



The London Sexual Health Programme



HIV late diagnosis target in London

Progress and information to assist commissioning

January 2010

Contents

1	Summary.....	3
2	Introduction and background to the target.....	4
2.1	Strategic context.....	4
2.2	The target.....	4
3	Progress on the late diagnosis target.....	5
4	Summary of current HIV testing guidelines.....	7
5	Examples of implementation of the HIV testing guidelines.....	8
5.1	Department of Health funded pilot projects.....	8
5.2	Other examples of HIV testing strategies.....	8
5.2.1	Community testing.....	8
5.2.2	Primary care.....	9
5.2.3	Testing patients with tuberculosis for HIV.....	9
5.3	Collation of HIV testing project results.....	10
6	Data available to support commissioners.....	11
6.1	Local populations.....	11
6.2	Populations currently living with HIV.....	11
6.3	Current HIV Testing.....	11
7	Commissioning guidance on meeting the target.....	12
7.1	Key points.....	12
7.2	Provision of HIV testing.....	12
7.2.1	Optimise existing HIV testing services.....	12
7.2.2	Introduce universal testing for specific settings.....	13
7.2.3	Establish community based rapid HIV point of care testing (see section 5.2.1).....	13
7.2.4	Pilot opt-out testing in primary care.....	13
7.2.5	Pilot opt-out testing in acute setting.....	13
7.3	Promoting uptake of HIV testing.....	14
7.3.1	Understanding the requirements for HIV testing.....	14
7.3.2	Raising awareness amongst all clinicians of clinical indicators of HIV.....	14
7.4	Work with high risk communities to promote testing.....	15
7.5	HIV testing – technical and laboratory considerations.....	15
7.5.1	Rapid point of care test (POCT).....	15
7.5.2	Local Laboratories.....	15
7.6	HIV care pathway.....	15
7.7	How to evaluate.....	15
8	Conclusion.....	17
	Appendix 1.1: Information about the late diagnosis indicator data collected by the HPA.....	18
	Appendix 1.2: Late diagnoses by London PCT: 2004/5 to 2008.....	19
	Appendix 1.3: Late diagnoses by London PCT (CD4<200 and CD4<350 cells/mm ³): 2008.....	20
	Appendix 1.4: Late diagnoses by London PCT, by mode of acquisition: 2008.....	21
	Appendix 1.5: Late diagnoses by London PCT: 2004/5 and 2008.....	22
	Appendix 1.6: Map of late diagnoses by London PCT: 2008.....	23
	Appendix 1.7: Late diagnoses by London PCT, MSM: 2004/5 to 2008.....	24
	Appendix 1.8: Late diagnoses by London PCT, MSM: 2004/5 and 2008.....	25
	Appendix 1.9: Late diagnoses by London PCT, heterosexuals: 2004/5 to 2008.....	26
	Appendix 2.0: Late diagnoses by London PCT, heterosexuals: 2004/5 and 2008.....	27
	Appendix 2.1: Map of PCTs performance against their trajectories in 2008.....	28
	Appendix 2.2: Persons living with diagnosed HIV infection by PCT of residence: 2008.....	29
	Appendix 2.3: Persons living with diagnosed HIV infection by MSOA of residence: 2008.....	30
	Appendix 2.4: MSM living with diagnosed HIV infection by MSOA of residence: 2008.....	31
	Appendix 2.5: Black-Africans living with diagnosed HIV infection by MSOA of residence: 2008.....	32
	Appendix 3.1: HIV testing information in GUM clinics: 2008.....	33
	Appendix 3.2: HIV testing information in antenatal care.....	34
	Appendix 4: Published studies of HIV testing in community settings in the UK.....	35
	Appendix 5: Number of level 2 sexual health services by PCT in London.....	36
	Acknowledgements.....	37

1 Summary

This toolkit updates PCTs on their progress in achieving the NHS London's HIV late diagnosis target and provides guidance and best practice for commissioning in 2010-11. It was produced by the London Sexual Health Programme and the Health Protection Agency.

Earlier HIV diagnosis improves morbidity and mortality and ensures that newly diagnosed people with HIV can receive effective treatment and support to reduce onward transmission. Reducing late diagnosis is part of standard one of the London Sexual Health Strategic Framework 2009 which is in the NHS London's Operating Framework guidance (2010-11) to PCTs for implementation. The target is for each PCT to reduce the late diagnosis of HIV to 15% by 2010-11.

In 2008, 31% of people diagnosed with HIV in London were diagnosed late (with CD4 cells counts <200 cells/mm³ within 91 days of diagnosis). More heterosexuals are diagnosed at a late stage of infection (44%) compared to men who have sex with men (18%).

This is a modest fall from the 34% diagnosed late at baseline (2004/5). However, there has been an apparent decline in performance compared to the indicator for 2007 when 29% were diagnosed late. Only nine London PCTs met their trajectory in 2008 compared to 19 in 2007 and ten PCTs have shown no improvement on their baseline compared to five in 2007.

National HIV testing guidelines recommend universal HIV testing in GUM or sexual health clinics; antenatal services, termination of pregnancy services, drug treatment programmes and health services for those diagnosed with hepatitis B or C, TB or lymphoma. It is also recommended that HIV testing should be offered to all adults in areas of high diagnosed HIV prevalence (more than two per 1,000) registering in general practice and all general medical admissions, based on evidence that such testing is likely to be cost-effective in areas with this high prevalence. In 2008, 25 London PCTs had a diagnosed prevalence at or above this threshold. This document contains information on HIV prevalence in different sub-PCT areas and information on local HIV testing. In addition, information that can be used to help commissioners is beginning to emerge from non-GUM based pilot HIV testing sites. Further information is available from PCT public health departments and local Health Protection Units.

The key points for commissioners are to:

- Learn from the experience of introducing HIV testing strategies elsewhere;
- Identify those most at risk in the population and areas with high HIV prevalence;
- Ensure HIV testing in GUM and antenatal care are optimised;
- Introduce the routine offer of an HIV test in specific services e.g. hepatitis clinics, termination of pregnancy services, TB services;
- Pilot and evaluate community based point of care testing;
- Pilot and evaluate HIV testing in primary care and the acute setting in high prevalence areas;
- Work with healthcare staff to:
 - Raise awareness of the clinical indicators of HIV;
 - Train staff and build up confidence in offering HIV testing aiming to 'normalise' the HIV test;
- Promote HIV testing in high risk communities and work on reducing stigma and discrimination;
- Ensure that robust and rapid pathways are in place for referral of people testing positive for HIV;
- Commission counselling and one-to-one interventions for people with HIV;
- Commission positive self management programmes for people with HIV.

Some PCTs have achieved or exceeded their trajectories and have commissioned best practice and innovative services. However, the majority of PCTs have not achieved their planned reductions. Reducing late diagnosis of HIV remains a priority for the NHS in London and will support PCTs to deliver the Quality, Innovative, Productivity and Prevention agenda.

2 Introduction and background to the target

Just under half of all individuals with HIV in the UK reside in London. This has significant cost implications for health service provision; 2010-11 estimates suggest the cost of outpatient care to be 250 million pounds (excludes inpatient and prevention costs). In addition, over the past three years there has been an annual growth in the number of people living with diagnosed HIV infection of 8-10%.

2.1 Strategic context

Sexual Health is one of five public health priorities in NHS London's Prevention Framework (2009). This includes the London HIV prevention performance indicator which the Strategic Health Authority has agreed as a tier three vital sign indicator with PCTs. The indicator has been endorsed by the London Sexual Health Commissioning Board that leads on Sexual Health Commissioning for London. It is one of a range of indicators listed in the London Sexual Health Strategic Framework (2009) for PCTs to use to improve the Sexual Health of Londoners (see www.londonsexualhealth.org). This indicator is unique to London and cited in the Review of the National Sexual Health and HIV (2008) that supported the use of a HIV late diagnosis indicator. The indicator is included in the Department of Health's (DH) Sexual Health Balanced Scorecard developed by the South West Public Health Observatory and due to be issued in 2010.

2.2 The target

Reducing the late diagnosis of HIV was chosen as an indirect performance measure of HIV prevention.

HIV late diagnosis is the most important factor associated with HIV related morbidity and mortality in the UK. A national audit by BHIVA (BHIVA 2005-6 mortality audit <http://www.bhiva.org/files/file1001379.ppt>) showed that 24% of deaths in those adults with HIV were directly attributable to the diagnosis of HIV being made too late for effective treatment. Late diagnosis of HIV infection is also linked to increased costs to healthcare services.

Early diagnosis of HIV is important in both reducing the risk of AIDS and death to the individual and reducing the risk of transmission to others. National surveillance data estimate that nearly one-third of all HIV infections are undiagnosed. Modelling studies in the United States suggest that over 50% of new cases of HIV infections arise through transmission from undiagnosed individuals.

The target is for each PCT to reduce the late diagnosis of HIV to 15% by 2010-11; the average from 2004 and 2005 data is used as the baseline. Late diagnosis is defined as people with HIV who have a CD4 count less than 200 per mm³. On average people with a CD4 count less than 200 per mm³ will have been infected about 8 years before their diagnosis. Prior to 2008, treatment guidelines stated treatment should start for people with CD4 counts of less than 200 per mm³. In 2008, guidelines were updated to recommend treatment discussions start once CD4 counts fall between 350 mm³ and 200 cells per mm³. Nationally, an estimated 31% of HIV infections are diagnosed late, however, this varies by region and risk group.

3 Progress on the late diagnosis target

In 2008, 31% (95%CI: 29-33%) of people diagnosed with HIV in London were diagnosed late (with CD4 cells counts <200 cells/mm³ within 91 days of diagnosis). This compares to 34% diagnosed late (95%CI: 33-36%) at baseline (2004/5) and 29% diagnosed late in 2007.

Table of late diagnosis of HIV compared to PCT trajectories (SOPHID HPA data)											
London Sector	PCT of residence	2004 & 2005 #	2004 & 2005 95% CI	2006 §	2007 §	2008	2008 95%CI	London Rank 2008 [§]	Change since 2004 & 2005	Trajectory 2007*	Trajectory 2008*
North Central London	Barnet	36%	27-46%	24%	38%	22%	11-32%	5	-14%	30.0%	25.0%
	Camden	27%	20-35%	35%	20%	20%	11-28%	3	-7%	30.0%	25.0%
	Enfield	38%	29-46%	50%	32%	37%	25-50%	21	-1%	33.3%	30.0%
	Haringey	36%	29-42%	34%	30%	26%	16-36%	9	-10%	35.9%	42.1%
	Islington	27%	20-34%	23%	22%	36%	25-47%	18	9%	23.5%	21.3%
Outer North East London	Barking & Dagenham	42%	32-51%	44%	35%	43%	29-58%	29	1%	40.0%	26.7%
	Havering	52%	34-69%	67%	39%	52%	33-71%	31	0%	50.0%	40.9%
	Redbridge	46%	35-56%	37%	35%	32%	17-48%	13	-14%	30.0%	25.0%
	Waltham Forest	47%	38-57%	43%	31%	35%	24-47%	17	-12%	25.0%	20.0%
Inner North East London	City and Hackney	30%	24-36%	30%	28%	23%	15-31%	8	-7%	29.8%	27.3%
	Newham	39%	32-45%	31%	34%	38%	29-46%	23	-1%	25.0%	22.5%
	Tower Hamlets	29%	22-36%	26%	20%	23%	13-32%	7	-6%	24.4%	22.1%
North West London	Brent	33%	25-41%	31%	42%	36%	24-47%	19	3%	31.0%	27.0%
	Ealing	42%	32-51%	38%	23%	31%	17-45%	12	-11%	40.0%	35.0%
	Hammersmith & Fulham	29%	20-38%	30%	20%	20%	10-29%	2	-9%	26.5%	22.4%
	Harrow	38%	24-52%	25%	30%	39%	16-61%	24	+1%	33.0%	30.0%
	Hillingdon	37%	24-51%	31%	28%	39%	26-53%	25	+2%	30.0%	25.0%
	Hounslow	41%	33-50%	34%	31%	35%	20-50%	16	-6%	33.8%	28.8%
	Kensington & Chelsea	21%	13-29%	41%	22%	12%	3-21%	1	-9%	16.2%	16.0%
	Westminster	28%	21-35%	13%	22%	22%	14-30%	6	-6%	21.1%	20.0%
South East London	Bexley	57%	43-71%	37%	42%	36%	17-55%	20	-21%	50.0%	35.3%
	Bromley	42%	29-55%	42%	32%	33%	14-52%	14	-9%	37.5%	28.0%
	Greenwich	45%	37-53%	36%	29%	45%	35-56%	30	0%	40.9%	36.7%
	Lambeth	27%	23-31%	30%	18%	21%	16-27%	4	-6%	31.0%	30.7%
	Lewisham	31%	24-37%	34%	43%	41%	33-50%	28	10%	35.4%	29.9%
	Southwark	31%	26-35%	32%	27%	30%	22-37%	11	-1%	30.5%	30.0%
South West London	Croydon	37%	31-43%	35%	37%	40%	30-50%	26	3%	33.0%	31.0%
	Kingston	34%	20-48%	26%	32%	33%	7-60%	15	-1%	31.8%	31.8%
	Richmond & Twickenham	35%	19-51%	13%	45%	29%	5-52%	10	-6%	30.0%	25.0%
	Sutton & Merton	43%	35-52%	37%	34%	41%	28-54%	27	-2%	40.0%	38.5%
	Wandsworth	34%	27-41%	28%	28%	37%	25-50%	22	3%	25.0%	23.0%
London		34%	33-36%	32%	29%	31%	29-33%		-3%		

Two years used for a robust baseline. No.s are small at the PCT level and will fluctuate from year to year.

