

A practical guide for Commissioners

October 2014
(Revised Edition)



Commissioning HIV Testing Services In England



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.

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

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Foreword

Professor Kevin A. Fenton, National Director for Health and Wellbeing, Public Health England

This toolkit, developed by NAT (National AIDS Trust), will make a welcome contribution to ensuring effective HIV testing services are commissioned across England and thus to reducing local late HIV diagnosis rates, which continue to be far too high.

Diagnosing people with HIV earlier will maximise their own health and well-being, and further reduce HIV transmission in our communities. I heartily commend it to the attention of all commissioning bodies; local authorities, Clinical Commissioning Groups and NHS England.

The practical resource includes an invaluable checklist of questions against which we can assess commissioning plans. It also rightly emphasises the importance of integration of efforts across different commissioning bodies, all working to a shared vision of need and a shared strategic approach.

A key role for Public Health England is to support commissioners at national and local levels with evidence, data and advice on best practice in order to improve the nation's well-being and reduce health inequalities. This toolkit signposts commissioners to the wide and rich range of data, knowledge and intelligence held by Public Health England on HIV testing and diagnosis, as well as other key resources which commissioners can access.

I look forward to this toolkit becoming a key reference point in our collective activity to ensure the highest quality HIV testing services across the country and in our ongoing efforts to reduce the number of people with HIV who are diagnosed late.





How this toolkit works

This toolkit is designed primarily for the many individuals and organisations who will have some responsibility for the commissioning of HIV testing services. But more broadly it will also be useful for the wide range of professionals and bodies with a responsibility for planning local health strategies and improving the quality of healthcare.

Commissioning for HIV testing

The commissioning of HIV testing services is the responsibility of a number of different commissioning bodies. It is therefore particularly important that all relevant commissioners

- recognise their role in commissioning HIV testing and reducing late HIV diagnosis
- ensure commissioning is integrated and complementary across all commissioners at a local level, with clarity on responsibility for commissioning/payment and care pathways
- work together to commission to a shared vision of need and a shared strategic approach to HIV testing
- include as partners key stakeholders from clinical, statutory, voluntary and community sectors.

The following table outlines the relevant commissioning bodies that are responsible for HIV testing:

Body	Level	Service	Commissioning responsibility
Local authorities	Local	Public health (including local sexual health/GU services and health promotion)	Testing in sexual health/GU clinics; testing in community settings; routine screening for public health purposes in primary and secondary care through local arrangements etc.; testing in drug treatment services
Clinical Commissioning Groups	Local	Secondary care (apart from specialised commissioning, which includes HIV treatment – this is commissioned by NHS England).	Testing in all relevant secondary care specialties for clinical indicator conditions/as part of patient care; testing in TOP services
NHS England	National	Primary care Specialised commissioning (including HIV treatment)	Testing in primary care as clinically indicated or when requested by patient; testing in SARC; testing in ante-natal care; testing in other NHS England commissioned services as part of patient care



How is this toolkit structured?

