) ***What are the KPIs / targets?***

Access KPI as per HIS standards, no population KPI currently as per LARC in past but could be discussed to increase offer and uptake. X/100,000

14) ***What are the plans for evaluation?***

Ideally formal research as per background evidence to show benefits in specific groups and cost effectiveness in relation to other models such as eprep.

15) ***What about the future? Could this care model be adapted for long-acting formulations?***

Yes with training, similar to practices providing depo for contraception.

e) Breakout Discussion Outreach / Reach out PrEP Models for specific groups experiencing geographic isolation

Leads: Dr Dan Clutterbuck (NHS Lothian), Dr Yvonne McFarlane (NHS Lothian), and Dr Erica Pool (UCL): three participants.

What key issues or gaps we have taken away from initial presentations, and what do you want to get out of today?

- Issues for those very geographically isolated e.g. Oban, they can't book GUM appts as postcode isn't right *(because of technical system issues between former health board areas)*. Interested in community pharmacy options to make pathways more streamlined

- Understanding ePrEP- what does this entail and when will it come? Discussed that it is in pilot form at present, planned online assessment form and postal testing kits and postal PrEP delivery
- GBMSM not attending SHS in context of geographical isolation including within urban centres and CSW; not all isolation is rural. 'Villages within cities'
- Realities of non-SHS service provision; GP, pharmacy and other settings eg Alcohol and Drugs Services – barriers and competing priorities.
- Mobile outreach; what opportunities are there based on existing examples?

Outreach

Important characteristics of successful work

- Linking in with third sector partners
- Linking in with other services; police, drug services, probation and custody services – opportunities to engage with very vulnerable populations who do not interact with (any) health care.

Equity

Importance of PrEP persistence (i.e. maintain or re-engage in care) as well as PrEP initiation - keeping them engaged in PrEP care. Barriers – although a systematic SMS reminder system is used for current cohort in one board, capacity for FU appts is less than the number that are needed (⅔ of the number of SMS sent).

Data and intelligence on follow-up, persistence and retention in care is a significant gap. Much better data needed to understand breaks in PrEP use, discontinuation and reasons for breaks/stopping and the factors involved (choice/circumstance/barriers)

Aim of an outreach pathway

Ensuring equity of access for people not currently benefitting from PrEP

Who do we want to reach?

- Black African women (especially hard to reach if in relationships - see opt out testing) and heterosexual men
- Heterosexual-identifying MSM especially if geographically isolated - see Tyrone Curtis publications (clearly recognised as an issue for rural Scotland)
- People of all genders and sexuality with low socio-economic status
- People who are racially minoritised
- Inclusion health

What settings would we prioritise?

- Community settings, schools, universities, inclusion health; prisons, custody settings, CSW, PEH, PWID.
- HIV testing is the point of access for PrEP and is the obvious entry point. Linking PrEP discussion/offer of PrEP to testing is an opportunity. Expansion of opt out testing (e.g. in Emergency Departments) requires some thought – i.e. a smaller proportion of those tested are likely to benefit from PrEP.
- There is a need for data.

Outreach services – what's needed?

Comprehensive 'Mobile' Outreach PrEP specialist start/dispensing service appropriate for some populations but recognised as resource intensive and not necessarily required in all settings. Addressing different steps on PrEP journey:

- **Engagement and information, t**hen signposting to SHS (or potentially other health services) for prescription. This could be linked to every offer of HIV testing (in person, postal, online, community settings - opportunities with Fast Track Cities). Tailored information and targeted mode of delivery according to setting. Consistency of message and pathways to PrEP for groups and individuals.

- **PrEP initiation-** possible in a range of settings, by many providers (assuming structural/attitudinal/cultural barriers overcome). Agreement that PrEP initiation is technically simple – need to 'demystify' PrEP. Historical parallels with exceptionalising HIV testing. Potential separation of information giving/assessment/prescribing/dispensing
- **PrEP follow up / maintenance**: Opportunities for GBMSM not accessing services and others at risk, what services are they accessing? CMHTs, drug and alcohol services, prisons, financial and social services. Integrative. Re-entry pathways into PrEP care.

Demystification PrEP needed - for non SHS providers, e.g. for GPs. Relinquishing control (noting medicalisation of PrEP assessment/prescribing/dispensing in early days, with persistent legacy effects barriers to delivery by other professional groups).

Videos on culturally sensitive conversations about PrEP (Waverley Care are developing these). Accessible information and training.