§ Rank 1=lowest proportion diagnosed late.

* Green=performance is within PCT trajectory, Amber = performance is not within PCT trajectory and over by 5% or less, Red=performance is not within PCT trajectory and over by more than 5%.

§ These data have not been updated to include reports received after the survey period for 2006 and 2007

** CD4 count<200 cells/mm³ within 91 days of diagnosis. Excludes patients where PCT of residence is not known.

Heterosexuals were significantly more likely to be diagnosed late compared to men who have sex with men (MSM) in 2008 (44% (95%CI: 40-47%) vs. 18% (95%CI: 15-20%) respectively).

Performance was extremely variable between PCTs in London, with the proportion of late diagnoses ranging from 12% to 41%. Only nine PCTs met their trajectories and ten PCTs showed no improvement on the baseline. It should be noted that underlying numbers are small for some PCTs and therefore the proportion diagnosed late will fluctuate markedly from year to year; this is indicated by the wide confidence intervals by site (main table).

In 2008, BHIVA's national treatment guidelines were updated to recommend that treatment commence when CD4 cell counts reach between 200 and 350 cells/mm³ (previous guidelines recommend treatment commenced when CD4 cell counts reached under 200 cells/mm³); the proportion of London patients who were diagnosed with a CD4 cell count at under 350 was 53% in 2008 (Appendix 1.3).

4 Summary of current HIV testing guidelines

In 2008 BHIVA, BASSH and BIS published joint HIV testing guidelines (<http://www.bhiva.org/HIVTesting2008.aspx>). The aim was to increase the uptake of HIV testing in all healthcare settings in order to reduce the proportion of individuals who are undiagnosed or who are diagnosed late (CD4 count <200 cells/mm³).

The guidelines make the following recommendations:

- Universal HIV testing in GUM or sexual health clinics; antenatal services, termination of pregnancy services, drug treatment programmes and health services for those diagnosed with hepatitis B or C, TB or lymphoma.
- In areas of HIV prevalence greater than 2 in 1000 (which is the case in 25 out of 31 PCTs in London), HIV testing should be offered to all adults registering in general practice and all general medical admissions. This recommendation is based on evidence that such testing is likely to be cost-effective in areas with this high prevalence.
- HIV testing should be recommended to patients who are identified as having a greater likelihood of being HIV positive. This will include:
 - Patients presenting with clinical symptoms where HIV is included in the differential diagnosis;
 - All patients diagnosed with a sexually transmitted infection;
 - All sexual partners of men and women known to be HIV positive;
 - All men who have disclosed sexual contact with other men;
 - All female sexual contacts of men who have sex with men;
 - All patients reporting a history of injecting drug use;
 - All men and women known to be from a country of high HIV prevalence;
 - All men and women who report sexual contact abroad or in the UK with individuals from countries of high HIV prevalence.
- HIV testing should be performed in the following groups as per Department of Health guidance:
 - Blood donors;
 - Dialysis patients;
 - Organ transplant donors and recipients.

Frequency of HIV testing: MSM should be tested annually; IDUs should be tested annually; pregnant women who refuse an HIV test at booking should be reoffered the test and should they decline again a third offer should be made at 36 weeks.

Onward referral into HIV care pathway: All HIV positive individuals must be immediately referred into specialist HIV services. It is recommended that any individual, who is diagnosed with HIV, should be seen by an HIV specialist health care worker or advisor as soon as possible; preferably within 48 hours of the test result.

Post-test discussion: There must be a clear process in place to communicate the test results, in particular in circumstances where the test result is positive. There should be an agreed recall process for patients who do not turn up to receive a positive result of an HIV test.

No requirement for pre-test counselling: All healthcare professionals should be able to obtain informed consent for HIV testing, as for any other clinical test. Pre-test discussions should address the benefits of the test to the individual and how the result will be given.

Partner notification: Services should have clear guidelines on partner notification in HIV, how it is offered, including offering clients the option of provider referral. Partner notification should be encouraged with all individuals immediately after HIV diagnosis and on an ongoing basis thereafter.

5 Examples of implementation of the HIV testing guidelines

Since the HIV testing guidelines were published and the London late diagnosis target was introduced there has been much work on implementing more widespread HIV testing. Unfortunately not all of this pilot or project work has been published but some of these are described in the sections below with pointers on how to access further information.

5.1 Department of Health funded pilot projects

The Department of Health has funded eight projects across the country which will pilot HIV testing in healthcare and community settings. These pilots are ongoing and results are expected by the end of August 2010 and are listed below (for further information please contact Alicia.Thornton@HPA.org.uk).

Project setting	Location	Routine testing or targeted testing	Summary of project
Primary care settings	Brighton	Routine	All new registrants, 16-59 years old, at 19 GP practices to be routinely offered HIV test.
	Lewisham, London	Routine	All new registrants attending up to 10 GP practices to be routinely offered HIV testing. These practices have high numbers of patients from African communities.
Community settings	Sheffield	Targeted	Home-sampling among MSM and black-African communities. Using promotion of sampling kits through the internet and community venues.
	London – Terrance Higgins Trust	Targeted	Nurse led service to provide HIV testing in money transfer shops used by African communities.
	South London GMI partnership	Targeted	Testing offered as part of a broader health screen to African communities and nurse and peer led testing of MSM communities.
Hospital settings	Leicester	Routine	All 15-59 year olds in an acute medical unit to be offered HIV testing.
	Brighton	Routine	All 16-59 year olds in an acute medical unit to be offered HIV testing.
	London	Routine	All 16-65 year olds in an emergency department, and acute medical unit, a haematology outpatients department and a dermatology outpatient department to be offered HIV testing.

5.2 Other examples of HIV testing strategies

5.2.1 Community testing

The Terrance Higgins Trust has established rapid HIV testing in community clinics in conjunction with local GUM clinics in London, Brighton, Bristol and Leeds. The fasTest service was evaluated over a six month period. This confirmed the feasibility of establishing community testing clinics linked to GUM services. Of those individuals who tested at the fasTest sites more than one third of individuals had never previously had an HIV test. Full reports can be found at: <http://www.sigmaresearch.org.uk/go.php/projects/project42>.

City and Hackney PCT have schemes in place to address HIV testing in high risk communities. They undertake HIV and STI testing at a local gay sauna every two weeks. The testing is popular with clients. There are some issues as regards the wide geographical residence of the clients.

City and Hackney PCT have also started the African near patient health care check in September 2009. This provides people from African communities with a wide range of health care services and HIV testing is one of these. This helps to avoid the stigma around HIV testing within these communities.

The HPA has reviewed HIV testing in community settings. The literature review defined community services as either specialised clinics providing sexual health services and rapid testing or those taking place in non-medical centres. Data that is specific to the UK setting was limited as most studies took place in the USA (Appendix 4). The review concluded that although there is a limited volume of published evidence, this does suggest that community HIV settings are effective for identifying undiagnosed HIV infection when targeted at groups known to be high risk.

5.2.2 Primary care

Rates of HIV testing in primary care increased between 1995 and 2005. However, rates still remain low and only half of HIV positive patients had their HIV status recorded in the medical notes (Evans et al, 2009).

A pilot project in East London assessed the acceptability and feasibility of routinely offering HIV tests to all 18-55 year old new registrants at a GP surgery. Nearly half of all eligible patients accepted a test. The most common reason for accepting the test was that it formed "part of a check-up". In this study some patients expressed concern about support for the newly diagnosed (Prost et al 2009). Effective referral and support of the newly diagnosed requires strong links with local HIV and GUM services and this should be considered before primary care testing is initiated. This pilot is now in its second stage and is part of a larger randomised control trial. There are considerations that need to be made around the immediacy of results and that it is more difficult for GP practices to be prepared for dealing with the results than in acute settings.

Many PCTs now have GP practices that are providing a level 2 sexual health service (Appendix 5).

City and Hackney have incentivised local enhanced schemes (LES) for HIV testing and a GP champion. The PCT has also employed an HIV nurse, who spends 60% of the time on promoting HIV testing in the community and the rest of the time in the acute setting.

The South West London HIV & GUM clinical testing network (SWAGNET) has developed a Primary Care Toolkit for Indicator Diseases for HIV Testing. GPs are given a presentation about the toolkit and provided with an A5 pad, with tear off sheets for patients. They also have a Wandsworth PCT initiative alongside the Roehampton Sexual Health Clinic. This is funded by the PCT and aims to deliver training on HIV indicators at all the practices within the PCT. Specialists go out to GP practices and provide training sessions to GPs and nurses (<http://www.swagnet.nhs.uk/>).

5.2.3 Testing patients with tuberculosis for HIV

A study in London has shown that in 2003/4 nearly half of patients with tuberculosis were not offered an HIV test. However, when the test is offered, uptake is high (Rodger et al, 2009). This setting represents a missed opportunity for HIV diagnosis.

An opt-out HIV testing programme is being offered through the London TB networks as part of the HPA National Knowledge Service Pilot. This began in September 2009 and the initial evaluation of the number of tests offered and uptake is currently being undertaken. HPA support materials are provided to supplement current knowledge, as clinics enrol in to the pilot programme. Patients are informed that HIV testing is part of the routine management of TB and are provided with leaflets in different languages. Initial challenges, as reported by some of the London TB network sector leads, were getting agreement from the clinicians and then ensuring adequate training of staff. Overall it has been greeted positively and uptake appears to be improving. They anticipate, once the six month pilot has been completed and discussed with commissioners, that opt-out testing will continue to be offered to all eligible patients, in line with BHIVA guidance. There is a strong argument for continued opt-out testing as a significant

proportion of patients are of Black African ethnicity and there are high levels of HIV and TB co-infection in a number of London boroughs.

5.3 Collation of HIV testing project results

It is very important that innovative work to reduce late diagnoses or to test in different ways or in different settings is piloted and evaluated and pilots are large enough to inform future strategies.

Where possible, details of these pilots and evaluations should be shared with the Health Protection Agency so that information about best practice can be collated and disseminated through documents such as this (Alicia.Thornton@hpa.org.uk).

6 Data available to support commissioners

Local Health Protection Units (HPUs) and PCT public health information teams will be able to support commissioners with information on their local populations, areas with high HIV prevalence and information on current HIV testing. HPUs typically produce an annual HIV report describing the epidemiology of HIV by geographical sector.

6.1 Local populations

The population groups most at risk of HIV in London are Black Africans, MSMs and injecting drug users. Other people who should be recommended HIV tests are listed in the national HIV testing guidance (see section 4).

PCTs will be aware of the ethnicity of their local populations and to a lesser extent, where MSMs are more likely to live and access services. It is important that PCTs develop their strategies based on their own demographic breakdown because the proportion of new diagnoses that are MSM (or inversely, heterosexuals) varies significantly across London (Appendix 1.3 and 1.4).

6.2 Populations currently living with HIV

In 2008, there were an estimated 83,000 people living with HIV infection in the UK, of whom 27% were estimated to be unaware of their HIV infection. Assuming this ratio is broadly consistent across geographical regions, the prevalence of diagnosed HIV can be used as an indicator of the prevalence of undiagnosed HIV. Consequently, national guidelines recommend that consideration should be given to offering HIV testing to all men and women registering in general practice as well as to all general medical admissions in areas where the prevalence of diagnosed HIV infections is greater than two per 1,000.

The HPA has used its latest data from its Survey Of Prevalent HIV Infections that have been Diagnosed (SOPHID) to show the PCTs where the prevalence of diagnosed HIV infection exceeded two adults per 1,000 population (aged 15-59 years) in 2008 (Appendix 2.2) which includes 25 PCTs in London. The HPA have also provided more detailed maps of this information by Middle Super Output Area (MSOA) to improve targeting of enhanced testing (Appendix 2.3).

Finally, the HPA have provided MSOA maps highlighting those areas where there are higher numbers of men who have sex with men (MSM) (Appendix 2.4) and Black Africans living with HIV (Appendix 2.5).

6.3 Current HIV Testing

PCTs will need a greater understanding of local HIV testing practice and where it can be optimised. The HPA has provided data on the uptake of testing in antenatal settings (Appendix 3.2 and in GUM clinics (Appendix 3.1). This highlights settings where there is potential to improve uptake of testing. There is no routine data from HIV testing in other settings (although testing data for TB patients may be available).

PCTs can consider further work to:

- Identify where HIV tests are being offered at a local level; e.g. TB clinics, TOP services, non-traditional settings;
- Audit uptake – offer and uptake;
- Collect non-routine HIV testing data;
 - Information on numbers of HIV tests and proportions positive from other hospital departments and primary care/community may be available from laboratories.
 - GP databases e.g. EMIS may be a source of information on HIV testing.

7 Commissioning guidance on meeting the target

Late diagnosis of HIV infection is associated with increased morbidity and mortality, increased costs to healthcare services and a reduced response to anti-retroviral treatment. Many of those who are diagnosed late were seen recently by a healthcare professional, and thus an opportunity for diagnosis was missed. An individual's knowledge of their HIV status is found to reduce their risk behaviour, and therefore reduce the risk of onward transmission. Commissioning services to provide HIV testing outside of GUM settings and to those groups with the highest rates of late diagnosis of HIV is key to meeting the target to reduce HIV late diagnosis.