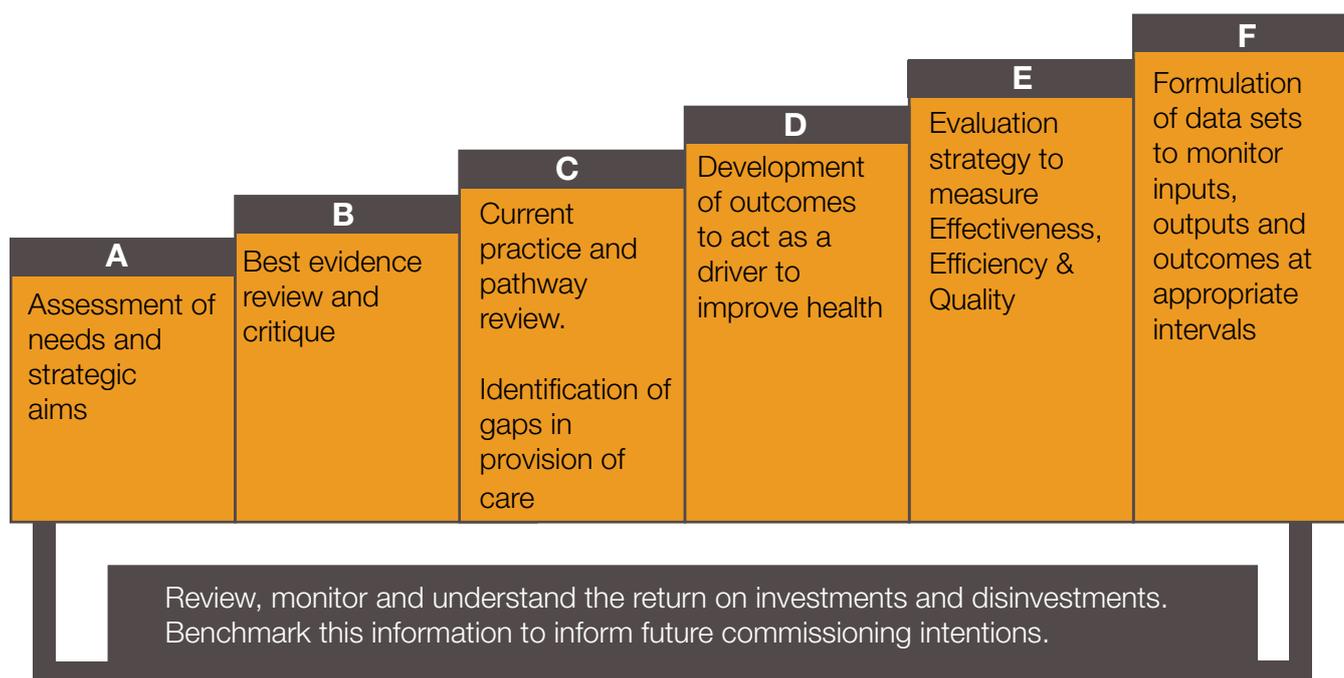
The ABC Model

The ABC Commissioning for Outcomes Model (figure 1) focuses on developing outcomes that are based on need, evidence, quality and knowledge.

The toolkit reflects the commissioning cycle and provides the commissioner with a foundation to develop outcomes within a competency framework.

Sections A, B and C focus on deciding on the high-level outcomes for a particular area through **A**ssessing need, identifying **B**est practice and relevant evidence and reviewing **C**urrent practice to identify gaps.

Section D helps the commissioner to **D**evelop high level outcomes to act as a driver to improve health, identify measures for **E**valuation and **F**ormulate an appropriate dataset.



References: <http://www.nice.org.uk/usingguidance/sharedlearningimplementingniceguidance/examplesofimplementation/eximpresults.jsp?o=384>

Callaghan. S., Perigo. G. (2011). ABC Commissioning for Outcomes Model: Can it be used for any service? Guidelines in Practice. Vol 14, (1); 27-34.



HIV testing is essential

Why effective commissioning of HIV testing is essential

To prevent further infections

According to Public Health England, in 2012 overall one in five people with HIV in the UK didn't know they had it (18% of MSM with HIV, 27% of Black African men with HIV and 21% of Black African women with HIV were unaware of their HIV positive status)¹.

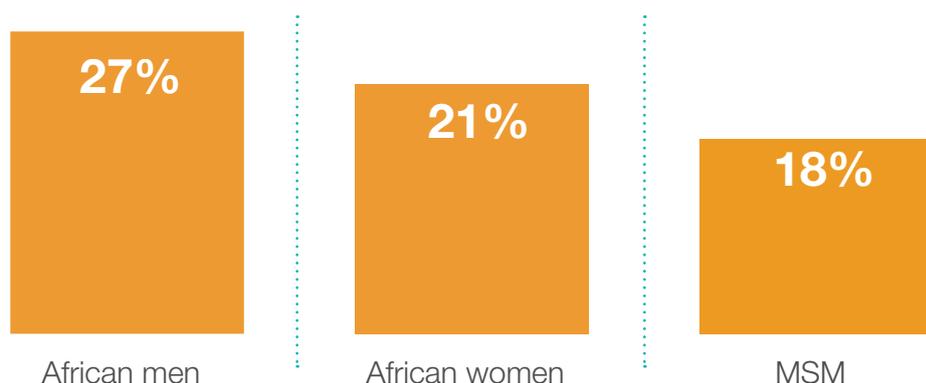
Diagnosing those with HIV promptly has a significant role in reducing the spread of HIV in the local population. Research estimates that it is the undiagnosed minority with HIV who are responsible for at least 50% of new infections (in fact recent modelling for HIV transmission amongst men who have sex with men (MSM) in the UK suggests 82% of transmissions are from the undiagnosed)².

There is particular value in diagnosing HIV at the early stage soon after infection, known as primary HIV infection, when in the majority of cases temporary symptoms occur. At this stage the individual is highly infectious and it is thought, especially for MSM, a significant proportion of HIV transmissions take place during this period (the same modelling study for UK MSM suggests 48% of HIV transmissions amongst MSM are from those in the stage of primary HIV infection).

Earlier HIV diagnosis reduces onward transmission of HIV among the population because:

- ▶ People tend to adapt sexual behaviours to reduce risk following diagnosis³.
- ▶ Effective treatment significantly reduces transmission risk⁴.