Barriers

- GUM clinic triage and appointment limitations (*time and specific remits – lost opportunities for comprehensive assessment of SH needs and opportunistic interventions)*
- HCP attitudes towards women and perceptions of risk even when requesting PrEP. *(Possible legacy of eligibility criteria)*
- "Eligibility" groups - targeted PrEP discussions to a relatively narrow range of individuals, should it be universal? E.g. every time a HIV test is done?
- Systems that identify people in need of HIV testing and PrEP services - they are unlikely to be attending SHS (A wider access issue than PrEP alone)
- Staff confidence – significant issue even within specialist services. PrEP as a 'specialist area' within services. Even more pronounced outwith SRHS – low levels of awareness.
- Stigma around PrEP with service users and HCPs - needs to be reframed positively

Facilitators / Opportunities

- Tying in PrEP info and discussion into EVERY HIV test; prisons, DDUs, ED. *Making every conversation count*. Info on back of results card
- Consistent information in a wide variety of formats and modes – consistent accessible messaging
- Linking QR codes and video information for more detail to this core info
- Info on culturally sensitive PrEP discussions – tailored information for specific groups and settings
- Community outreach integrated into other services (staff awareness and training for non SHS workers) and specialist PrEP. Levels of service - it might be signposting or a bespoke service delivery
- Single set of information like iBase Guide to PrEP for HCPs and service users – this information was appropriate for both beneficiaries and for most professionals- good principle to follow.

4. Conclusions

PrEP provision needs to meet the needs of all who could benefit. Although the fundamentals of safe prescribing and associated good medical care will need to be met irrespective of setting, this workshop has highlighted where creativity and an openness to new collaborations and links could deliver PrEP care models which people yet to benefit from PrEP may find appealing. Some suggestions could be relatively "quick fixes", whereas for others, NHS structural barriers such as drug procurement in community pharmacies, will need to be overcome. We hope that others find this a useful adjunct to published work as they develop services locally.

5.Acknowledgements.

We are immensely grateful to all the leads, participants and contributors who worked enthusiastically to short timelines. We thank Carole Brown (Scottish Government), Jacqueline Gray (Beyond BBV), and Karen McDairmant (Glasgow Caledonian University) for administrational support. We are very grateful to the Research Centre for Health (ReaCH) at Glasgow Caledonian University for hosting the event.

6. List of attenders & contributors

Co-chairs: Prof Claudia Estcourt (Beyond BBV, Glasgow Caledonian University) and Mr Grant Sugden (Waverley Care).

Group leads & facilitators: Dr Daniela Brawley (NHS Grampian), Dr Lewis Clarke (HIV Scotland), Dr Dan Clutterbuck (NHS Lothian), Katherine Davidson (NHS Lothian), Oliver Ellis (Waverley Care), Dr Marguerite Ferrier (NHS Greater Glasgow & Clyde), Prof Paul Flowers (University of Strathclyde), Dr Ross Kincaid (GCU), Dr Jen MacDonald (GCU), Julie MacLeod (GCU), Dr Yvonne McFarlane (NHS Lothian), Dr Erica Pool (UCL), Dr Andrew Radley (NHS Tayside), Prof Alison Rodger (UCL and BBBV), and Chris Ward (Waverley Care).

Attenders: Dr Kirsty Abu-Rajab (NHS Forth Valley), Dave Bingham (Terrence Higgins Trust), Aileen Boags (NHS Lothian), Flavien Coukan (UCL), Alan Eagleson (Terrence Higgins Trust), Barry Gemmell (NHS Dumfries and Galloway), Alan Harrison (NHS Greater Glasgow and Clyde), Ese Johnson (Waverley Care), Claire Kofman (Waverley Care), Pamela MacIntyre (NHS Greater Glasgow and Clyde), Oceana Maund (Scottish Trans Alliance), Lesley Maxwell (NHS Greater Glasgow and Clyde), Carolyn McDermott (Sandyford, NHS Greater Glasgow and Clyde), Adele McTaggart (NHS Ayrshire and Arran), Dr Rak Nandwani (GCU), Amanda Rae (Community Pharmacy Scotland), Dr Kirsty Roy (Public Health Scotland), Colin Strathern (Sandyford, NHS Greater Glasgow and Clyde).

Non-attending contributors: Professor Nicola Steedman, Dr Catriona Morton (Royal College of General Practitioners of Scotland), Nathan Burley (Sandyford, NHS Greater Glasgow & Clyde), Dr Lesley Wallace (Public Health Scotland (PHS)), Beth Cullen (PHS), Duncan McMaster (PHS), Stuart Wrigglesworth (PHS), and David Henderson (PHS).