25 YEARS OF
SHAPING ATTITUDES
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TRANSFORMING THE UK'S RESPONSE TO HIV

NAT

Report: April 2012

HIV Testing Action Plan

to reduce late HIV diagnosis in the UK

Second edition 2012

Contents and Foreword

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Foreword

In the short time that I have been a doctor there have been tremendous advances in the fight against HIV. Development of effective treatment and prevention options has slowed the spread of HIV throughout the world. Perhaps most significantly we now know that people receiving effective HIV treatment are 96% less likely to transmit the disease to their sexual partners. Treatment is prevention. Science and technology should therefore be winning, but are being held back by some very simple social issues.

Treatment can only occur if testing and diagnosis have taken place. The number of people living with HIV in the UK will reach a record 100,000 this year, but 25% are unaware that they are infected. Over 50% of HIV transmissions are from these 25% who are undiagnosed and without intensified testing efforts, the numbers of people with HIV will continue to increase. Furthermore half of those diagnosed are being diagnosed 'late', several years after infection and after the point when they should have started treatment, with sometimes serious consequences for their ongoing health. Evidence on the preventive benefits of treatment shows that earlier diagnosis can not only benefit personal health, but has massive public health benefits too, while saving significant sums of money for the NHS.

As outlined in this vital strategy document, HIV testing is key to prevention. The UK must move from reliance on its traditional 'opt-in' model of voluntary HIV testing to an 'opt-out' approach across the range of healthcare settings including all newly registering patients in general practice, and all general hospital admissions, in every high HIV prevalence area across the country. Instigating this will require, in England, the co-operation of a wide range of bodies - the Department of Health, Public Health England, NHS Commissioning Board, Clinical Commissioning Groups and Health & Wellbeing Boards - and it is to these groups and every individual healthcare worker in this country that I appeal. Amid great financial pressure and organisational change, it's vital that we maintain focus on increasing regular HIV testing as a key component of prevention and care in the UK.

Science will continue to make breakthroughs, but these will be wasted unless we can identify, in time, those who will benefit from this progress. HIV is controllable. The recommendations in this strategy are practical and workable. We must make them happen.

Good health!

Christian Jessen

Dr Christian Jessen
April 2012

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Introduction

HIV testing is at the heart of any effective strategy for tackling HIV in the UK. One of NAT's key strategic goals is to ensure early diagnosis of HIV through ethical, accessible and appropriate testing in a range of settings. We have consistently called upon a wide variety of stakeholders to make this a reality through increased commitment and resources.

In 2009 NAT produced an HIV Testing Action Plan which provided an overview of our thinking on the UK's testing strategies and made a comprehensive set of recommendations. We identified priorities in policy, political commitment and resources in order to increase (on the basis of need) the number of people testing and reduce rates of undiagnosed HIV and late HIV diagnosis.

Since then, however, much has changed. The economic crisis has brought with it increased pressure on spending across the NHS and local authorities, including cuts to HIV budgets. The NHS is also undergoing massive reorganisation, bringing with it challenges for integrated sexual health planning.

One encouraging development is that late HIV diagnosis has been successfully secured as an indicator in the new Public Health Outcomes Framework. At the same time new guidelines, evidence and reports have updated our thinking in a number of key areas. Most notably, robust data has emerged demonstrating that 'treatment is prevention' - effective anti-retroviral drugs resulting in an undetectable viral load reduces the risk of heterosexual transmission in sero-discordant couples by 96%.[1] NICE's guidance on testing among men who have sex with men (MSM) and African communities, and the Department of Health and Gilead funded testing pilots, have also proved vital contributions to the momentum behind better HIV testing in the UK.[2]

Progress has been made on the ground, too. Fourth generation testing is now almost exclusively used for laboratory HIV tests, while there has been some welcome reduction in rates of late diagnosis (particularly very late diagnosis in London) and undiagnosed HIV.[3] This refreshed and revised action plan takes account of all of these developments and makes updated recommendations in light of them. It looks to highlight new priorities for action on HIV testing in England in ways which commissioners, clinicians and decision makers at all levels can make sense of under the new NHS arrangements. Recommendations are also made to the relevant bodies in Scotland, Wales and Northern Ireland.

There are elements both of 'supply' and 'demand' in improving HIV testing in the UK. An effective HIV testing strategy needs the latest technology, expertise and appropriate standards, along with consistent and appropriate testing provision and promotion. But it also needs the public, particularly those in communities most at risk of HIV, to be aware of the benefits of knowing one's HIV status, when they need to test and where, and to be willing to do so. NAT therefore seeks to address both supply and demand sides to this issue.