Percentage of people unaware of their HIV positive status



¹ [Public Health England, 2013 'HIV in the United Kingdom: 2013 report'](#)

² Marks G et al., 2006 'Estimating sexual transmission of HIV from persons aware and unaware that they are infected with the virus in the USA' AIDS vol.20 no.10

Phillips AN, et al., 2013 'Increased HIV Incidence in Men Who Have Sex with Men Despite High Levels of ART-Induced Viral Suppression:

Analysis of an Extensively Documented Epidemic.' PLOS ONE 8(2):e55312

³ [Public Health England, 2014 'Addressing Late HIV Diagnosis through Screening and Testing: An Evidence Summary' p.9](#)

⁴ See ['Position statement on the use of antiretroviral therapy to reduce HIV transmission BHIVA/EAGA'](#) January 2013



In the UK, it is estimated that a 43% increase in HIV testing amongst MSM (from the actual 25% currently testing) would lead to a 25% reduction in the HIV incidence in this group.⁵

To reduce late HIV diagnosis, so also reducing morbidity and mortality

In 2012, 47% of people diagnosed with HIV in the UK were diagnosed late, that is after the point at which they should have started HIV medication (CD4 cell count <350 cells/mm³). Being diagnosed late is, on average, equivalent to having had HIV without knowing it for at least five years.⁶ Late HIV diagnosis remains clearly linked to increased rates of illness, hospital admission and mortality, as well as reduced life expectancy, for the individual concerned, in addition to increased onward transmission.⁷ Late diagnosis (CD4 cell count <350 cells/mm³) leaves an individual ten times more likely to die within a year of diagnosis.⁸

An individual diagnosed very late (CD4 <200 cells/mm³) with HIV is thought to have a life expectancy at least ten years shorter than somebody who starts treatment at CD4 350 cells/mm³. In 2012, 28% of people diagnosed with HIV were diagnosed very late.⁹ Over the last decade 81% of AIDS-related deaths in England and Wales were attributable to late diagnosis.¹⁰

To meet nationally agreed health indicators

The [Public Health Outcomes Framework](#) has as one of its outcome indicators 'People presenting with HIV at a late stage of infection' where late stage of infection is defined as a CD4 cell count <350 cells/mm³ (Indicator 3.04). There is also an indicator on 'Access to non-cancer screening programmes' which includes infectious disease testing in pregnancy, and within that, ante-natal screening for HIV (Indicator 2.21).

Reducing late HIV diagnosis will additionally have a positive impact on the following public health outcome indicators:

- employment for those with a long-term health condition (Indicator 1.08 i)
- sickness absence (Indicator 1.09)
- self-reported well-being (Indicator 2.23)
- mortality from causes considered preventable (Indicator 4.03)
- mortality from all cardiovascular diseases (Indicator 4.04)
- mortality from cancer (Indicator 4.05)
- mortality from liver disease (Indicator 4.06)
- mortality from respiratory diseases (Indicator 4.07)



47% of people with HIV are diagnosed late

⁵ Phillips AN, Cambiano V, Nakagawa F, Brown AE, Lampe F, Rodger A, et al., 2013 'Increased HIV incidence in men who have sex with men despite high levels of ART-induced viral suppression: analysis of an extensively documented epidemic.' PLoS One; 8(2):e55312.

⁶ CASCADE collaboration 'Differences in CD4 cell counts at seroconversion and decline among 5739 HIV-1-infected individuals with well estimated dates of seroconversion' J Acquir Immune Defic Syndr 2003; 34:76-83

⁷ UK CHIC, 2011 'Impact of late diagnosis and treatment of life expectancy

in people with HIV-1: UK Collaborative HIV Cohort (UK CHIC) Study', BMJ: 343:d606

⁸ Stockle, M et al., 2012 'Morbidity and mortality in HIV infection,' Internist (Berl); Antinori, A et al., 2011 'Late presentation of HIV infection: a consensus definition.' HIV Medicine, 12 (1): 61-64

⁹ [Public Health England, 2014 'Addressing Late HIV Diagnosis through Screening and Testing: An Evidence Summary'](#) p.8

¹⁰ [Public Health England, 2013 'HIV in the United Kingdom: 2013 report'](#)



Late HIV diagnosis increases the risk of mortality for the conditions specified in the relevant indicators above.

[The NHS Outcomes Framework 2014/15](#) is also relevant since indicators include ‘preventing people from dying prematurely’ (Domain 1), ‘Enhancing quality of life for people with long-term conditions’ (Domain 2) and ‘Helping people to recover from episodes of ill health or following injury. (Domain 3).¹¹ HIV is a long-term condition and reducing late HIV diagnosis contributes to these outcome indicators.

To reduce costs to the NHS and to local authorities

There are also clear economic benefits to effective commissioning of HIV testing, even as health budgets come under pressure. Reduced rates of late HIV diagnosis not only save lives, but save money too:

Earlier HIV diagnosis reduces onward transmission. Each new HIV infection costs the NHS between £280,000 and £360,000 in lifetime treatment. According to PHE, ‘if the 3,640 UK-acquired HIV diagnoses made in 2010 had been prevented, between £1.0 and £1.3 billion lifetime treatment and clinical care costs would have been saved.’¹²

HIV care in the first year after diagnosis costs the NHS twice as much if the patient is diagnosed late, because of the significant rates of morbidity associated with late diagnosis. Thereafter, the costs of HIV care remain 50% higher for each year following diagnosis.¹³

In the UK, data from 1996 – 2008 showed that the annual estimated cost for starting standard first line anti-retroviral therapy was £12,812 for HIV positive individuals who were severely immunocompromised (CD4 count <200cells/µl blood), but 18% less (£10,478) if treatment was initiated at CD4 count > 200 cell/ µl blood.¹⁴

NICE estimate that an improvement of just 1% in patients being diagnosed earlier could save the NHS between £212,000 and £265,000 a year.