The highest rates of late diagnosis are in the heterosexual population, mainly in the Black African population (Appendix 1.9 and Appendix 2.0). PCTs will need to substantially increase HIV testing among heterosexuals to reduce late diagnoses. However, HIV testing will need to be improved among MSM in parallel so that the overall percentage diagnosed late reaches the HIV Prevention Indicator target of 15% or less by 2010-11 (this may mean that late diagnosis in 2010-11 is below 15% among MSM and above 15% among heterosexuals). Interventions which promote HIV testing and raise awareness of the benefits of early HIV diagnosis in high prevalence groups will be important but unlikely to be sufficient to meet the performance target on their own. PCTs will need to address how to develop new models of service provision in both primary and secondary care. All services offering HIV tests should consider how they might reduce barriers to presentation such as stigma and discrimination.

7.1 Key points

- Learn from the experience of introducing HIV testing strategies elsewhere
- Identify those most at risk in the population and areas with high HIV prevalence
- Ensure current HIV testing in GUM and antenatal care are optimised
- Introduce the routine offer of an HIV test in specific services e.g. hepatitis clinics, termination of pregnancy services, TB services
- Pilot and evaluate community based point of care testing
- Pilot and evaluate HIV testing in primary care and the acute setting in high prevalence areas
- Work with healthcare staff to:
 - Raise awareness of clinical indicators of HIV;
 - Train staff and build up confidence in offering HIV testing aiming to 'normalise' the HIV test.
- Promote HIV testing in high risk communities and work on reducing stigma and discrimination
- Ensure that robust and rapid pathways are in place for referral of people testing positive for HIV
- Commission counselling and one-to-one interventions for people diagnosed with HIV in acute and community settings
- Commission positive self management programmes for people with HIV

7.2 Provision of HIV testing

7.2.1 Optimise existing HIV testing services

PCTs should ensure that current services which routinely provide HIV testing are achieving existing targets of the National Strategy for Sexual Health and HIV e.g. antenatal and GUM clinics. Work should initially focus on improving services within PCTs that are failing to meet performance targets although data quality may be an issue in some of these services. It has been shown that an opt-out HIV testing service in GUM increases the uptake of HIV testing.

The UK National Guidelines for HIV Testing set out auditable standards for HIV that can be used to monitor current services (<http://www.bhiva.org/documents/Guidelines/Testing/GlinesHIVTest08.pdf>). Standards include offer and uptake of HIV testing in GUM and antenatal clinics.

7.2.2 Introduce universal testing for specific settings

Universal opt-out HIV testing should be introduced in settings where clients may have an increased HIV prevalence. In addition to GUM / sexual health clinics (including Level 2 sexual health services, which may be in polyclinics) and antenatal clinics, this will include:

- Termination of pregnancy services;
- Drug dependency programmes;
- Hepatitis B and C services;
- Services for people with lymphoma;
- TB services - The NHS National Standards for TB recommend that all patients presenting with/being treated for TB are offered and recommended an HIV test (see section 5.2.3).

7.2.3 Establish community based rapid HIV point of care testing (see section 5.2.1)

Evidence suggests that development of outreach community services targeted towards groups known to be at high risk of HIV infection may be an effective way of identifying undiagnosed HIV infections. Key issues to consider are:

- Who is the target population for community based settings? Local prevalence data should be used to decide who and where the service is provided i.e. high prevalence groups should be targeted;
- How to promote the new service to the target group?
- How to link into services currently providing HIV testing, usually the local GUM / sexual health clinic?

7.2.4 Pilot opt-out testing in primary care

Primary care has a key role in providing more widespread HIV testing, outside the traditional GUM settings. This can contribute to 'normalising' HIV testing so it is seen as a routine rather than a specialised clinical investigation. Lessons can be learnt from the Chlamydia Screening Programme. The National Chlamydia Screen Programme Commissioning document stated that there was a significant amount of service capacity not utilised but recognised that incentives are required to engage general practice. Key points to consider when commissioning services in primary care are:

- **UK National Guidelines for HIV Testing:** This recommends that HIV testing should be considered in all men and women registering in general practice where the prevalence of HIV in the local population is two or more per 1000. Testing is likely to be most effective if targeted at people aged between 15 and 59 years old.
- **Deciding which practice patients should be offered HIV testing:** In areas of high prevalence some pilots have targeted all new patients whilst others have targeted all patients in the appropriate ages. In terms of affordability some form of initial risk assessment may be considered, especially in areas with lower prevalence of HIV. Possible frameworks for risk assessment should include those groups identified in the national HIV testing guidance as being particularly at risk (see section 4). Patients should be informed that the groups numerically most affected by HIV infection are black Africans and MSM and it may not be necessary for them to disclose behaviour which may have put them at risk of infection.
- **Deciding on incentives:** Incentives are very important and need careful consideration e.g. whether to pay per positive test or just per test.
- **Championing:** An example of best practice from The National Chlamydia Screen Programme showed that identifying a GP champion to promote screening through the Local Medical Committee significantly increased the uptake of Chlamydia screening over and above that of an incentive alone and identifying a GP champion for HIV testing is recommended. GPs commissioned to provide enhanced sexual health services may be suitable for such a role. The availability of enhanced sexual health services varies by area.

7.2.5 Pilot opt-out testing in acute setting

The UK National Guidelines for HIV Testing recommend that universal HIV testing should be offered to all general medical admissions where HIV prevalence in the local population exceeds two per

1,000. Opt-out testing has been found to have a higher uptake in other settings. PCTs will have to consider how to best incentivise testing in acute settings.

7.3 Promoting uptake of HIV testing

PCTs will need to commission interventions to promote HIV testing, to run parallel with the interventions designed to increase provision of testing. Effective commissioning will address both these broad areas in order to fully maximise HIV testing.

PCTs need to consider how to:

- Raise health care workers awareness of the symptoms of AIDS related illnesses (see section 4);
- Ensure that patients who present with a possible HIV related illness are routinely offered HIV testing.

7.3.1 Understanding the requirements for HIV testing

Currently some health care professionals still perceive HIV as a specialist test that cannot be offered outside a specialist setting, such as GUM. Clinicians have training needs that should be addressed to raise awareness of the need for HIV testing, the barriers to HIV testing and legal aspects associated with HIV.

Work should be done to ensure that all healthcare professionals are aware that:

- It is within the competence of any doctor, midwife, nurse or trained healthcare worker to obtain consent for and conduct an HIV test (UK National Guidelines for HIV testing);
- There are no special competencies required by health professionals to consent for and conduct an HIV test.

It is important to engage with staff who will be implementing HIV testing programmes and to ensure appropriate training packages are in place. This will enable staff to feel more confident in approaching patients for HIV testing and reduce barriers to implementation of programmes.

7.3.2 Raising awareness amongst all clinicians of clinical indicators of HIV

The UK National Guidelines for HIV Testing (2008) advises that patients with specific indicator conditions should be routinely recommended to have an HIV test.

Individuals with undiagnosed HIV may be seen in any primary or secondary health setting and work on raising non-HIV clinicians' awareness of HIV/AIDS related illness needs attention. Local sexual health clinical networks may be able to offer support with this.

- BASHH provide a two day training course: Sexually Transmitted Infections Foundation (STIF) course. This is aimed at medical professionals who may encounter patients with STIs. It includes sections on HIV counselling and testing http://www.bashh.org/education_training_and_careers/stif.
- MedFASH, working with the RCGP, has developed the Introductory Certificate in Sexual Health, which is appropriate for GPs, Practice Nurses and other practitioners working in general practice at all stages in their careers. It aims to support the development of competencies at an introductory level for generalists. To obtain the certificate, participants should first complete the e-learning module on doctors.net.uk. Further information on the next course is available at: http://www.medfash.org.uk/publications/documents/Mar_09_RCGP_ICSH_info_and_booking%20form.pdf
- The Medical Foundation for AIDS and sexual health (MedFASH) has produced two books specifically addressing the needs of non-specialist clinicians in regard to HIV knowledge and skills, 'HIV in Primary Care' and 'HIV for non-HIV specialists'. The resource pack, 'Tackling HIV Testing', contains the above booklet ('HIV for non HIV specialists') as well as template documents for use in non-specialist settings (for example posters, patient information leaflets and frequently asked questions) and slide sets on the guidelines, HIV epidemiology and barriers to testing. These are all freely downloadable from the MedFASH website (<http://www.medfash.org.uk/>).

7.4 Work with high risk communities to promote testing

The fear of results, stigma and discrimination are frequently reported by individuals to be barriers to HIV testing and will need to be addressed. In addition surveys have shown the public to have considerable knowledge gaps regarding HIV infection. Community HIV groups have much to offer and can have a substantial effect.

Therefore local work is needed to:

- Identify barriers to uptake: e.g. access to services / lack of information on available services;
- Work to improve knowledge of HIV and HIV testing and the benefits of early diagnosis;
- Work to reduce stigma; e.g. link with black Africans and MSM through community groups / third sector.

7.5 HIV testing – technical and laboratory considerations

7.5.1 Rapid point of care test (POCT)

These have the advantage of providing a result within minutes from either a finger prick or salivary test. Although the sensitivity of the test is high the specificity is lower so all patients with a positive test will require a confirmatory serological test (to minimise false positive results). This may not be appropriate where blood can be taken and may not be appropriate in low prevalence settings/population groups.

The draft BASHH and MedFASH guidelines for the management of sexually transmitted infections (December 2009 http://www.bashh.org/news/435_bashh-standards-for-the-management-of-sexually-transmitted-infections) states that POCT should only be used as a screening test, when validation data are available. Confirmation of a reactive POCT by an established laboratory test is mandatory.

7.5.2 Local Laboratories

The implementation of new HIV testing strategies will lead to an increase in the number of HIV tests that local microbiology laboratories would have to process. Therefore it would be important to have a discussion with the local microbiologists about the impact of the new HIV strategies and the capacity and resources of the laboratory to deal with this increased demand.

7.6 HIV care pathway

PCTs should commission a care pathway that aims to prevent onward transmission of HIV. It is essential that the patient pathway for HIV testing is robust, especially for new testing provision.

- **Referral:** All HIV positive individuals must be immediately referred into specialist HIV services. It is recommended that any individual, who is diagnosed with HIV, should be seen by an HIV specialist health care worker or advisor as soon as possible; preferably within 48 hours of the test result.
- **Behavioural and emotional support:** People diagnosed should be offered counselling and one-to-one interventions in line with NICE guidelines on STIs and referred to positive self-management programmes that are shown to increase confidence to better access services and promote safer sex.
- **Recall of Patients:** In acute settings it may be difficult to recall patients to inform them of results. Therefore there should be systems in place to deal with this and consideration of whether GUM clinics can support with this. In addition, patient records are often not up to date e.g. with current address and contact details. This should be addressed systematically when offering the test.
- **Rapidity of Results:** In community settings, where point of care testing (POCT) is used, the results are obtained almost immediately. In these circumstances it is important that clinicians are able to deal with the outcome of a positive result and communicating this to patients appropriately and arranging a confirmatory serological test and referral.

7.7 How to evaluate

As there is limited evidence of the acceptability and effectiveness of interventions to increase the uptake of HIV testing, PCTs should consider how to evaluate new services or pilots including the cost

of services. These need to be made available to others. Data is collected nationally for HIV testing conducted in GUM and antenatal services. However, new testing strategies should be evaluated locally.

The following variables are essential in assessing testing strategies in healthcare and community settings:

- Number of people offered testing;
- Number of people tested;
- Number of individuals with reactive results;
- Number of individuals confirmed positive;
- Number of confirmed positives individuals who are successfully transferred to care;
- Staff resource requirements and time dedicated to HIV testing;
- Cost per HIV test.

Additional patient data that is useful in evaluating HIV testing strategies are:

- Age;
- PCT of residence;
- Sex;
- Sexuality and ethnicity of patients who accept and decline testing;
- CD4 count at diagnosis for those newly diagnosed with HIV;
- History of HIV testing.

Possible outcome measures include:

- The proportion of patients offered testing in various settings;
- The uptake of testing (number of tests offered and number accepted) in different population groups;
- Diagnosis rates;
- Referral to care rates;
- Times for referral;
- Acceptability;
- Median CD4 count at diagnosis;
- Percentage of healthcare settings where appropriate written information about HIV testing is available (MedFash);
- Percentage of healthcare settings where appropriate written information about HIV testing is available (MedFash);
- Percentage of healthcare settings, e.g. GP surgeries where HIV testing is undertaken on patient request (MedFash);
- Percentage of tests received with seven days of blood sample being taken (MedFash);
- Percentage of initial positive samples which were followed by confirmatory tests (MedFash);
- Percentage of people with HIV who were seen in a specialist HIV treatment and care clinic within 14 days of receipt of confirmation of seropositivity (MedFash and BHIVA).

8 Conclusion

This toolkit shows that there has been a modest reduction in late diagnosis of HIV compared to the 2004-5 baseline. However, there is clearly much to do to reach the target of 15% by end of March 2011.

Some PCTs have achieved or exceeded their trajectories to reduce late diagnosis of HIV and have commissioned best practice and innovative services. However, the majority of PCTs have not achieved their planned reductions and this toolkit provides commissioning guidance and best practice to support their 2010-11 plans.

Reducing late diagnosis of HIV remains a priority for the NHS in London and will support PCTs to deliver the Quality, Innovative, Productivity and Prevention agenda.

Appendix 1.1: Information about the late diagnosis indicator data collected by the HPA

Background information

Earlier diagnosis of HIV can reduce the risk of HIV related death. It also allows diagnosed people to make behavioural changes to avoid infecting others and can reduce infectivity due to earlier initiation of antiretroviral therapy.