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[1] NAT (2011): HIV Treatment as Prevention

[2] NICE (2011): Public guidance on increasing the uptake of HIV testing among men who have sex with men. NICE (2011): Public guidance on increasing the uptake of HIV testing among Black Africans in England. HPA (2011): Time to Test for HIV: Expanded healthcare and community testing in England

[3] HPA (2010): 'Survey results at the end of 2010 (late diagnosis)', http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HIV/CD4TcellData/Surveillance/

HIV testing action plan

Why transforming HIV testing matters

The scale of the UK's challenge on HIV testing is clear. Despite the progress that has been made since the start of the epidemic and over the last decade, this year the number of people living with HIV in the UK will reach a record 100,000 - 25% of whom are unaware that they are infected. New HIV diagnoses among men who have sex with men (MSM) totalled 2,880 in 2010, the equal highest number since records began.[4]

As worryingly, the Health Protection Agency (HPA) showed that in 2010 half (50%) of HIV positive adults were diagnosed late, after the point at which they should have started treatment (CD4 cell count <350 cells/mm^3 within three months of diagnosis), and 28% very late (CD4 <200 cells/mm^3). Late and very late diagnoses remain especially high among heterosexual men (63% late, 40% very late) and women (58%; 34%).[5]

All evidence shows that late diagnosis increases the chances of morbidity, mortality and onward transmission. Late diagnosis also results in significant ill health for people with HIV, increased rates of hospital admission and increased costs of anti-retroviral therapy. Of those with HIV who were reported to have died in 2010, two thirds had been diagnosed late – late diagnosis leaves an individual ten times more likely to die within a year, while a 20 year old diagnosed very late with HIV is thought to have a life expectancy at least ten years shorter than somebody who starts treatment at CD4 350 cells/mm^3. [6] [7]

HIV testing is now also recognised to be a key prevention intervention. One reason for this is that over 50% of HIV transmissions are from people who are undiagnosed.[8] People diagnosed with HIV are likely to pay greater attention to reducing risk of HIV transmission, and once on treatment their viral load will reduce and they will become significantly less infectious. [9] Without intensified testing efforts, the numbers of people infected with HIV will continue to increase.

Why HIV testing is worth investing in

As health budgets come under pressure across the country, it is more important than ever for decision makers, health commissioners and providers to recognise that HIV testing is cost-effective. In fact, increased testing and earlier diagnosis actually save the NHS money. Owing to increased hospital admission, HIV care in the first year after diagnosis costs the NHS twice as much if the patient is diagnosed with a CD4 count less than 350 cells/mm^3, because of the significant rates of morbidity linked to late diagnosis. Thereafter, the costs of HIV care remain 50% higher for each year following diagnosis.[10]

An improvement of just 1% in patients being diagnosed earlier could save £212,000 a year for MSM, and £265,000 for black African men and women in England.[11] As has been stated, testing also has preventive benefits, given that those diagnosed reduce risky behaviour. This brings additional savings – NICE estimate that if testing guidance was implemented, 3,500 cases of onward transmission could be prevented within 5 years, saving the NHS £18 million per year in treatment costs.[12] For this reason, it is imperative that Public Health England and local authorities, as well as relevant authorities across all devolved nations, increase and sustain funding in HIV testing initiatives.

Meeting the UK's testing needs

Expanded 'opt-out' HIV testing

It is important that testing efforts reach those most at risk from HIV and, in particular, those who would otherwise be diagnosed late. To do this, the UK must move from reliance on its traditional 'opt-in' model of voluntary HIV testing, usually conducted within sexual health clinics, to a more 'opt-out' approach (also known as provider-

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4. HPA (2011): HIV in the UK: 2011 report.

5. HPA (2011): Surveillance of CD4 cell counts: survey results to the end of 2010. http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1203064758366

6. UK Chic (2011). 'Impact of late diagnosis and treatment on life expectancy in people with HIV-1: UK Collaborative HIV Cohort (UK CHIC) Study', BMJ

7. Health Protection Agency (2011). http://www.nat.org.uk/HIV-Facts/Statistics/Latest-UK-statistics/Late-diagnosis.aspx

8. Marks, G, Crepaz N, Janssen RS (2006) 'Estimating sexual transmission of HIV from persons aware and unaware that they are infected with the virus in the USA. AIDS. 2006 Jun 26;20(10):1447-50

9. NAM (2008): Preventing HIV; NAT (2008): Primary HIV infection; Fox J et al (2009): 'Reductions in HIV transmission risk behaviour following diagnosis of primary HIV infection: a cohort of high-risk men who have sex with men', HIV Medicine, vol. 10.