NICE also estimate that if testing guidance (detailed later in this resource) was implemented, 3,500 cases of onward transmission could be prevented within 5 years, saving the NHS £18 million per year in treatment costs.¹⁶

Reduced rates of late diagnosis (and therefore chronic illness or morbidity) will reduce the need for and costs of Local Authority-provided social care. Analysis of reasons for people with HIV requesting emergency financial help found that the third most common reason was poor physical and/or mental health, usually linked to late HIV diagnosis.¹⁷

¹¹ The [NHS Outcomes Framework 2014/15](#)

¹² HPA, 2011 ‘Evidence and resources to commission expanded HIV testing in priority medical services in high prevalence areas,’ Colindale

¹³ 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’

¹⁴ Beck EJ, Mandalia S, Sangha R, Sharott P, Youle M, Baily G, et al., 2011

‘The Cost-Effectiveness of Early Access to HIV Services and Starting cART in the UK’ 1996-2008. PLoS One; 6(12)

¹⁵ 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’

¹⁶ Ibid.

¹⁷ NAT and THT, 2010 ‘Poverty and HIV 2006-2009’ p.16



To reduce health inequalities

NHS England and Clinical Commissioning Groups have a legal responsibility to have due regard to reducing health inequalities. The [Public Health Outcomes Framework](#), against which the public health performance of local authorities will be assessed, has as one of its two high-level outcome measures, 'Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities)'.

HIV disproportionately affects marginalised, disadvantaged and socially excluded people, in particular gay and bisexual men, and African men and women. In 2012, Public Health England reported that MSM remain the group most affected with 47 per 1,000 living with HIV. Black African men and women were the second largest group affected, with 38 per 1,000 living with HIV.¹⁸

There is also elevated prevalence amongst Caribbean communities, people who inject drugs, prisoners and migrants from high prevalence countries. There are within these disadvantaged populations specific groups with particularly poor outcomes.

For example, late diagnosis amongst black African men in 2012 was at 66% and amongst black African women was 61%, compared with the overall average of 47%.¹⁹

The most deprived areas of the country also have the highest HIV prevalence. This is particularly evident in London, where diagnosed HIV prevalence is as high as 7.0 per 1,000 in the most deprived areas and less than 2.4 per 1,000 in the least deprived areas.²⁰

Diagnosing people with HIV in good time, and so maximising the benefits of treatment, will help commissioners in public health and the NHS deliver reductions in health inequalities.



¹⁸ [Public Health England, 2013 'HIV in the United Kingdom: 2013 report'](#)

²⁰ Ibid.

¹⁹ Ibid.

HIV saliva screen - collection kit
DT 25190

This test is run by doctors and offers a convenient and accurate way to understand that this test can tell you if you don't have HIV.

when to use this pack?
You need to use this pack within 30 days and the pack contains a pre-paid return box. So if you receive the pack, you need to use it within 30 days and the pack contains a pre-paid return box. So if you receive the pack, you need to use it within 30 days and the pack contains a pre-paid return box.

check the pack
To use this service, follow these simple steps:

label the tube
The tube contains a pre-paid return box. Inside the tube is a pre-paid return box. The tube has a small amount of liquid inside. The tube has a small amount of liquid inside. The tube has a small amount of liquid inside.

Diagnosing people with HIV earlier will maximise their own health and well-being, and further reduce HIV transmission in our communities.
Kevin Fenton
Public Health England

COZART®

ID Saliva Collection Tube (b)
Date

WRITE YOUR NAME AND DATE ON THE SEAL.
KEEP THE SEAL OUTWARDS TO PREVENT LEAKS IN THE SEAL.



A) Assess need

Assess the needs to be met to improve prompt identification of HIV infection and reduce late HIV diagnosis in your area

Some of the resources and links still refer to the Health Protection Agency (HPA) – previously responsible for this work.

Much essential HIV data and information for your local authority area can be provided by Public Health England - a key source of evidence and expertise.

There are 15 local Public Health England Centres (PHECs) distributed in four regions: London, North of England, South of England, Midlands/ East of England. You can find the [contact details](#) for your regional and local centres online.

Key online resources include:

[Sexual and Reproductive Health Profiles](#) – you can see data for your local authority on diagnosed HIV prevalence, late diagnosis rate, and HIV testing uptake and coverage in GUM clinics.