A late HIV diagnosis is defined as a CD4 cell count less than 200 cells per mm³. This indicates that on an average the individual has been infected with HIV for about 8 years prior to diagnosis. Some individuals who were infected abroad will not have spent all their time between infection and diagnosis in the UK. However, the majority of individuals infected abroad live with undiagnosed HIV infection for several years before diagnosis and many opportunities for earlier HIV diagnosis are missed.

Prior to 2008, treatment guidelines stated that treatment should start for people with CD4 counts of less than 200 per mm³. In 2008, guidelines were updated to recommend treatment discussions start once CD4 counts fall between 350 mm³ and 200 cells per mm³.

Numerator definition

The total number of HIV-infected London residents aged 15 years or above who were diagnosed in a calendar year with PCT of residence and CD4 cell count reported where the CD4 cell count was less than 200 cells per mm³.

Denominator definition

The total number of HIV-infected London residents aged 15 years or above who were diagnosed in a calendar year with PCT of residence and CD4 cell count reported. Important note: this will not amount to the total number of new HIV diagnoses among residents in each PCT.

Confidentiality statement

No names are collected in HIV Surveillance systems. No patient-level data are ever released and aggregate data are only published after ensuring that deductive disclosure cannot occur. HIV voluntary reporting systems have approval (renewed each year) under the Section 251 regulations of the NHS Act 2006. In addition, all data are stored on restricted and secure databases at the HPA, with strict adherence to the Data Protection Act and Caldicott Guidelines.

Appendix 1.2: Late diagnoses by London PCT: 2004/5 to 2008

London Sector	PCT of residence	Baseline: 2004 + 2005*				2006*				2007*				2008			
		n with CD4	n <200	% <200		n with CD4	n <200	% <200		n with CD4	n <200	% <200		N	n <200	% <200	95%CI
North Central London	Barnet	107	39	36%		46	11	24%		55	21	38%		60	13	22%	11% 32%
	Camden	140	38	27%		92	32	35%		75	15	20%		81	16	20%	11% 28%
	Enfield	117	44	38%	33%	54	27	50%	33%	47	15	32%	27%	59	22	37%	25% 50%
	Haringey	183	65	36%		86	29	34%		76	23	30%		69	18	26%	16% 36%
	Islington	147	40	27%		75	17	23%		93	20	22%		70	25	36%	24% 47%
Outer North East London	Barking & Dagenham	108	45	42%		64	28	44%		52	18	35%		46	20	43%	29% 58%
	Havering	33	17	52%		15	10	67%		18	7	39%		27	14	52%	33% 71%
	Redbridge	85	39	46%		35	13	37%		37	13	35%		37	12	32%	17% 48%
	Waltham Forest	116	55	47%	38%	72	31	43%	35%	58	18	31%	30%	65	23	35%	24% 47%
Inner North East London	City And Hackney	206	62	30%		94	28	30%		122	34	28%		113	26	23%	15% 31%
	Newham	236	91	39%		109	34	31%		105	36	34%		112	42	38%	29% 46%
	Tower Hamlets	163	47	29%		72	19	26%		83	17	20%		71	16	23%	13% 32%
North West London	Brent	137	45	33%		65	20	31%		72	30	42%		70	25	36%	24% 47%
	Ealing	101	42	42%		52	20	38%		52	12	23%		42	13	31%	17% 45%
	Hammersmith & Fulham	97	28	29%		46	14	30%		59	12	20%		66	13	20%	10% 29%
	Harrow	47	18	38%	33%	28	7	25%	28%	23	7	30%	27%	18	7	39%	16% 61%
	Hillingdon	51	19	37%		32	10	31%		36	10	28%		51	20	39%	26% 53%
	Hounslow	138	57	41%		38	13	34%		51	16	31%		40	14	35%	20% 50%
	Kensington & Chelsea	110	23	21%		34	14	41%		81	18	22%		49	6	12%	3% 21%
	Westminster	161	45	28%		91	12	13%		123	27	22%		95	21	22%	14% 30%
South East London	Bexley	49	28	57%		35	13	37%		24	10	42%		25	9	36%	17% 55%
	Bromley	57	24	42%		24	10	42%		31	10	32%		24	8	33%	14% 52%
	Greenwich	156	70	45%	33%	89	32	36%	33%	72	21	29%	28%	88	40	45%	35% 56%
	Lambeth	401	108	27%		188	56	30%		214	38	18%		217	46	21%	16% 27%
	Lewisham	219	67	31%		144	49	34%		133	57	43%		123	51	41%	33% 50%
	Southwark	385	118	31%		185	59	32%		215	59	27%		152	45	30%	22% 37%
South West London	Croydon	225	83	37%		111	39	35%		78	29	37%		85	34	40%	30% 50%
	Kingston	44	15	34%		23	6	26%		22	7	32%		12	4	33%	7% 60%
	Richmond And Twickenham	34	12	35%	37%	15	2	13%	32%	20	9	45%	34%	14	4	29%	5% 52%
	Sutton & Merton	130	56	43%		65	24	37%		68	23	34%		54	22	41%	28% 54%
	Wandsworth	156	53	34%		54	15	28%		65	18	28%		59	22	37%	25% 50%
		4339	1493	34%	34%	2153	696	32%	32%	2260	650	29%	29%	2094	651	31%	
*§ These data have not been updated to include reports received after the survey period for 2006 and 2007.																	

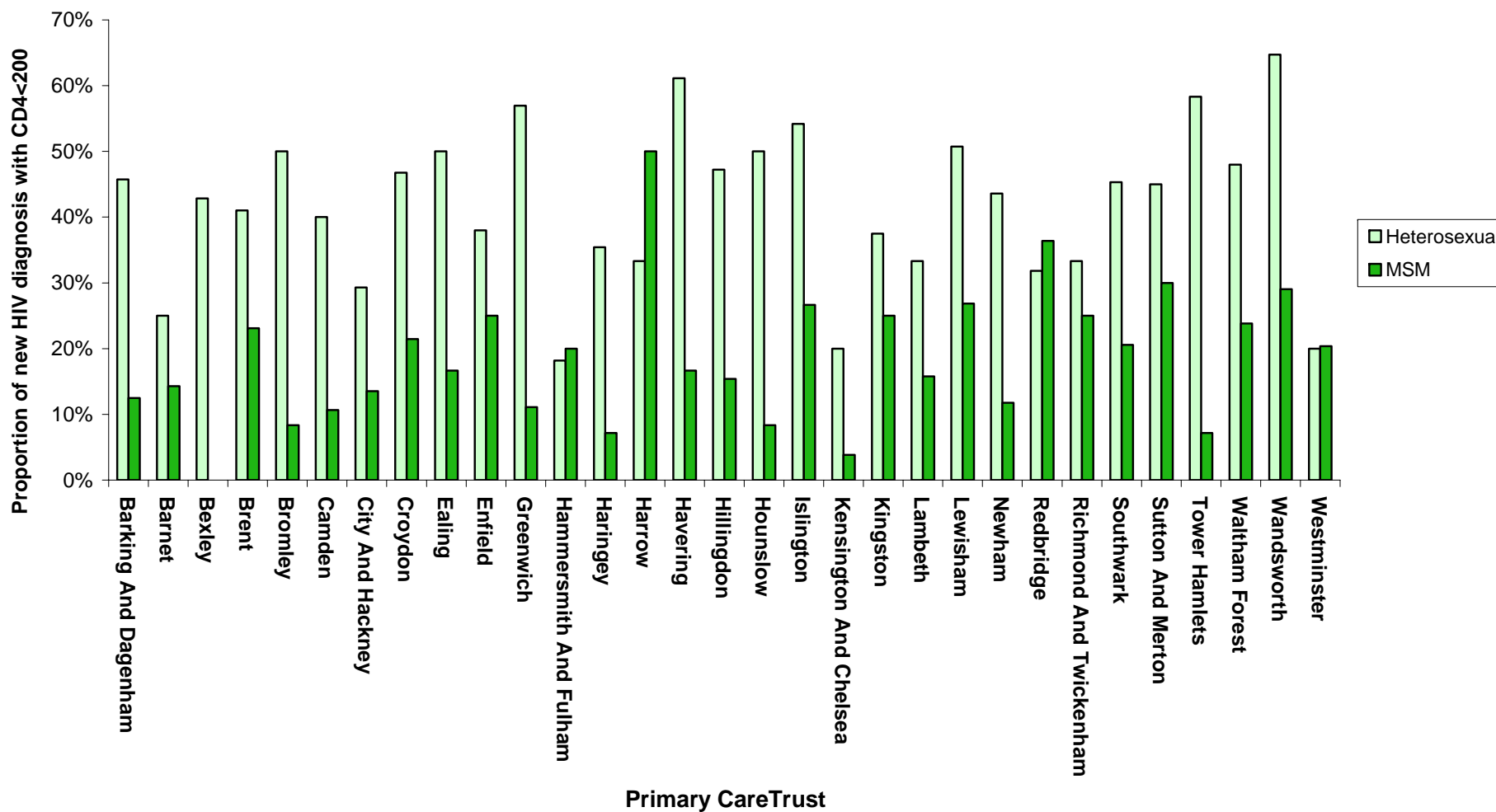
Appendix 1.3: Late diagnoses by London PCT (CD4<200 and CD4<350 cells/mm³): 2008

Proportion of patients diagnosed with CD4 counts <200 and <350 cells/mm ³ *													
Sector	PCT of residence	N	n <200	%<200	95%CI		Rank	N	n<350	%<350	95%CI		Rank
North Central London	Barnet PCT	60	13	22%	11%	32%	5	60	31	52%	39%	64%	14
	Camden PCT	81	16	20%	11%	28%	3	81	33	41%	30%	51%	1
	Enfield PCT	59	22	37%	25%	50%	21	59	35	59%	47%	72%	18
	Haringey Teaching PCT	69	18	26%	16%	36%	9	69	30	43%	32%	55%	4
	Islington PCT	70	25	36%	24%	47%	18	70	36	51%	40%	63%	13
	Total		339	94	28%	23%	32%	-	339	165	49%	43%	54%
Outer North East London	Barking & Dagenham PCT	46	20	43%	29%	58%	29	46	31	67%	54%	81%	30
	Havering PCT	27	14	52%	33%	71%	31	27	17	63%	45%	81%	24
	Redbridge PCT	37	12	32%	17%	48%	13	37	19	51%	35%	67%	12
	Waltham Forest PCT	65	23	35%	24%	47%	17	65	36	55%	43%	67%	15
Inner North East London	City & Hackney Teaching PCT	113	26	23%	15%	31%	8	113	55	49%	39%	58%	8
	Newham PCT	112	42	38%	29%	46%	23	112	69	62%	53%	71%	20
	Tower Hamlets PCT	71	16	23%	13%	32%	7	71	32	45%	33%	57%	6
	Total		471	153	32%	28%	37%	-	471	259	55%	50%	59%
North West London	Brent Teaching PCT	70	25	36%	24%	47%	19	70	45	64%	53%	76%	26
	Ealing PCT	42	13	31%	17%	45%	12	42	21	50%	35%	65%	10
	Hammersmith & Fulham PCT	66	13	20%	10%	29%	2	66	31	47%	35%	59%	7
	Harrow PCT	18	7	39%	16%	61%	24	18	12	67%	45%	88%	28
	Hillingdon PCT	51	20	39%	26%	53%	25	51	26	51%	37%	65%	11
	Hounslow PCT	40	14	35%	20%	50%	16	40	24	60%	45%	75%	19
	Kensington & Chelsea PCT	49	6	12%	3%	21%	1	49	21	43%	29%	57%	2
	Westminster PCT	95	21	22%	14%	30%	6	95	41	43%	33%	53%	3
Total		431	119	28%	23%	32%	-	431	221	51%	47%	56%	-
South East London	Bexley PCT	25	9	36%	17%	55%	20	25	16	64%	45%	83%	25
	Bromley PCT	24	8	33%	14%	52%	14	24	14	58%	39%	78%	16
	Greenwich Teaching PCT	88	40	45%	35%	56%	30	88	58	66%	56%	76%	27
	Lambeth PCT	217	46	21%	16%	27%	4	217	97	45%	38%	51%	5
	Lewisham PCT	123	51	41%	33%	50%	28	123	76	62%	53%	70%	21
	Southwark PCT	152	45	30%	22%	37%	11	152	74	49%	41%	57%	9
	Total		629	199	32%	28%	35%	-	629	335	53%	49%	57%
South West London	Croydon PCT	85	34	40%	30%	50%	26	85	53	62%	52%	73%	22
	Kingston PCT	12	4	33%	7%	60%	15	12	8	67%	40%	93%	29
	Richmond & Twickenham PCT	14	4	29%	5%	52%	10	14	10	71%	48%	95%	31
	Sutton & Merton PCT	54	22	41%	28%	54%	27	54	32	59%	46%	72%	17
	Wandsworth PCT	59	22	37%	25%	50%	22	59	37	63%	50%	75%	23
	Total		224	86	38%	32%	45%	-	224	140	63%	56%	69%
Grand Total		2094	651	31%	29%	33%	-	2094	1120	53%	51%	56%	-

*Data source: SOPHID and CD4 surveillance data. Only includes patients with a CD4 count within three months of diagnosis, and patients where PCT of residence is available.