10. NICE (2011): Increasing the uptake of HIV testing among black Africans in England and increasing the uptake of HIV testing among men who have sex with men: costing report – implementing NICE guidance.

11. Ibid

12. Ibid. Page 37-38

initiated testing) across a range of healthcare settings. This is where an HIV test is usually offered alongside other routine tests; the patient can turn down the offer, but must explicitly say no. Opt-out testing in antenatal care has already proved highly effective in reducing mother-to-child HIV transmission.

The 2008 UK National Guidelines for HIV Testing (BHIVA/BASHH/BIS) recommended that an 'opt-out' HIV test be offered to all newly registering patients in general practice, and all general hospital admissions, in every high HIV prevalence area across the country (>= HIV diagnosed persons 2 per every 1,000 15-59 year olds). Pilots of these recommendations showed that such testing was acceptable to patients - with the HPA's analysis stating they were "feasible, acceptable and effective" in reducing undiagnosed HIV, as well as cost-effective.[13] The House of Lords Select Committee on HIV and AIDS also backed the measures.[14]

Opt-out testing in high prevalence areas has been proven to improve health outcomes and save money. The Government should endorse the recommendations contained within the 2008 National Testing Guidelines and integrate them within all relevant forthcoming sexual health policy documents. In England, Public Health England should work with local health authorities and the NHS Commissioning Board to ensure they are put into practice as soon as possible. The UK National Screening Committee should also consider the case for further recommended aspects of HIV testing to be included within the national screening programme.

Routine opt-out testing is also necessary in the following settings, as recommended in the 2008 National Testing Guidelines:

- GUM/sexual health clinics
- Antenatal services
- Termination of pregnancy services
- Drug dependency programmes
- Healthcare services for those diagnosed with TB, Hep B & C, and lymphoma.

Clear targets and audits should now be agreed to secure implementation. More broadly, the guidelines list a number of other 'clinical indicator diseases' (such as bacterial pneumonia, oral candidiasis and anal cancer) where an HIV test should also be offered to the patient – these recommendations also need to be widely implemented as soon as possible.[15] The necessary funding – in all parts of the UK – must be made available to secure these changes.

Financial incentives

Commissioning currently makes use of a number of financial incentives to encourage good practice in clinical settings. HIV testing needs to be promoted through such financial mechanisms. We would like to see Commissioning for Quality and Innovation (CQUIN) and health premium payments used to increase the number of HIV tests offered in high prevalence areas, as well as enhancing partner notification amongst newly diagnosed patients.

In addition, the Quality Outcomes Framework (QOF) is a key national voluntary incentive programme for all GP surgeries in England, rewarding general practices for the provision of 'quality care' and helping to standardise improvements in the delivery of clinical care. 'Late HIV diagnosis' should also be added to the QOF as a 'significant event' triggering a review by GP practices. This review (currently reserved for such events as suicides, medication errors and new cancer diagnoses) would ideally see staff formally discuss the 'what and why' of a late diagnosis and identify any actions to prevent re-occurrence.[16]

HIV partner notification

Partner notification for those recently diagnosed with HIV can prove an effective means by which to test those who may have been exposed to the risk of infection. Audits suggest, where HIV partner notification is performed thoroughly, around 27% of partners traced and tested through partner notification go on to be newly diagnosed with HIV. It has also proven effective in getting people who have not previously tested, or thought about testing, to test for HIV.[17] By getting individuals tested, diagnosed and on to treatment, HIV partner notification could make a significant contribution to

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13. HPA (2011): Time to Test for HIV

14. House of Lords Select Committee on HIV and AIDS (2011): No vaccine, no cure: HIV and AIDS in the United Kingdom

15. BHIVA, BASHH, BIS (2008): UK National Guidelines for HIV Testing

16. BMA, NHS Employers (2011) : Quality and Outcomes Framework for GMS contract 2011/2012.

17. NAT (2012): HIV Partner Notification. (Forthcoming)

the personal and public health benefits of earlier HIV diagnosis, including reduced onward transmission.

However, at present, practice around HIV partner notification is rather disparate and under-prioritised. In fact, documentation and auditing of partner notification is so thin in many places that no proper national picture exists. It is seen to be at the bottom of a long list of needs for a newly diagnosed HIV patient, with staff and patients often reticent to fully engage in the process. No national performance standard exists for HIV partner notification, unlike for other STIs such as chlamydia. This must be addressed in order to maximise the potential of partner notification as an HIV prevention and testing intervention. Partner notification should be commissioned consistently to national quality standards across the country. To inform such standards a nationwide audit of current practice around HIV partner notification should also be undertaken.