[Diagnosed HIV prevalence Upper Tier Local Authorities in England 2012](#) - provides for each Upper Tier Authority the number of local authority residents accessing HIV care, and diagnosed HIV prevalence per 1,000 in the local resident population.

[HIV and STI web portal](#)

Local Authority Sexual Health Epidemiology Reports are available to sexual health commissioners and Directors of Public Health. These reports describe STIs and HIV in the local area to inform local Joint Strategic Needs Assessments (JSNAs) so that commissioners can effectively target service provision. They are produced annually, in the autumn of each year.

More detailed breakdown of data within your local authority area can be accessed by talking with your regional and local **[PHE teams](#)**.



Actions to consider

Strategy

1. Has the ‘need’ been clearly identified by your local authority? Have HIV testing and late diagnosis rates been included or addressed through the Joint Strategic Needs Assessment (JSNA) process?

Knowing local data

2. Do you know the rate of late diagnosis (CD4 cell count <350 cells/mm³) and very late diagnosis (CD4 <200 cells/mm³) in your local area, and how they compare with national and regional averages?

Very late diagnosis data for your local area are available on request from PHE.

3. Do you know the prevalence of HIV in your local area and have you addressed the implications if the HIV diagnosed prevalence is 2 or more per 1,000 population? If so it will require additional testing interventions according to the [UK National Guidelines for HIV Testing](#) and NICE public health guidance.

4. Do you consider your local authority area, or part of that area, to be one where there is a ‘large community of men who have sex with men’?

If so it will require additional testing interventions in primary care according to [NICE public health guidance on improving HIV testing amongst MSM](#).

5. In some lower prevalence areas (i.e. less than 2 per 1,000 diagnosed with HIV) late diagnosis rates may not be statistically significant (see PHE’s Sexual and Reproductive Health Profiles). It may be best in such cases to begin by focusing on the population groups and areas where you know the prevalence and reported diagnoses of HIV are greatest. You can also focus on addressing very late diagnosis (CD4 <200 cells/mm³) which often involves failures in local health services offering an HIV test at earlier presentations even though clinically indicated.

Do you understand the specific geographical variation in HIV testing needs in your local area, for example variations in HIV prevalence between Middle Super Output Areas (MSOA) within your local authority? There may be specific geographical areas of significant need even in a lower prevalence local authority.

Local data by MSAOA are available in the local authority sexual health epidemiology reports.

Current service provision

6. Have you done service mapping in your local area of HIV testing provision and how it maps against the analysis of need?

7. Do you know where your local residents are testing for HIV (including outside your local area) and where people are being diagnosed HIV positive?



Supporting further testing

8. Do you know about local communities who may be at greater risk of HIV – for example, men who have sex with men (MSM), black African men and women, people who inject drugs – their numbers, distribution, their HIV testing rates, knowledge of and attitudes to current testing services, barriers identified to their testing, appropriate opportunities/ settings for health promotion with these groups?

Further disaggregated data are available from the local authority sexual health epidemiology reports.

9. Are all relevant clinical staff in primary and secondary care in your area aware of the clinical indicator conditions where an HIV test is recommended?





B) Best practice and relevant evidence

Key guidance on HIV testing

■ NICE: [Increasing the uptake of HIV testing to reduce undiagnosed infection and prevent transmission among men who have sex with men](#), London, March 2011.

Implementation tool: [NICE costing report](#)

■ NICE: [Increasing the uptake of HIV testing to reduce undiagnosed infection and prevent transmission among black African communities living in England](#), London, March 2011.

Implementation tool: [NICE costing report](#)

■ British HIV Association (BHIVA), British Association of Sexual Health and HIV (BASHH), British Infection Society (BIS): [UK National Guidelines for HIV Testing](#), September 2008.

Other relevant documents

■ PHE: [Addressing late HIV Diagnosis through Screening and Testing: An Evidence Summary](#), April 2014.

■ MEDFASH, The Greater Manchester Sexual Health Network, 'Halve It': [Halving late diagnosis of HIV: a toolkit for action – Learning from a local engagement pilot in Manchester](#), July 2014.

■ NICE: [local government briefing HIV testing](#), June 2014.

■ HPA (now PHE): [Evidence and resources to commission expanded HIV testing in priority medical services in high prevalence areas](#), April 2012.

■ BHIVA: [Standards of Care for People Living with HIV 2013](#), December 2012.

■ HPA (now PHE): [Time to Test for HIV: Expanded healthcare and community HIV testing in England](#), Sept 2011.

Guidance with content on HIV testing

■ BASHH/MEDFASH: [Standards for the management of sexually transmitted infections \(STIs\)](#), Jan 2014.

■ Department of Health: [Integrated Sexual Health Services: National Service Specification](#), June 2013.

■ BASHH: [2012 Partner Notification statement](#), July 2012.

■ UK National Screening Committee: [Infectious Diseases in Pregnancy Screening Programme - Programme Standards](#), Sept 2010.