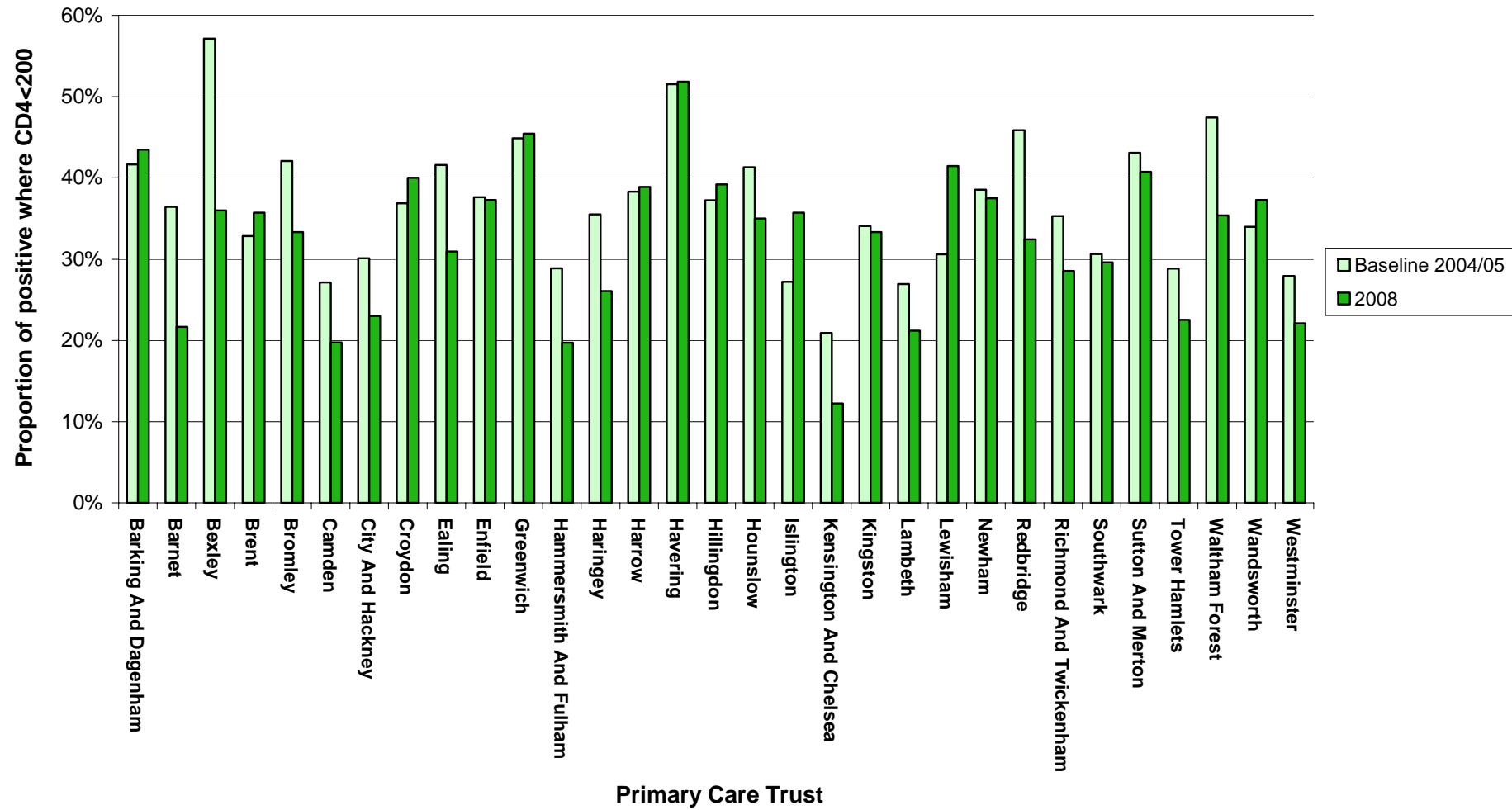
Appendix 1.4: Late diagnoses by London PCT, by mode of acquisition: 2008

Proportion of new HIV diagnosis that are diagnosed late in 2008 by PCT and mode of acquisition



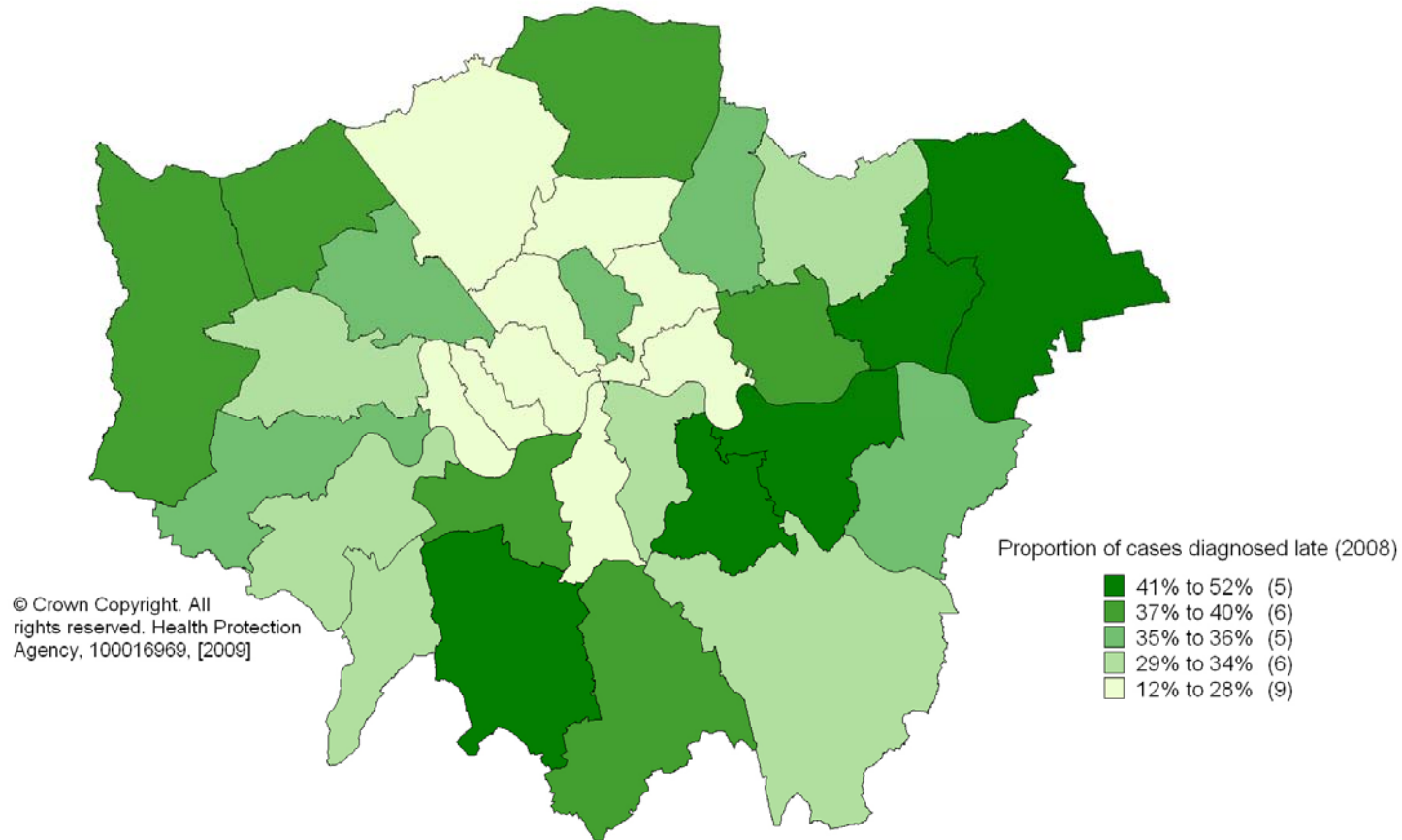
Appendix 1.5: Late diagnoses by London PCT: 2004/5 and 2008

Proportion of new HIV diagnosis that are diagnosed late by PCT



Appendix 1.6: Map of late diagnoses by London PCT: 2008

Due to issues of deductive disclosure this map is not for publication and is confidential to the NHS/HPA



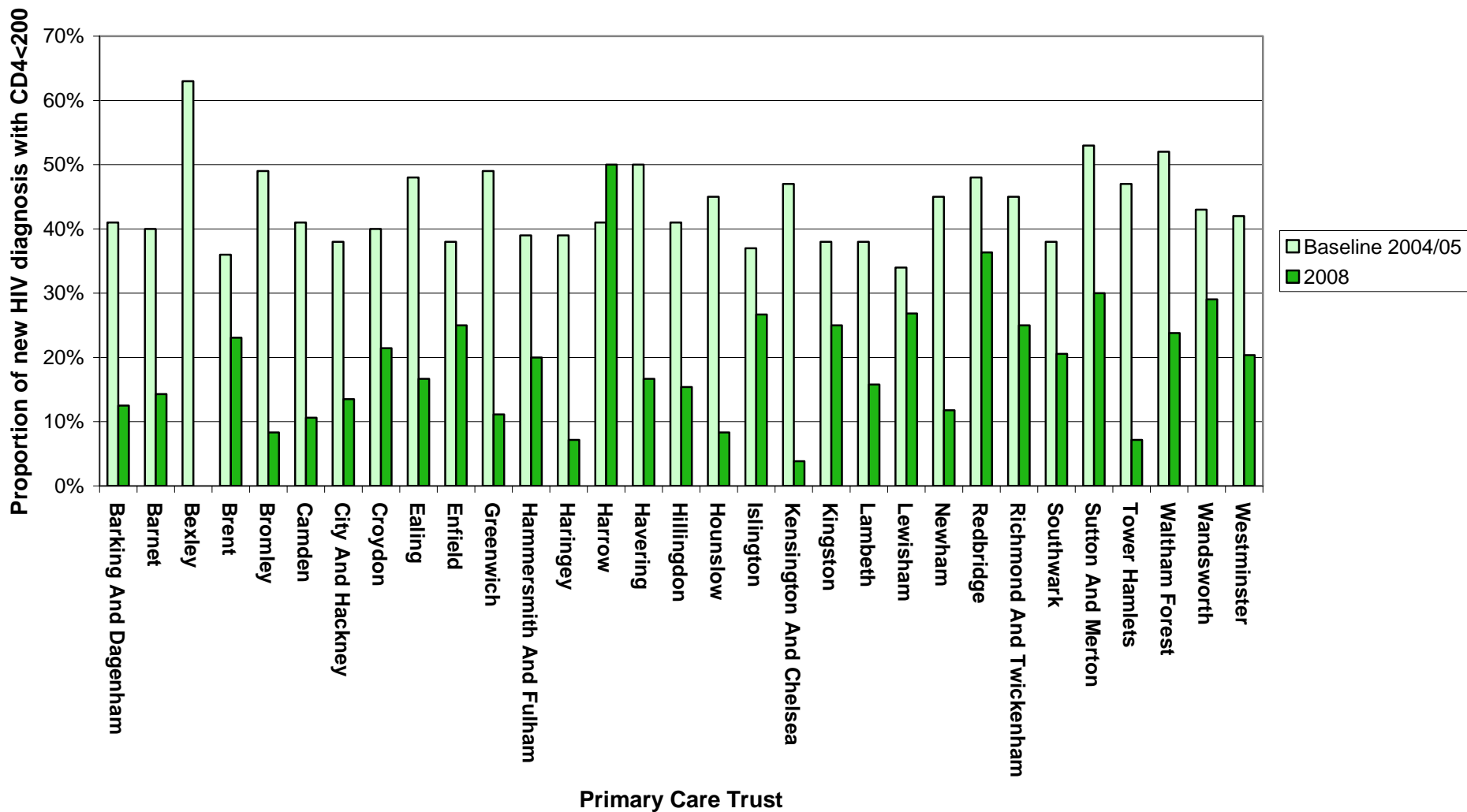
Appendix 1.7: Late diagnoses by London PCT, MSM: 2004/5 to 2008

Late diagnosis in MSM by PCT (HPA data)		Baseline: 2004 + 2005*				2006*				2007*				2008					
London Sector	PCT of residence	n with CD4	n <200	% <200		n with CD4	n <200	% <200		n with CD4	n <200	% <200		n with CD4	n <200	% <200	95%CI		
North Central London	Barnet	29	7	24%	14%	16	2	13%	21%	22	4	18%	15%	14	2	14%	-0%	33%	16%
	Camden	85	14	16%		53	16	30%		42	5	12%		47	5	11%	2%	19%	
	Enfield	23	6	26%		6	2	33%		9	1	11%		8	2	25%	0%	55%	
	Haringey	51	13	25%		19	2	11%		28	5	18%		14	1	7%	0%	21%	
	Islington	95	19	20%		45	7	16%		51	8	16%		30	8	27%	11%	42%	
Outer North East London	Barking & Dagenham	10	4	40%	23%	2	0	0%	15%	2	0	0%	15%	8	1	13%	0%	35%	15%
	Havering	5	3	60%		2	2	100%		4	2	50%		6	1	17%	0%	46%	
	Redbridge	8	2	25%		2	0	0%		3	0	0%		11	4	36%	8%	65%	
	Waltham Forest	30	10	33%		18	4	22%		22	0	0%		21	5	24%	6%	42%	
Inner North East London	City & Hackney	90	18	20%	22%	29	4	14%	17%	44	6	14%	18%	37	5	14%	2%	25%	17%
	Newham	43	5	12%		20	1	5%		11	2	18%		17	2	12%	0%	27%	
	Tower Hamlets	126	30	24%		44	7	16%		49	10	20%		42	3	7%	0%	15%	
North West London	Brent	31	6	19%	22%	14	3	21%	17%	18	4	22%	18%	26	6	23%	7%	39%	17%
	Ealing	35	10	29%		10	1	10%		22	3	14%		24	4	17%	2%	32%	
	Hammersmith & Fulham	56	13	23%		24	5	21%		31	3	10%		30	6	20%	6%	34%	
	Harrow	5	1	20%		0	0	-		4	2	50%		4	2	50%	1%	99%	
	Hillingdon	11	2	18%		3	0	0%		6	1	17%		13	2	15%	0%	35%	
	Hounslow	46	16	35%		12	4	33%		16	2	13%		12	1	8%	0%	24%	
	Kensington & Chelsea	94	16	17%		33	5	15%		48	12	25%		26	1	4%	0%	11%	
	Westminster	110	22	20%		48	6	13%		72	12	17%		54	11	20%	10%	31%	
South East London	Bexley	7	1	14%	19%	5	0	0%	19%	2	0	0%	12%	4	0	0%	0%	0%	18%
	Bromley	22	7	32%		5	2	40%		14	2	14%		12	1	8%	0%	24%	
	Greenwich	26	6	23%		19	4	21%		17	3	18%		18	2	11%	0%	26%	
	Lambeth	203	35	17%		90	18	20%		116	11	9%		114	18	16%	9%	22%	
	Lewisham	55	9	16%		42	6	14%		28	4	14%		41	11	27%	13%	40%	
	Southwark	158	32	20%		62	12	19%		82	10	12%		73	15	21%	11%	30%	
South West London	Croydon	33	7	21%	23%	18	3	17%	18%	17	4	24%	20%	14	3	21%	0%	43%	27%
	Kingston	12	3	25%		7	2	29%		12	1	8%		4	1	25%	0%	67%	
	Richmond & Twickenham	21	5	24%		7	0	0%		10	2	20%		8	2	25%	0%	55%	
	Sutton & Merton	31	4	13%		16	3	19%		17	6	35%		10	3	30%	2%	58%	
	Wandsworth	80	21	26%		26	5	19%		35	5	14%		31	9	29%	13%	45%	
			1631	347		21%	21%	697		126	18%			854	130	15%		773	

* These data have not been updated to include reports received after the survey period for 2006 and 2007.