New testing technologies

NAT welcomes the fact that fourth generation testing is now used for the vast majority of laboratory HIV tests. This means a greater chance of detecting primary infection, as there is no longer a three-month 'window period' before HIV can be detected – fourth generation laboratory tests can reliably detect HIV one month from possible exposure. However, there is some evidence that the new fourth generation *rapid* tests (otherwise known as point-of-care tests) produce a worrying percentage of false negatives for those recently infected, as well as a significant number of false positives.[18] As rapid tests are increasingly used to expand testing access, it is important to stress that those suspected of recent infection need fourth generation laboratory tests. This should be incorporated into information on HIV testing and appropriate protocols should be put in place to ensure referral. More research should be conducted on the effectiveness and use of fourth-generation rapid tests.

It may be useful for an organisation such as BASHH or the HPA to provide accessible information on the various tests approved for use in the UK (including sensitivity, specificity and window period) and protocols to ensure appropriate use - especially in relation to recent infection and to testing in areas of different prevalence. This would be particularly valuable as testing is rolled out by a wider range of providers in different settings.

Self-testing kits for HIV could also have an important role to play in reaching people who are unable or unwilling to test in GUM or healthcare settings. At the moment, self-testing kits are unlawful under the HIV Testing Kits and Services Act (1999). NAT has been amongst those calling on the Government for a number of years to amend this regulation to permit proper, quality-controlled and regulated self-testing for HIV.[19]

Waiting times for HIV tests

Regrettably, the national target requiring GUM clinics to ensure a maximum 48 hours waiting time for an HIV test has now been removed. This target enabled great progress to be made in making HIV testing more accessible by reducing the period a patient had to wait before obtaining an appointment for an HIV test in a GUM clinic. It is vital that this standard is maintained in order to break down barriers to HIV testing and incentivise the uptake of testing among most-affected communities. Furthermore, results of opt-out laboratory HIV tests should also be returned within 72 hours, in line with the 2008 National Testing Guidelines.[20]

Reminders to test

NAT also believes there is a case for investigating the possibility of an at least annual 'reminder to test' text from the GUM clinic the patient last attended. This should be targeted at all MSM who have previously come in for an HIV test or sexual health check up, subject to their agreement. A six-month 'reminder to test' text is already sent by some clinics to those diagnosed with an STI, and has yielded new HIV positive diagnoses.

Community HIV testing

Evidence suggests that HIV testing in the community, whether in drop-in centres, saunas or other easy to access settings, can prove attractive and result in significant HIV positive diagnoses.[21] Advantages can include

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[18] O'Shea, S, Dunn, H and Fox, J (2010) 'Low rates of p24 antigen detection using a fourth-generation point of care HIV test', Sexually Transmitted Diseases.; Pebody, R (2012): 'Rapid combination test fails to detect many cases of acute HIV infection', NAM, www.aidsmap.com

[19] NAT (2008): Home Testing for HIV; THT (2011): HIV Home Testing Kits: time to legalise and regulate

[20] BHIVA, BASHH, BIS (2008): UK National Guidelines for HIV Testing

[21] HPA (2011): Time to Test for HIV

more convenient opening hours and peer-led services, for example. Further research is needed on how community-based testing can enhance and add to that provided in NHS secondary and primary care, further reducing late HIV diagnoses.

Commissioning HIV testing

In England, new Health and Wellbeing Boards (HWBs) will from 2013 undertake Joint Strategic Needs Assessments (JSNA) to determine local healthcare needs. These should be used to collect data on the nature of HIV prevalence and late diagnosis within their local area, including demographic breakdown of data. Likewise, the HWB's Joint Strategic Health and Wellbeing Strategies (JSHWS) should look to proactively meet testing need, bearing in mind the public health outcome indicator of late HIV diagnosis and local performance against that indicator.

The integration of testing needs assessments and strategies at a local level is all the more important given the dangers of fragmentation under the new commissioning arrangements in England. In the priorities for action set out below there are a number of responsible bodies repeatedly cited. The NHS Commissioning Board will commission both GP and HIV treatment services; clinical commissioning groups (consisting of GP practices) will commission most of the rest of secondary (hospital) care; local authorities will commission sexual health services including GUM clinics and community sexual health promotion. There is a challenge for so many stakeholders to develop and implement a coordinated strategy to reduce late HIV diagnosis and promote appropriate HIV testing, all playing their part.