■ BHIVA/CHIVA: ['Don't forget the children' - Guidance for the HIV testing of children with HIV positive parents](#), July 2009.

■ NICE: [One to one interventions to reduce the transmission of sexually transmitted infections including HIV, and to reduce the rate of under 18 conceptions, especially among vulnerable and at risk groups](#), London, February 2007.

Useful resource for clinicians on HIV testing

■ MEDFASH: [HIV in Primary Care](#), May 2011.



C) Review current practice

Consider the following questions and actions when reviewing services

Implementing agreed and best practice

1. Have providers achieved agreed inputs, outputs and outcomes as outlined in service specifications and national guidance?
2. Are look-backs taking place by HIV clinics, as recommended in the BHIVA Standards of Care, of those diagnosed 'very late' (CD4 <200 cells/mm³)? If yes, what, if any, lessons are emerging for NHS services, in particular in identifying earlier occasions to test for HIV?

Service user/ community feedback

3. What can you learn about HIV testing services in your local area from relevant stakeholders, users and professionals, and from communities most at risk of HIV (e.g. from evaluation reports, user experience surveys etc)? Can you reflect on positive and negative feedback on services, identified barriers to testing and where people prefer to test, for example?

Access to care

4. Do you have information from providers on time between performing an HIV diagnostic test and the results being available/shared with the patient?²¹

5. What proportion of people newly diagnosed with HIV have an assessment in an HIV specialist department within 2 weeks of diagnosis? Or within 24 hours if newly diagnosed and presenting with signs/symptoms attributable to HIV infection?

The proportion of patients integrated into HIV care within one month and three months can be known from the data collected for the HIV Quality Dashboard by PHE and made available at a Trust level. The 2 week and 24 hour quality statements are from the BHIVA Standards of Care for People Living with HIV 2013 – local arrangements will need to be made to measure performance at two weeks.

Sexual health clinics and drug treatment services

6. Do your local residents have access to a sexual health clinic within 48 hours of contacting the service?
7. Are all sexual health clinics in your area offering on an opt-out basis an HIV test to all newly attending service users not previously diagnosed HIV positive? Is the offer and uptake of testing being audited within each service?

PHE sexual health profiles show uptake of testing.

²¹ BHIVA Standards of Care recommend this time interval be reduced to a minimum with preferably the result being shared within 48 hours.



8. Are all those diagnosed with an STI in other settings in your local area, outside the sexual health clinic, being offered HIV testing on an opt-out basis?

9. Are all patients newly diagnosed with HIV having a discussion of partner notification within 4 weeks of diagnosis?

10. Is there scope for improvement/innovation in testing practice in your sexual health clinics e.g. more accessible/timely services/opening times, recalls/reminders to repeat test, use of Point of Care tests (POCTs), use of home sampling kits?

11. Are HIV tests being routinely offered on an opt-out basis in drug treatment services?

GPs

12. Are GP practices testing for HIV when clinically indicated and recommended according to national guidelines (see list of clinical indicator conditions in [UK National Guidelines for HIV Testing](#))?

13. Are GP practices offering HIV tests to [MSM](#) and to [people from African communities](#) as recommended in NICE public health guidance?

14. If you are in a high prevalence area (diagnosed prevalence of 2 or more per 1,000) are GP practices offering on an opt-out basis an HIV test to all new registrants either at new patient check or first clinical consultation?

Secondary care services

15. Are HIV tests being routinely offered on an opt-out basis in ante-natal care and termination of pregnancy services?

16. Are secondary care specialties which treat clinical indicator conditions for HIV routinely testing for HIV (see list of clinical indicator conditions in [UK National Guidelines for HIV Testing](#))?

17. If you are in a high prevalence area (diagnosed prevalence of 2 or more per 1,000) are all general medical admissions being routinely offered an HIV test on an opt-out basis? And/or are HIV tests routinely offered on an opt-out basis to all people in health services having a blood test?

Healthcare professional training

18. Have clinical staff in primary and non-HIV secondary care received training in the offer and performing of HIV tests?

Community testing services

19. Has there been consideration of increasing HIV testing rates in most at risk communities through community testing interventions, whether fixed venue community settings or mobile services (for example in saunas)?

20. What local evidence is there as to what works well in promoting HIV testing and increasing HIV test take-up amongst relevant and most at risk local populations?



21. What is the proportion of all HIV tests taken in your local area which are taken in community settings? What is the proportion of all new HIV diagnoses in a year which were made in community settings? What is the proportion of all HIV tests taken in community settings which are confirmed as HIV positive?

22. Are residents, and especially those from at risk communities, using HIV home sampling services in order to test for HIV? Is there any data on positivity rates?