Appendix 1.8: Late diagnoses by London PCT, MSM: 2004/5 and 2008

Proportion of new diagnosis of HIV in MSM that are diagnosed late by PCT



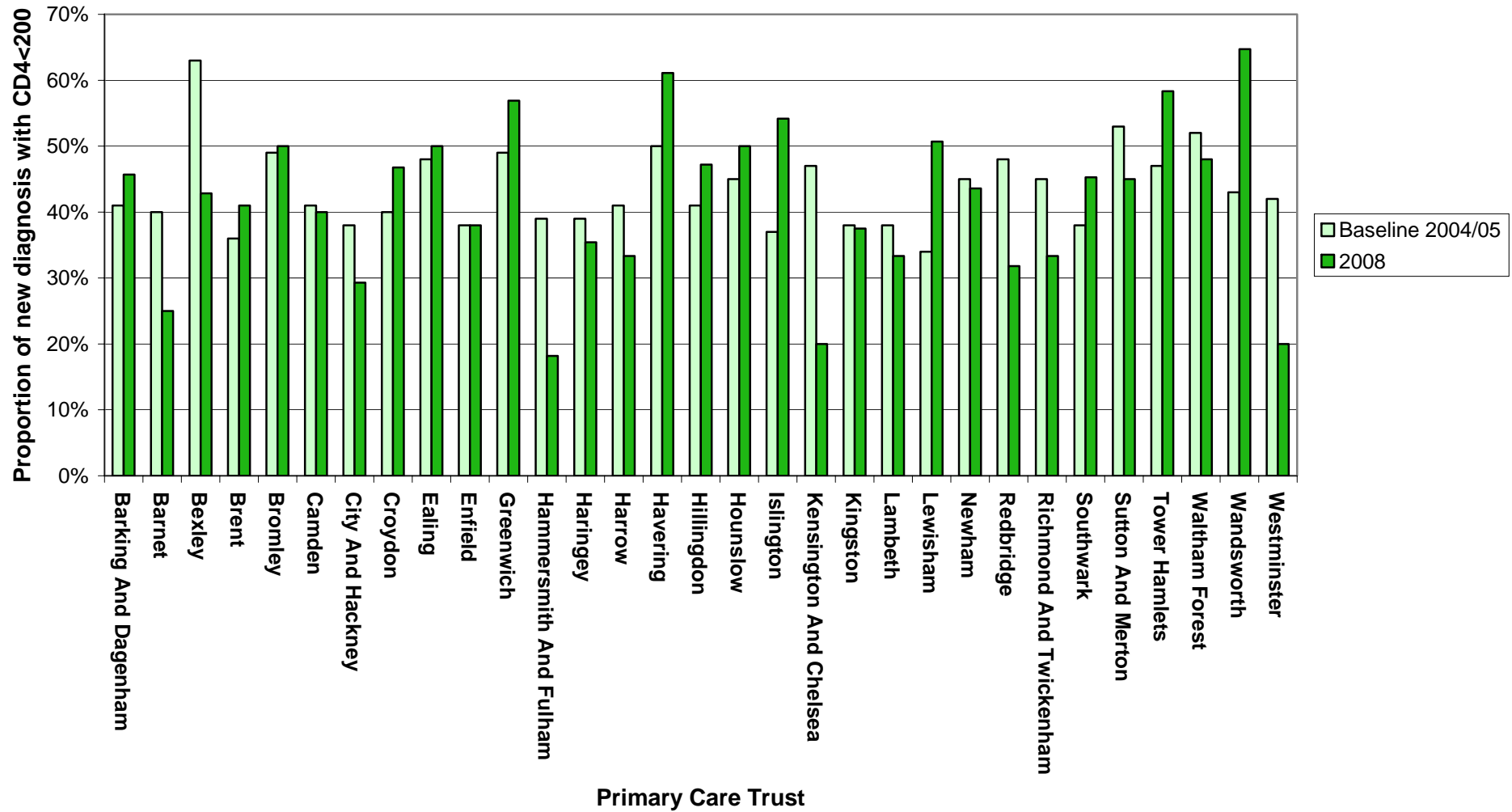
Appendix 1.9: Late diagnoses by London PCT, heterosexuals: 2004/5 to 2008

London Sector	PCT of residence	Baseline: 2004 + 2005*				2006*				2007*				2008				
		n with CD4	n <200	% <200		n with CD4	n <200	% <200		n with CD4	n <200	% <200		N	n <200	% <200	95%CI	
North Central London	Barnet	73	29	40%	35%	25	7	28%	44%	31	15	48%	41%	44	11	25%	12%	38%
	Camden	51	21	41%		17	8	47%		19	7	37%		25	10	40%	21%	59%
	Enfield	91	35	38%		43	23	53%		34	14	41%		50	19	38%	25%	51%
	Haringey	128	50	39%		59	26	44%		41	17	41%		48	17	35%	22%	49%
	Islington	43	16	37%		18	8	44%		18	5	28%		24	13	54%	34%	74%
Outer North East London	Barking & Dagenham	97	40	41%	45%	59	25	42%	44%	45	17	38%	39%	35	16	46%	29%	62%
	Havering	28	14	50%		13	8	62%		14	5	36%		18	11	61%	39%	84%
	Redbridge	75	36	48%		32	13	41%		30	13	43%		22	7	32%	12%	51%
	Waltham Forest	84	44	52%		47	26	55%		28	14	50%		25	12	48%	28%	68%
Inner North East London	City & Hackney	107	41	38%	45%	52	21	40%	44%	62	25	40%	39%	58	17	29%	18%	41%
	Newham	191	86	45%		84	32	38%		84	32	38%		78	34	44%	33%	55%
	Tower Hamlets	34	16	47%		9	6	67%		13	2	15%		12	7	58%	30%	86%
North West London	Brent	105	38	36%	42%	46	15	33%	36%	50	25	50%	37%	39	16	41%	26%	56%
	Ealing	64	31	48%		35	15	43%		25	9	36%		18	9	50%	27%	73%
	Hammersmith & Fulham	36	14	39%		15	7	47%		11	4	36%		22	4	18%	2%	34%
	Harrow	41	17	41%		27	6	22%		18	4	22%		12	4	33%	7%	60%
	Hillingdon	39	16	41%		27	10	37%		29	9	31%		36	17	47%	31%	64%
	Hounslow	92	41	45%		25	9	36%		26	11	42%		24	12	50%	30%	70%
	Kensington & Chelsea	15	7	47%		15	7	47%		16	3	19%		10	2	20%	0%	45%
	Westminster	45	19	42%		9	3	33%		20	8	40%		20	4	20%	2%	38%
South East London	Bexley	41	26	63%	41%	29	12	41%	42%	22	10	45%	42%	21	9	43%	22%	64%
	Bromley	35	17	49%		19	8	42%		16	8	50%		10	5	50%	19%	81%
	Greenwich	129	63	49%		68	28	41%		50	14	28%		65	37	57%	45%	69%
	Lambeth	182	70	38%		77	30	39%		57	20	35%		51	17	33%	20%	46%
	Lewisham	159	54	34%		89	39	44%		79	41	52%		69	35	51%	39%	63%
	Southwark	214	82	38%		94	41	44%		75	32	43%		53	24	45%	32%	59%
South West London	Croydon	189	75	40%	43%	92	36	39%	38%	55	23	42%	44%	62	29	47%	34%	59%
	Kingston	32	12	38%		13	3	23%		10	6	60%		8	3	38%	4%	71%
	Richmond & Twickenham	11	5	45%		8	2	25%		10	7	70%		3	1	33%	0%	87%
	Sutton & Merton	97	51	53%		47	19	40%		45	15	33%		40	18	45%	30%	60%
	Wandsworth	74	32	43%		25	10	40%		23	12	52%		17	11	65%	42%	87%
Grand Total		2602	1098	42%	42%	1218	503	41%	41%	1056	427	40%	40%	1019	431	42%	39%	46%

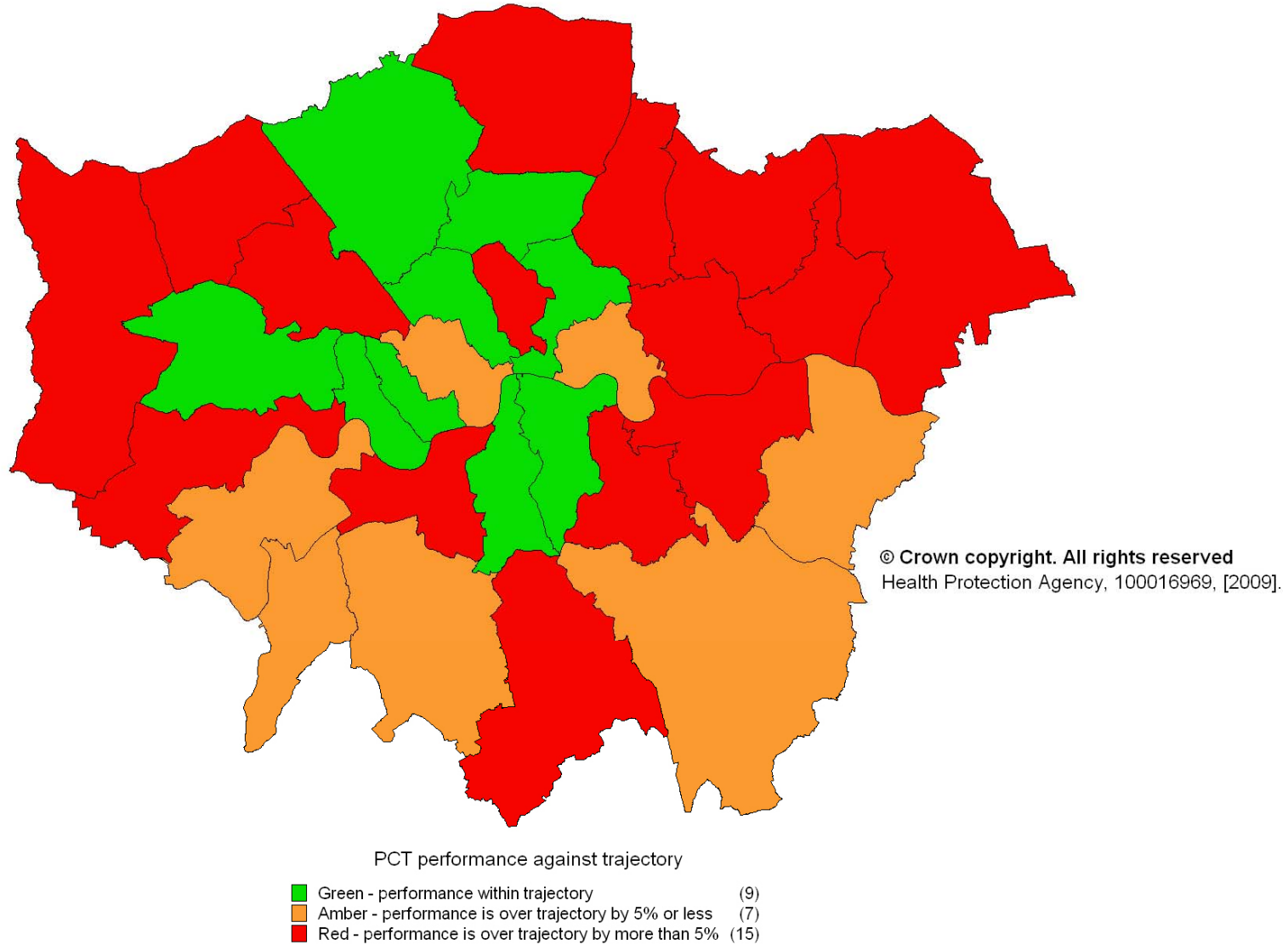
* These data have not been updated to include reports received after the survey period for 2006 and 2007.