In addition to the local integration required of Health and Wellbeing Boards using JSNAs and JSHWSs, a national coordinating and strategic approach is required. The Government should set out a national vision for HIV testing as soon as possible to ensure such action, and integration of planning and efforts. As important will be guidance and leadership from Public Health England from April 2013, setting out how all relevant commissioners should work together to address the late HIV diagnosis indicator.

Similar assessment and strategy must be undertaken in Scotland, Wales and Northern Ireland among the relevant health authorities.

Making the UK HIV aware

Establishing consistent testing messages for MSM

The UK 2008 National Guidelines for HIV Testing recommended that all sexually active MSM test at least annually, and more frequently if they have put themselves at risk (this was reiterated by NICE in 2011). Much progress has been made in HIV testing – the numbers of MSM who report 'ever testing' for HIV in the Gay Men's Sex Survey have gone up from 59% in 2003 to 75% in 2008, a time in which general public knowledge about HIV has declined.[22] But there remains an enormous amount of work left to do. We are still a long way from all MSM testing once a year. Only around 30% of MSM in that same 2008 survey who last tested negative did so within the last 12 months.[23] In addition the HPA estimates suggest that, though there may be an upward trend in testing, the proportion of MSM who test in a given year is significantly lower (it is probable that the Gay Men's Sex Survey over-samples men likely to test). In fact, HPA data suggests of those MSM attending sexual health clinics who do test, only around 33% of them re-test at the same clinic within a year.[24] We also know that 40% of MSM diagnosed with HIV are diagnosed late – meaning on average they are living undiagnosed with HIV for at least 5 years.[25]

For this reason it is vital that funding for testing programmes is increased and sustained in all parts of the UK to drive awareness of the annual testing recommendation among MSM and meet testing demand. In each UK nation there must be a nationwide HIV prevention programme which focuses on the prevention and testing needs of MSM as a key priority. Further work also needs to be done to build consensus on when MSM should test more frequently than once a year. NAT supports the HPA's recent proposal that the working definition should be at least every six months for "anyone having unprotected anal intercourse with casual and new sexual partners".[26]

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[22] Gay Men's Sex Survey (2003), Sigma Research. Gay Men's Sex Survey (2008), Sigma Research.

[23] Gay Men's Sex Survey (2008), Sigma Research.

[24] Health Protection Agency (2008-2010).

[25] HPA (2011): Surveillance of CD4 counts.

[26] HPA (2011): Sexually transmitted infections in men who have sex with men: 2011 report.

There would be value also in having broader consensus and consistent messaging on this recommendation.

New testing messages for African communities

The challenges to securing an increase in testing among African communities are even greater. A 2008-2009 BASS Line survey on the prevention needs of Africans in England found that 40% had never tested and of that 40% a majority (53%) said they had never tested because they had 'no reason to think they had HIV'. There is an urgent need to increase awareness of the risk of HIV among African communities. One in 20 Africans in the UK are living with HIV, and Africans account for two-thirds of all heterosexually-acquired HIV diagnoses in the UK; 66% of newly diagnosed African men and 61% of African women were diagnosed late. There is also evidence of significant rates of UK acquired HIV infection amongst Africans within the UK, including amongst those who have previously tested HIV negative.[27]

Unlike MSM, people from countries of high prevalence are not included among those groups who, according to the 2008 National Guidelines for HIV Testing, should be provided with or recommended repeat testing. NICE's 2011 guidance on testing among African communities also stops short of making an explicit recommendation on frequency, instead outlining various 'trigger points' (e.g the start of a new relationship). There has been some resistance to targeted African interventions around HIV as a result of concerns over stigma.

However, NAT believes that the urgency of the need to increase awareness of the risk of HIV among African communities - and the low knowledge of risk behaviours among those communities - justifies a new recommendation for sexually active Africans to test at least annually being incorporated within national and local HIV prevention campaigns. This must be delivered appropriately, with input from African communities into the design and implementation of interventions and services.