Effective commissioning

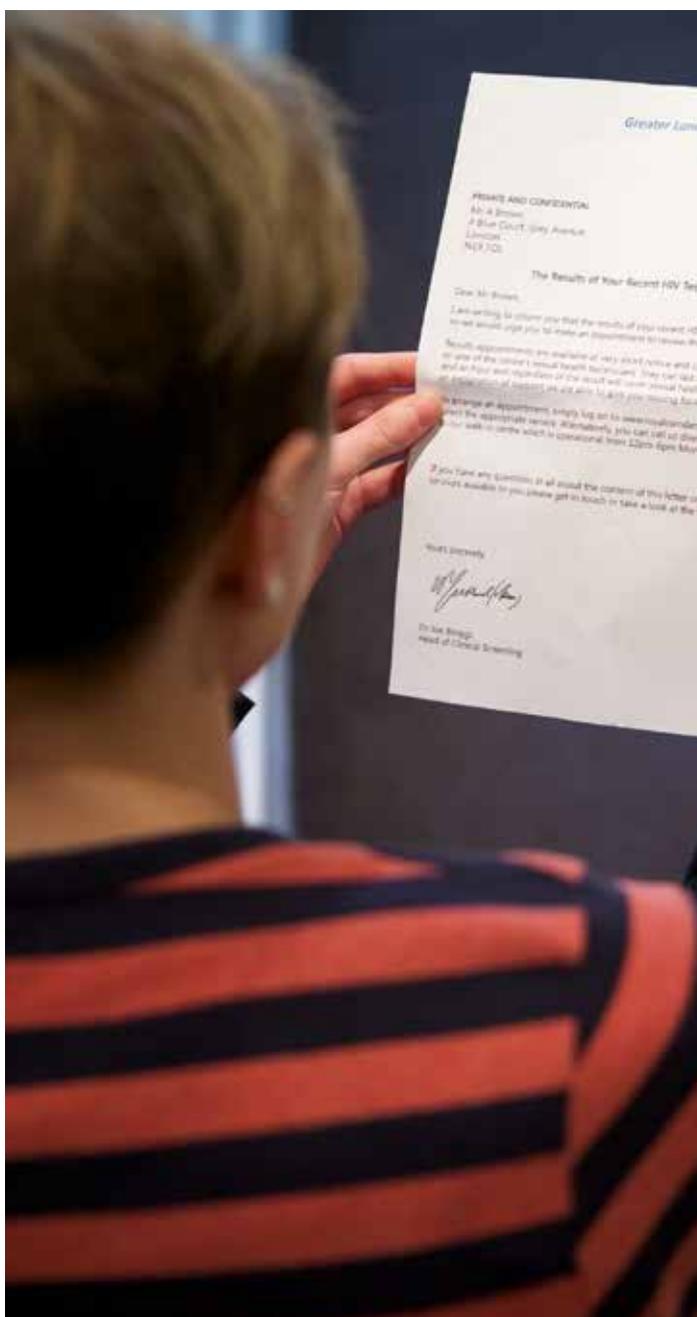
23. Is there clarity amongst all relevant commissioners in different commissioning bodies as to their respective responsibilities for commissioning HIV testing in your local area, and how their different commissioning activities around HIV testing are effectively integrated at a local level?

24. In high prevalence areas, is there explicit consideration of HIV testing in the local Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy?

25. Do you have, as recommended in NICE Public Health Guidance, a strategy to increase uptake of HIV testing among MSM and among black African communities?

26. Is local planning and commissioning of HIV testing services drawing on resources and activities of the national HIV prevention programme (HIV Prevention England), for example national HIV testing week?

27. Has there been consideration of any joint commissioning of HIV testing across local authority boundaries?





D) Develop outcomes, Evaluate practice and Formulate data set

Standard	Outcome Measure	Guidance	Dataset
People with HIV are diagnosed in good time so as to start treatment when clinically recommended	The proportion of people diagnosed late (CD4 <350mm ³)	Public Health Outcomes Framework	Sexual and Reproductive Health Profiles PHE
	The proportion of people diagnosed very late (CD4 <200mm ³)		Enquiry to PHE centre
	The proportion of people in most at risk populations who have tested in the last 12 months	UK National Guidelines for HIV Testing	Local determination (e.g. local community surveys)
Healthcare services and staff undertake HIV testing in accordance with recommended clinical practice	The proportion of people newly attending at sexual health services a) with a documented offer of an HIV test in their clinical record b) and who also have a documented HIV test result	BASHH/MEDFASH Standards for the management of STIs	Sexual and Reproductive Health Profiles PHE
	The proportion of people with HIV who have a documented discussion about partner notification with a health advisor within four weeks of diagnosis	BASHH Partner Notification Statement 2012; Integrated Sexual Health Services: National Service Specification	Clinical audit
	The proportion of people with ongoing mononucleosis-like illness a) with a documented offer of an HIV test in their clinical record b) and who also have a documented HIV test result	UK National Guidelines for HIV testing	Clinical audit