Appendix 2.0: Late diagnoses by London PCT, heterosexuals: 2004/5 and 2008

Proportion of new diagnosis of HIV in heterosexuals that are diagnosed late by PCT



Appendix 2.1: Map of PCTs performance against their trajectories in 2008



Appendix 2.2: Persons living with diagnosed HIV infection by PCT of residence: 2008

Diagnosed HIV prevalence by Strategic Health Authority (SHA) and Primary Care Trust (PCT) in England, 2008					
London Sector	Primary Care Trust	Residents accessing HIV related care*(aged 15-59)	Estimated resident population in 1,000s** (aged 15-59)	Diagnosed HIV prevalence per 1,000 (aged 15-59)	Rank
North Central London	Barnet PCT	557	205.6	2.71	22
	Enfield PCT	647	178.3	3.63	20
	Haringey Teaching PCT	1,068	155.7	6.86	10
	Camden PCT	1,219	172.3	7.07	8
	Islington PCT	1,191	138.9	8.57	3
North West London	Harrow PCT	249	134.9	1.85	28
	Hillingdon PCT	366	158.6	2.31	25
	Ealing PCT	596	206.1	2.89	21
	Hounslow PCT	540	147.8	3.65	19
	Brent Teaching PCT	723	179.6	4.03	18
	Westminster PCT	1,204	170.8	7.05	9
	Hammersmith And Fulham PCT	928	121.9	7.61	7
	Kensington And Chelsea PCT	947	121.6	7.79	6
Outer North East London	Havering PCT	162	135.2	1.20	31
	Redbridge PCT	427	161.1	2.65	23
	Waltham Forest PCT	649	145.3	4.47	16
	Barking And Dagenham PCT	475	102.8	4.62	15
Inner North East London	Tower Hamlets PCT	884	156.8	5.64	12
	Newham PCT	1,308	165.4	7.91	5
	City And Hackney Teaching PCT	1,193	149.4	7.99	4
South East London	Bexley PCT	247	133.1	1.86	27
	Bromley PCT	342	179.1	1.91	26
	Greenwich Teaching PCT	782	143.1	5.46	13
	Lewisham PCT	1,213	178.8	6.78	11
	Southwark PCT	1,966	197.6	9.95	2
	Lambeth PCT	2,535	197.2	12.85	1
South West London	Kingston PCT	179	105.9	1.69	30
	Richmond And Twickenham PCT	199	113.4	1.75	29
	Sutton And Merton PCT	665	251.6	2.64	24
	Croydon PCT	897	215.0	4.17	17
	Wandsworth PCT	961	205.2	4.68	14
	Total	25,325	2,793.3	9.07	

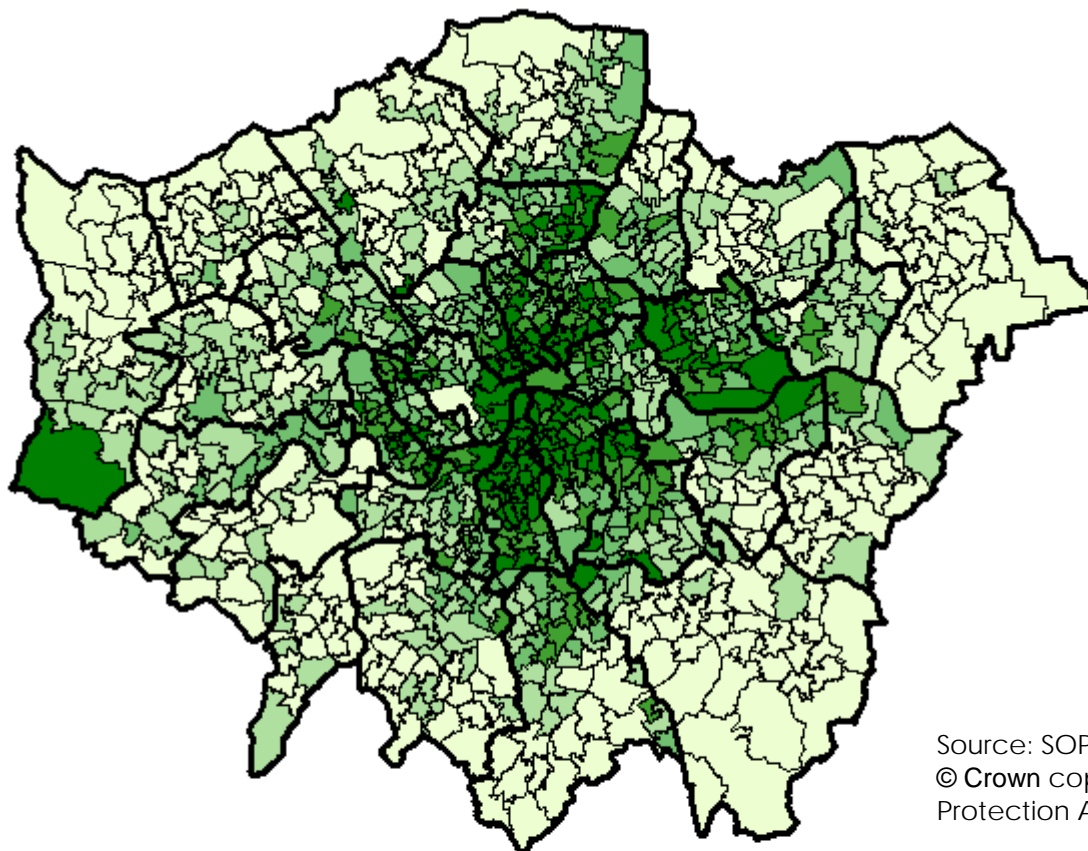
Data Sources

* SOPHID - Survey of prevalent HIV infections diagnosed 2008, Health Protection Agency.

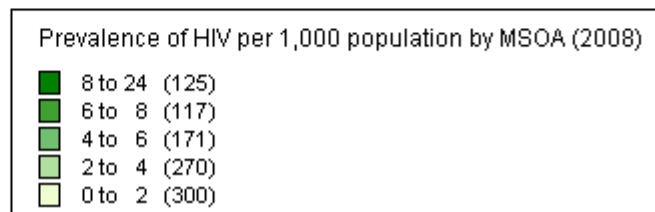
** Office for National Statistics mid-2008 population estimate.

Appendix 2.3: Persons living with diagnosed HIV infection by MSOA of residence: 2008

Due to issues of deductive disclosure this map is not for publication and is confidential to the NHS/HPA

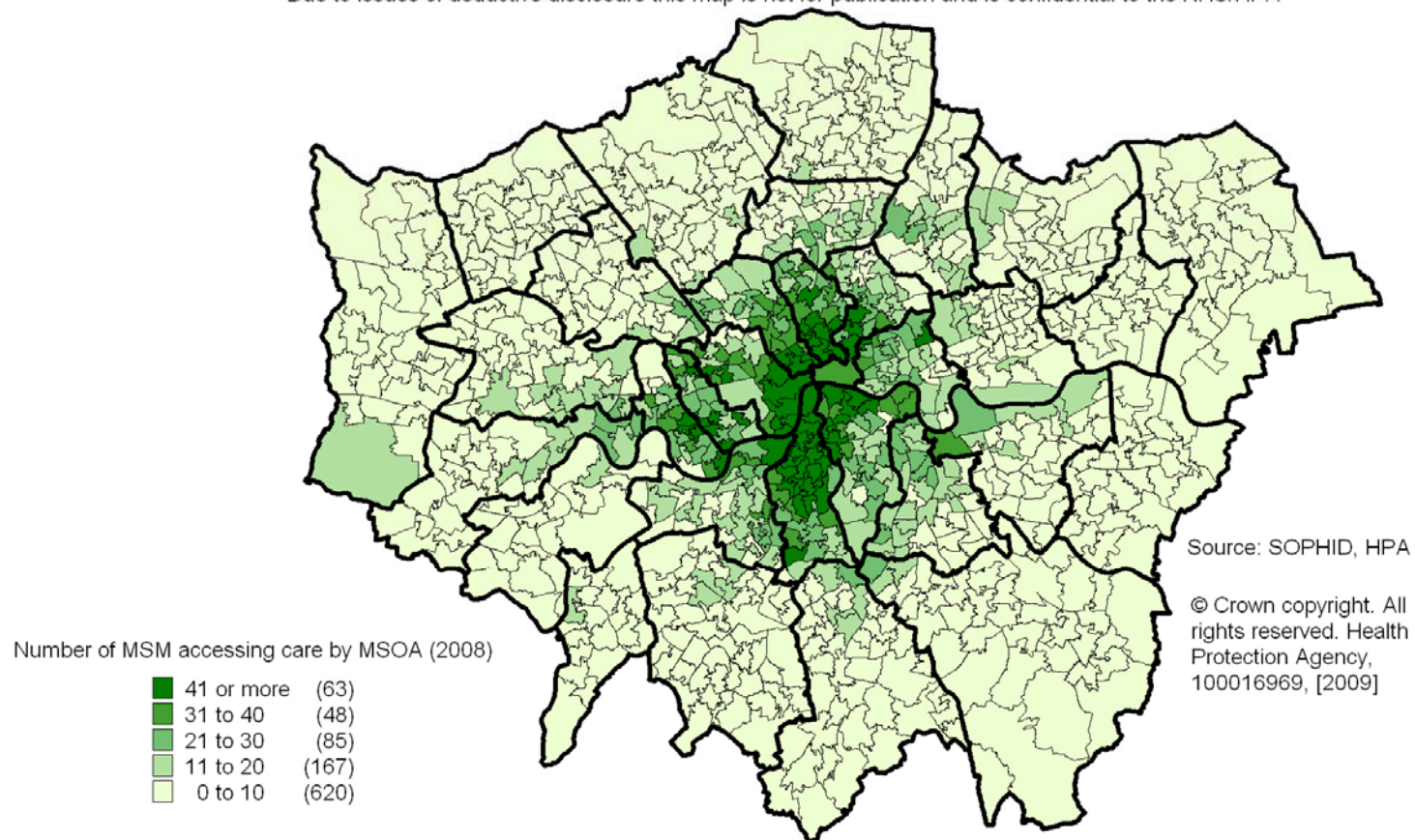


Source: SOPHID, HPA
© Crown copyright. All rights reserved. Health Protection Agency. 100016969 [2009]



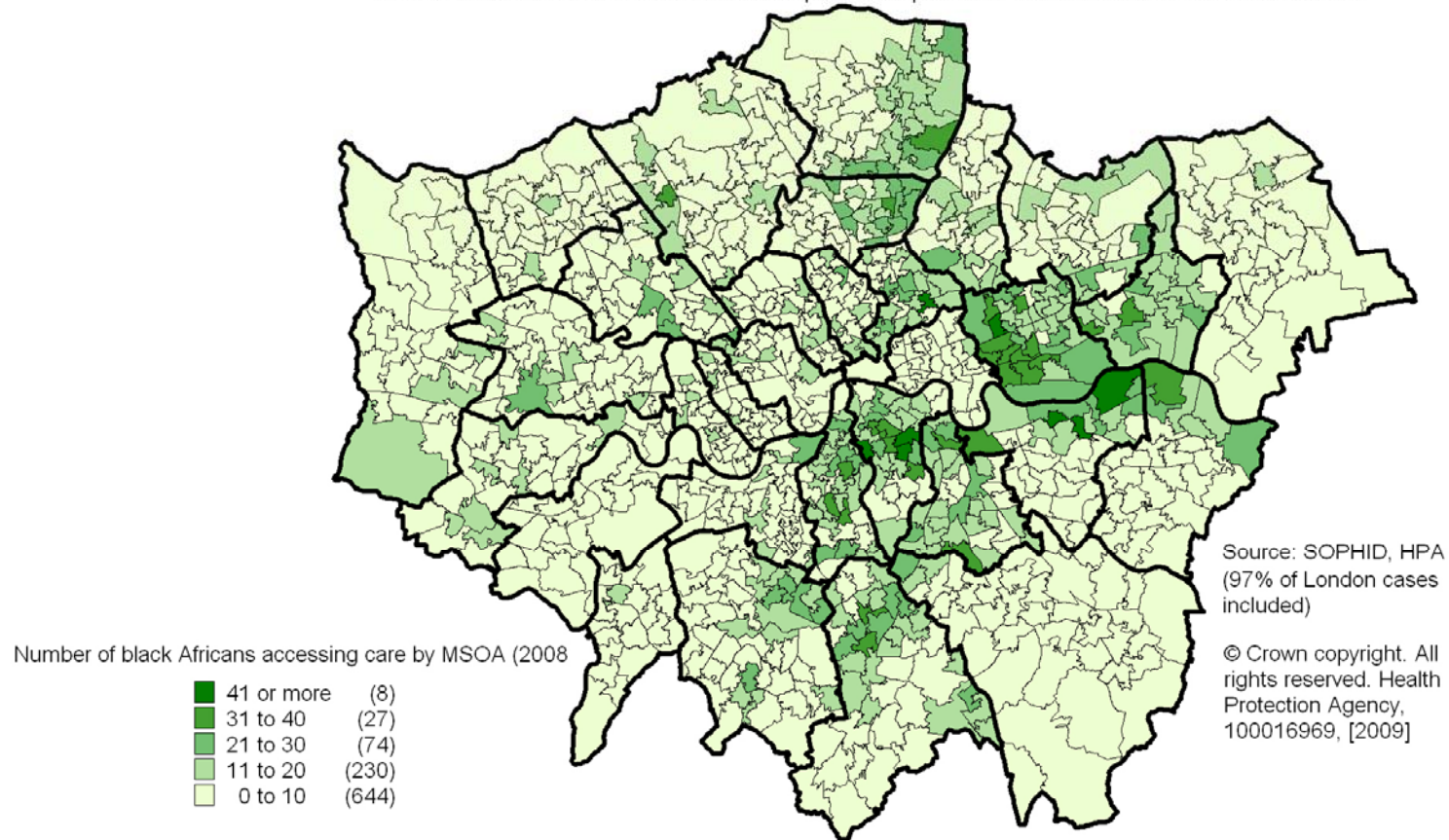
Appendix 2.4: MSM living with diagnosed HIV infection by MSOA of residence: 2008