Testing messages for the wider public

Research commissioned in 2000, 2005, 2007 and 2010 from Ipsos MORI by NAT has documented a decline in public knowledge about how HIV is transmitted. No doubt related to this, we are seeing a gradual increase in the number of non-African heterosexuals being diagnosed with HIV, having been infected in the UK. Survey evidence in 2010 highlighted poor understanding amongst the general public of HIV testing, diagnosis and treatment, and late diagnosis is particularly high among British-born heterosexuals. NAT does not at this stage believe a national campaign aimed at the whole population, on the scale of the 1980s public health messages around AIDS, would prove cost-effective given the still relatively low level of HIV prevalence among non-MSM and non-African groups. But there are a number of measures which could be taken to increase testing among non-African heterosexuals: local campaigns in areas of high HIV prevalence may be appropriate and should be considered, while information on the benefits of early testing for HIV must be incorporated within wider sexual health campaigns and information. Public Health England should develop a separate strategic approach to address 'wider public' prevention and testing needs. The Government must also take steps to increase awareness of the risk of HIV when travelling abroad, since roughly a third of HIV infections among non-African heterosexuals diagnosed in the UK actually occur whilst travelling abroad.[28]

Early HIV diagnosis

The UK's testing strategy should aim not just to avoid late HIV diagnosis, but maximise early diagnosis too. The sooner someone knows they are HIV positive the better it is for their own health and that of their sexual partners. Symptoms of early, or 'primary', HIV infection occur in around 70-90% of people recently infected with HIV. The most common symptoms are the combination of a fever, sore throat and a rash. This usually occurs around 10 days after transmission, but for no more than 2-3 weeks, after which no further symptoms are generally experienced until several years later - at which point the patient may be very ill, with an extremely damaged immune system and reduced life expectancy. Research suggests that up to 50% of

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[27] NAT (2012) HIV testing in African communities: the case for an annual testing recommendation

[28] NAT (2010): Factsheet: HIV prevention needs and the wider population. http://www.nat.org.uk/media/Files/Policy/2011/HIV%20PREVENTION%20AND%20THE%20WIDER%20UK%20POPULATION.pdf

HIV transmissions are from people who are themselves recently infected, due to the extremely high viral load at this stage of the infection.[29]

The symptoms of recent infection therefore present a vital window of opportunity to diagnose HIV, with benefits for both personal and public health. Unfortunately, as research shows, knowledge of primary infection among at-risk groups and healthcare professionals is worryingly low.[30] It is crucial that training of GPs – including existing GPs - and other healthcare workers incorporates information on identifying primary HIV infection, ensuring they are comfortable and confident talking to patients about symptoms and risk. In particular, GPs and other healthcare professionals should implement the National HIV Testing Guidelines recommendation to test for HIV anyone presenting with a 'mononucleosis-like syndrome (primary HIV infection)'.

NHS gatekeeper and out-of-hours services, such as NHS 111, also have a role to play by recognising primary HIV infection within their software algorithms, and referring people with symptoms for an HIV test – at present they do not. In addition, health promotion among MSM and African communities needs urgently to incorporate primary infection and the benefits of early diagnosis within their testing messages.

Of course if MSM and Africans in the UK test at least annually, and more frequently in relation to significant risk, early diagnosis rates will increase substantially. Furthermore, the roll-out of RITA (Recently Infected Testing Algorithm) would enhance and concentrate partner notification efforts on behalf of recently infected individuals, supporting earlier testing of sexual partners who may themselves have been only recently infected.

Research

Our knowledge of HIV has increased dramatically since the early days of the epidemic. This has significantly aided testing and prevention efforts in the UK. However, further research is needed to develop our testing strategies going forward. This includes:

- The reasons for late HIV diagnosis
- Cost-effectiveness of different HIV testing models and settings for different communities
- Rates of testing in communities with high prevalence
- Barriers to testing in communities with high prevalence
- Sensitivity, specificity and acceptability of different testing technologies
- HIV partner notification: the cost effectiveness of HIV PN; barriers to better practice; the use of RITA within HIV PN process.

Funding agencies, such as the Medical Research Council and Public Health England, should ensure that resources are allocated to improve evidence in these important areas.

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29. NAT (2008): Primary HIV infection

30. NAT (2011): Primary HIV infection: knowledge among gay men

Priorities for action

Priorities for action

The England-based organisations identified here are those currently being set up in shadow form, to become fully operational in April 2013. As these organisations look forward towards the new NHS, Public Health and Social Care arrangements, the priorities below provide a framework within which to think about HIV testing and their responsibilities in this area. All recommendations also duly apply in the interim to PCTs, who will retain responsibility for commissioning prevention, treatment and care throughout 2012.

Outcomes:

- Halve the number of people living with undiagnosed HIV by 2015.[31]
- Halve the numbers of people diagnosed late with HIV by 2015.[32]
- Increase in the number of tests offered and taken up in line with testing guidelines.
- Increase in regular repeat testing among high risk groups.
- Increase in HIV awareness, including knowledge of primary infection and HIV testing recommendations, among healthcare professionals and those at risk.