Standard	Outcome Measure	Guidance	Dataset
	The proportion of people newly diagnosed with Hepatitis B a) with a documented offer of an HIV test in their clinical record b) and who also have a documented HIV test result	UK National Guidelines for HIV Testing	Clinical audit
	The proportion of people newly diagnosed with Hepatitis C a) with a documented offer of an HIV test in their clinical record b) and who also have a documented HIV test result	UK National Guidelines for HIV Testing	Clinical audit
	The proportion of people newly diagnosed with TB a) with a documented offer of an HIV test in their clinical record b) and who also have a documented HIV test result	UK National Guidelines for HIV Testing	Clinical audit
	The proportion of people newly diagnosed with lymphoma a) with a documented offer of an HIV test in their clinical record b) and who also have a documented HIV test result	UK National Guidelines for HIV Testing	Clinical audit



Standard	Outcome Measure	Guidance	Dataset
	<p>The proportion of people newly attending drug treatment programmes</p> <p>a) with a documented offer of an HIV test in their clinical record</p> <p>b) and who also have a documented HIV test result</p>	UK National Guidelines for HIV Testing	Clinical audit
	The proportion of women who are tested for HIV in ante-natal services	UK National Guidelines for HIV Testing	Clinical audit
	The proportion of women who are tested for HIV in Termination of Pregnancy services	UK National Guidelines for HIV Testing	Clinical audit
<p><i>For high prevalence areas (HIV diagnosed prevalence of 2:1,000 or greater)</i></p>	<p>The proportion of people newly registered in general practice with</p> <p>a) the documented offer of an HIV test either at new patient check or first clinical consultation</p> <p>b) and who also have a documented HIV test result</p> <p><u>and</u></p> <p>The proportion of general practice surgeries which are offering an HIV test either at a new patient check or first clinical consultation</p>	UK National Guidelines for HIV Testing; NICE Public Health Guidance	Clinical audit



Standard	Outcome Measure	Guidance	Dataset
<p><i>For high prevalence areas (HIV diagnosed prevalence of 2:1,000 or greater)</i></p>	<p>The proportion of people admitted to secondary care</p> <p>a) with a documented offer of an HIV test during admission</p> <p>b) and who also have a documented HIV test result</p> <p>and/or</p> <p>The proportion of people undergoing blood tests</p> <p>a) with a documented offer of an HIV test</p> <p>b) and who also have a documented HIV test result</p>	<p>UK National Guidelines on HIV Testing; NICE Public Health Guidance</p> <p>NICE Public Health Guidance</p>	<p>Clinical audit</p> <p>Clinical audit</p>
<p>People receive their HIV test result with minimum delay</p>	<p>The proportion of people who receive the result of an HIV diagnostic assay ('fourth generation assay') within 48 hours</p>	<p>BHIVA Standards of Care 2013</p>	<p>Clinical audit</p>
<p>People newly diagnosed with HIV are promptly referred (and within 2 weeks) into HIV specialist care</p>	<p>The proportion of people newly diagnosed in primary care who are seen in an HIV specialist department within 2 weeks of diagnosis</p>	<p>BHIVA Standards of Care 2013</p>	<p>Clinical audit</p>
	<p>The proportion of people newly diagnosed in secondary care who are seen in an HIV specialist department within 2 weeks of diagnosis/discharge from hospital</p>	<p>BHIVA Standards of Care 2013</p>	<p>Clinical audit</p>



Standard	Outcome Measure	Guidance	Dataset
	The proportion of people newly diagnosed in community settings who are seen in an HIV specialist department within 2 weeks of diagnosis	BHIVA Standards of Care 2013	Clinical audit
Service users have a good experience of HIV testing services	Evidence of at least one user experience survey annually	Integrated Sexual Health Services: National Service Specification	Local determination
	Proportion of service user feedback on surveys that rates satisfaction as good or excellent	Integrated Sexual Health Services: National Service Specification	Local determination

Notes

The outcomes and measures above are drawn from key guidance on HIV testing including the Public Health Outcomes Framework, the BHIVA Standards of Care, NICE Public Health Guidance on HIV testing (PH33 and PH34), the Department of Health 'Integrated Sexual Health Services: National Service Specification' and the UK National Guidelines on HIV Testing (BHIVA, BASHH, BIS 2008).

In relation to HIV testing where clinical indicator conditions are present, mononucleosis-like illness, TB, lymphoma, Hepatitis B and Hepatitis C have been selected as outcomes/measures because of evidence of particularly elevated rates of undiagnosed HIV amongst those with these conditions or other important clinical reasons to test. They can also be considered to some extent as evidence of wider commissioning engagement on HIV testing in relation to clinical indicator conditions. HIV testing is, of course, also very important for other clinical indicator conditions and local commissioners may well wish to add further outcomes and measures in this area. Further appropriate measures can be used for all other clinical indicator conditions.

For all these measures there will, depending on sample size, also be value in disaggregating by at-risk group, gender, ethnicity, age, and other key variables.



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