Due to issues of deductive disclosure this map is not for publication and is confidential to the NHS/HPA



Appendix 2.5: Black-African individuals living with diagnosed HIV infection by MSOA of residence: 2008

Due to issues of deductive disclosure this map is not for publication and is confidential to the NHS/HPA



Appendix 3.1: HIV testing information in GUM clinics: 2008

HIV testing in GUM clinics 2008 by GUM clinic (KC60 data)								
London Sector	PCT where tested	GUM Clinic	Homosexual men			Heterosexuals		
			HIV Test Offered	HIV Test Taken	% Uptake	HIV Test Offered	HIV Test Taken	% Uptake
North Central London	Barnet	Barnet Hospital	50	47	94	3184	2828	89
	Camden	Archway Sexual Health Clinic	260	238	92	8983	8016	89
	Camden	Mortimer Market Centre	1788	1512	85	13125	12159	93
	Camden	The Royal Free Hospital	223	208	93	3645	3447	95
	Enfield	Town Clinic						
	Haringey	St Ann's Hospital	288	243	84	8830	7087	80
North East London	City & Hackney	Homerton Hospital	292	290	99	10430	10245	98
	City & Hackney	St Bartholomew's Hospital	1597	1303	82	6749	5509	82
	Havering	Queens Hospital	66	55	83	1846	1689	91
	Newham	Newham General Hospital	21	18	86	8521	6653	78
	Redbridge	Barking Hospital	44	44	100	3776	3629	96
	Tower Hamlets	The Royal London Hospital	1295	1088	84	13834	11047	80
	Waltham Forest	Whipps Cross University Hospital	32	26	81	1746	1443	83
North West London	Brent	Central Middlesex Hospital	187	180	96	6291	5812	92
	Brent	Northwick Park Hospital	154	142	92	6305	5537	88
	Ealing	Ealing Hospital, Pasteur Suite	178	159	89	5542	4630	84
	Hammersmith & Fulham	Charing Cross Hospital	1012	890	88	13930	10503	75
	Hillingdon	Tudor Centre	95	81	85	5248	4407	84
	Hounslow	West Middlesex University Hospital	444	393	89	7410	5243	71
	Kensington & Chelsea	John Hunter Clinic	1100	981	89	12440	10442	84
	Westminster	Dean St Clinic	4939	4354	88	9545	7330	77
	Westminster	St Mary's Hospital London	3489	2809	81	22303	16512	74
South East London	Bromley	Beckenham Hospital	76	70	92	4908	3300	67
	Greenwich	Trafalgar Clinic	287	252	88	7653	6096	80
	Lambeth	Guys Hospital	2037	1774	87	8443	6766	80
	Lambeth	St Thomas's Hospital	1599	1390	87	10838	8562	79
	Southwark	King's College Hospital NHS Foundation Trust	820	639	78	10870	7455	69
South West London	Croydon	Mayday University Hospital	2	2	100	8022	7080	88
	Kingston	Kingston Hospital	612	529	86	8592	6929	81
	Sutton & Merton	St Helier Hospital	94	76	81	5199	3727	72
	Wandsworth	Queen Mary's Hospital	201	167	83	6204	4238	68
	Wandsworth	St George's Hospital	299	273	91	16839	12903	77

Green >90%, Amber >80%, <90%, Red <80%

Appendix 3.2: HIV testing information in antenatal care

Uptake of antenatal HIV testing by sector and acute trust/clinic (AISS data): London, 2008

Sector	NHS Trust/Clinic	Bookings ¹	HIV Tests ¹	Proportion tested for HIV in relation to number booked ¹
North Central London	Barnet and Chase Farm	6286	5861	93.2%
	North Middlesex	4302	4271	99.3%
	Royal Free ²	1939	1853	95.6%
	University College	5167	5124	99.2%
	Whittington	4581	4473	97.6%
North East London	Barking, Havering and Redbridge	11217	10575	94.3%
	Homerton	5791	5027	86.8%
	Newham	6899	6403	92.8%
	Royal London	5795	5230	90.3%
	Whipps Cross	6788	6535	96.3%
North West London	Central Middlesex	2097	2092	99.8%
	Chelsea and Westminster	6381	6260	98.1%
	Ealing	3588	3419	95.3%
	Hillingdon	4921	4488	91.2%
	Northwick Park	3946	3944	99.9%
	Queen Charlotte's	6036	5980	99.1%
	St. Mary's	4195	4078	97.2%
West Middlesex	4960	4693	94.6%	
South East London	Farnborough	4385	4225	96.4%
	Guy's and St. Thomas ³	6472	6424	99.3%
	King's College	6265	6073	96.9%
	Lewisham	5911	5826	98.6%
	Queen Elizabeth	4326	4079	94.3%
Queen Mary's	3549	3336	94.0%	
South West London	Kingston	6669	6650	99.7%
	Mayday	6097	6078	99.7%
	St. George's	5743	5714	99.5%
	Epsom & St Helier	5675	5505	97.0%
Total ⁴		149981	144216	96.3%

Green >95%, Amber >90%, <95%, Red <90%

Notes:

A dash indicates that no data were reported for this time period or, in the case of a calculation, that denominator data was unavailable. Data are derived from maternity generated figures (number of bookings in each quarter) and HIV tests conducted within laboratories (number of tests conducted). In some instances and for a variety of reasons, the number of tests conducted may exceed the number of bookings.

¹ The number of HIV tests includes all quarters for which this data was available, the number of bookings includes all quarters for which this data was available and for which HIV test data was available, the proportion testing includes all quarters for which both HIV test data and booking data was known.

² Data for quarter 1 2008 to quarter 2 2008 only.

³ Data for quarter 2 2008 to quarter 4 2008 onwards (booking data not available for earlier quarters).

⁴ The proportional uptake of HIV testing figure for the whole of London is calculated as the mean of the proportions for all clinics for whom this information is known.

Appendix 4: Published studies of HIV testing in community settings in the UK

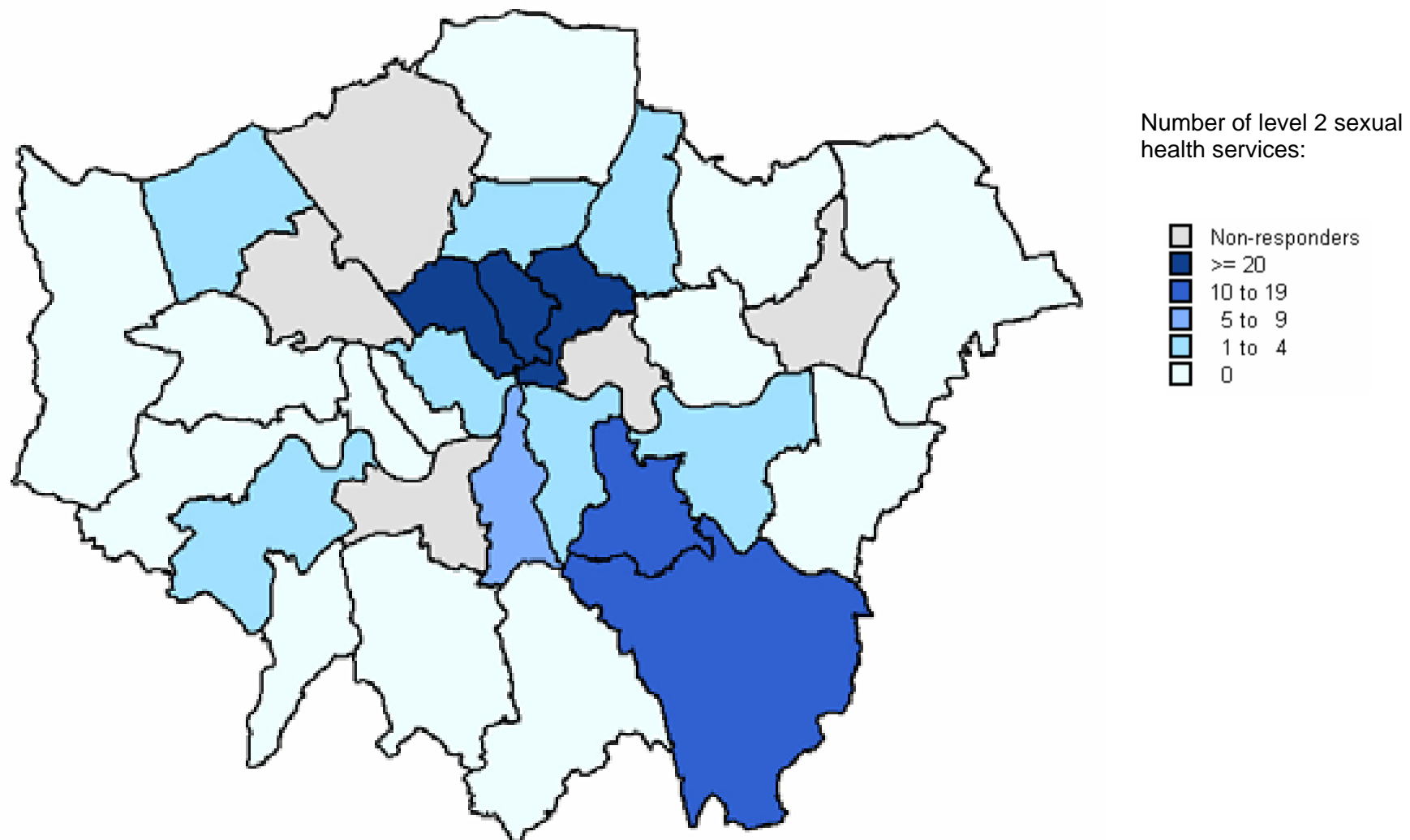
A review of literature and conference proceedings conducted in July 2008 identified the following UK based studies:

1. Jones KE, Beeching BA, Roberts P, Devine M, Davies J, Bates CM & Jones C, 2006. Success of a nurse led community based genitourinary medicine clinic for young people in Liverpool: review of the first year. *Sex Transm Infect* 82 (4): 318-20.
2. Lewis DA, McDonald A, Thompson G & Bingham JS, 2004. The 374 clinic: an outreach sexual health clinic for young men. *Sex Transm Infect* 80 (6):480-3.
3. Mugezi R, Barrat A, Wilkinson A, Waters A, McOwan A & Sullivan AK, 2005. KNOW4SURE - a community-based rapid point of care test (POCT) clinic. *HIV Med* 6 (S1) Abstract P137.
4. Mugezi R, Wilkinson A, Kalidini U, Betourney R, Waters A, Anderson J & Sullivan AK, 2005. Uptake of HIV test is enhanced by a special post-carnival KNOW4SURE clinic offering rapid point of care testing (POCT). *HIV Med* 6 (S1): Abstract P146
5. Power L & Greenway D, 2007. Provision of community-based HIV and STI screening in for young people in a Northern English city: initial data on use. *HIV Med* 8 (S1). Abstract P65.
6. Prost A, Chopin M, McOwan A, Elam G, Dodds J, Macdonald N & Imrie J, 2007. "There is such a thing as asking for trouble": taking rapid HIV testing to gay venues is fraught with challenges. *Sex Transm Infect* 83 (3):185-8.
7. Prost A, Sseruma WS, Fakoya I, Arthur G, Taegtmeier M, Njeri A, Fakoya A & Imrie J, 2007. HIV voluntary counselling and testing for African communities in London: learning from experiences in Kenya. *Sex Transm Infect* 83 (7): 547-51.
8. Weatherburn P, Clarke M, Pye K, Sharkey K, Russell T, Smith C, Maleham K, Devlin W & Mital D, 2006. HIV testing for African people and MSM: comparing needs access and effectiveness in clinic and community settings in a UK city. *HIV Med* 7 (S1) Abstract P82.
9. Williamson LM, Hart GJ, Flowers P, Frankis JS & Der GJ, 2001. The Gay Men's Task Force: the impact of peer education on the sexual health behaviour of homosexual men in Glasgow. *J Sex Transm Infect* 77 (6): 427-32

A full electronic version of the review is available below:



Appendix 5: Number of level 2 sexual health services by PCT in London.



Acknowledgements

The authors would like to thank GUM clinics for supplying the HIV data and colleagues involved in HIV testing pilots for sharing information.

The following contributed to this document:-

Anita Brock	Information Officer, South East London Health Protection Unit, HPA
Alison Brown	Lead Scientist, SOPHID and CD4 surveys, HIV and STI Department, HPA Centre for Infections, HPA
Paul Crook	Sexual Health Lead for HPA London, South West London Health Protection Unit, HPA
Josh Forde	STI Senior Information Officer, HPA London, HPA
Alan Hunter	Information Analyst, CD4 surveys, HIV and STI Department, HPA Centre for Infections, HPA
Charlotte Ingram	Information officer, South West London Health Protection Unit, HPA
Binta Sultan	SpR, South West London Health Protection Unit, HPA
Hong Tan	London Sexual Health Programme Director
Alicia Thornton	Epidemiologist, Sexual Health Promotion Unit, HIV and STI Department, HPA Centre for Infections, HPA