Outcomes 1 and 2 are in line with the aims of the national Halve It campaign, of which NAT is a member .[33]

Meeting the UK's testing needs

Priorities for action include:	With leadership from:
Opt-out HIV testing in high prevalence areas for: (a) all men and women registering in general practice; and (b) all general medical admissions. Agreed targets and audits in relation to the rolling out of this service.	**England:** Department of Health, Public Health England, NHS Commissioning Board, Clinical Commissioning Groups, Health & Wellbeing Boards **Scotland:** NHS Boards
Universal opt-out HIV testing in: • GUM/sexual health clinics • Antenatal services • Termination of pregnancy services • Drug dependency programmes • Healthcare services for those diagnosed with TB, Hep B, Hep C and lymphoma. Agreed targets and audits in relation to the rolling out of these services.	**England:** Public Health England, NHS Commissioning Board, Clinical Commissioning Groups, local authorities **Scotland:** NHS Boards **Wales:** Local Health Boards **Northern Ireland:** Health and Social Services Boards

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[31] Base year: 2010

[32] Ibid

[33] Halve It (2010). Early Testing Saves Lives: HIV is a public health priority http://www.halveit.org.uk

Priorities for action include:	With leadership from:
HIV partner notification for those newly diagnosed with HIV needs to be better prioritised, resourced and performed.	**England:** Sexual Health Clinics, Local Authorities **Scotland:** NHS Boards **Wales:** Local Health Boards **Northern Ireland:** Health and Social Services Boards
A nationwide audit of current performance around HIV partner notification.	Sexual Health Clinics, British Association of Sexual Health and HIV (BASHH)
The development of appropriate standards for HIV partner notification.	BASHH, British HIV Association (BHIVA)
Increased use of financial incentives, including CQUIN payments, the Quality Outcomes Framework (QOF) and the Health Premium to improve testing and late diagnosis through, for example:	**England:** Public Health England, NHS Commissioning Board, Clinical Commissioning Groups, Local Authorities
(a) an increase in opt-out HIV testing in high-prevalence areas (b) HIV partner notification among the newly diagnosed (c) HIV testing, diagnosis and referral in GP services.	For QOF: NICE (UK-wide)
The UK National Screening Committee to consider the case for further recommended aspects of HIV testing to be included within the screening programme.	UK National Screening Committee
NICE Quality Standards to reflect the need for a universal offer of an HIV test in the case of 'clinical indicator diseases' for HIV in specific, non-HIV healthcare settings (such as antenatal services, TB and Hep B).	NICE
Relevant secondary care specifically commissioned to offer opt-out HIV testing to all who present with clinical indicator diseases.	**England:** Clinical Commissioning Groups **Scotland:** NHS Boards **Wales:** Local Health Boards **Northern Ireland:** Health and Social Services Boards

Priorities for action include:	With leadership from:
Overall increase of HIV testing in primary care with GPs confident of taking a sexual health history, as well as offering and performing an HIV test.	**England:** NHS Commissioning Board, Royal College of GPs **Scotland:** NHS Boards, Royal College of GPs Scotland **Wales:** Local Health Boards **Northern Ireland:** Health and Social Services Boards
Amend the HIV Testing Kits and Services Act (1999) to permit and regulate HIV self-testing kits, ensuring proper quality control and management of self-testing.	Government
Provide accurate, clear and up-to-date advice on the characteristics of approved HIV tests in the UK (including sensitivity, specificity, window period) with recommendations in relation to relevant issues such as diagnosing recent infection.	BASHH or HPA
Ensure all manufacturers of self-testing kits for HIV provide access to post-test counselling and referral to local sexual health/HIV clinics as an integral part of their service.	Government, regulatory agencies
Increased and sustained funding for testing initiatives to reduce undiagnosed HIV.	**England:** Public Health England and Local Authorities **Scotland:** NHS Boards **Wales:** Local Health Boards **Northern Ireland:** Health and Social Services Boards

Priorities for action include:	With leadership from:
Ensure patient waiting times for: (a) appointments for HIV tests at GUM clinics are within 48 hours; and (b) results of laboratory HIV tests are within 72 hours.	Public Health England, Local Authorities, HIV clinics and laboratories.
Research and guidelines produced on the effectiveness and use of fourth generation rapid HIV tests.	HIV sector, researchers
Further research on the contribution of community-based testing in reducing undiagnosed HIV and late diagnosis, and roll-out of appropriate community testing.	HIV sector, researchers, local authorities
Changes in policy and practice, with appropriate training/information for relevant healthcare professionals and NHS gatekeeper services (such as NHS 111) so they recognise the symptoms of HIV infection, including early stage symptoms.	NHS Commissioning Board, healthcare training bodies, NHS gatekeeper services
Funding for research to develop understanding of areas such as the reason for late HIV diagnosis, rates of testing in most affected communities and the cost effectiveness of different HIV testing models for different communities.	e.g. Public Health England, Medical Research Council, other funding bodies
Further roll-out of RITA to establish recent infection, support partner notification and develop understanding of HIV incidence and of success in promoting earlier diagnosis.	Public Health England
Northern Ireland: Funding for pilots that look to expand opt-out testing in secondary care.	Health and Social Services Boards

Priorities for action include:	With leadership from:
Northern Ireland: Implement proposals from the advisory sub-group's *Northern Ireland Testing Strategy for HIV and STIs in High Risk Groups*.	Health and Social Services Boards, Department of Health Northern Ireland
Scotland: Implementation of Healthcare Improvement Scotland's *Standards for HIV Testing*.	NHS Boards

Needs assessment and testing strategy

Priorities for action include:	With leadership from:
The Government to endorse the 2008 UK National Guidelines for HIV Testing, and NICE guidance on increasing the uptake of HIV testing among MSM and black Africans in England (2011) in all relevant policy documents.	Department of Health
The Government should set out a national vision for HIV testing as soon as possible, in light of reforms to the NHS.	Department of Health
Joint Strategic Needs Assessments (JSNA) conducted in every area identify testing need and data on late diagnosis (including breakdowns/characteristics of those diagnosed late), comparing local late diagnosis data with regional and national averages.	Health & Wellbeing Boards
Joint Health and Wellbeing Strategies (JHWS) to develop a plan and targets to reduce late diagnosis, with strategies and resources to meet those targets.	Health & Wellbeing Boards
Wales: Revise Sexual Health and Wellbeing Action Plan to recognise the challenge of late diagnosis (particularly among MSM and heterosexual women) and the value of addressing primary infection.	**Wales:** Welsh Government, Local Health Boards

Increasing appropriate demand for HIV testing

Priorities for action include:	With leadership from:
Continued and sustained funding for local and voluntary groups to promote HIV testing to MSM, African communities and others at risk of HIV.	Local Authorities, Public Health **England:** Government **Scotland:** NHS Boards **Wales:** Local Health Boards **Northern Ireland:** Health and Social Services Boards
Information on the importance of at least annual testing for MSM further promoted, with additional clear recommendations agreed and disseminated on more frequent testing for MSM at elevated risk.	HIV sector, LGBT media, Public Health England, Local Authorities, Sexual Health Clinics, GPs
Investigate the possibility of sending a 'reminder to test' text to every consenting MSM a year after they have tested on the premises.	Sexual Health Clinics
Information on the importance of early and repeat testing (at least annually) for sexually active African men and women in the UK promoted and disseminated.	HIV sector, African community groups and faith groups, black African media, Sexual Health Clinics, GPs
Information on primary HIV infection and its symptoms, and the benefits of early diagnosis, disseminated amongst MSM and African communities to promote early testing and diagnosis of HIV.	HIV sector, MSM and African community and health promotion bodies, Sexual Health Clinics, GPs
A separate strategic plan to meet the prevention needs of the wider public (i.e. non-MSM and African communities). This may include:	Public Health England
• Integrate HIV into wider sexual health information and campaigns.	Public Health England, Local Authorities
• Raise awareness of the risk of HIV infection when travelling abroad.	Public Health England, Government (FCO), GPs, travel agencies, tour operators

NAT
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NAT is the UK's leading charity dedicated to transforming society's response to HIV. We provide fresh thinking, expertise and practical resources. We champion the rights of people living with HIV and campaign for change.

TRANSFORMING THE UK'S RESPONSE TO HIV

NAT

25 YEARS OF

SHAPING ATTITUDES
CHALLENGING INJUSTICE
CHANGING LIVES

Our vision:

Our vision is a world in which people living with HIV are treated as equal citizens with respect, dignity and justice, are diagnosed early and receive the highest standards of care, and in which everyone knows how, and is able, to protect themselves and others from HIV infection.

Our strategic goals:

All our work is focused on achieving five strategic goals:

- effective HIV prevention in order to halt the spread of HIV
- early diagnosis of HIV through ethical, accessible and appropriate testing
- equitable access to treatment, care and support for people living with HIV
- enhanced understanding of the facts about HIV and living with HIV in the UK
- eradication of HIV-related stigma and discrimination.

www.NAT.org.uk

www.lifewithHIV.org.uk - a resource for HIV positive people

www.HIVaware.org.uk - what everyone should know about HIV

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