Fairer Health for All Fellowship Cohort 1: Final report

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Job Title	GP
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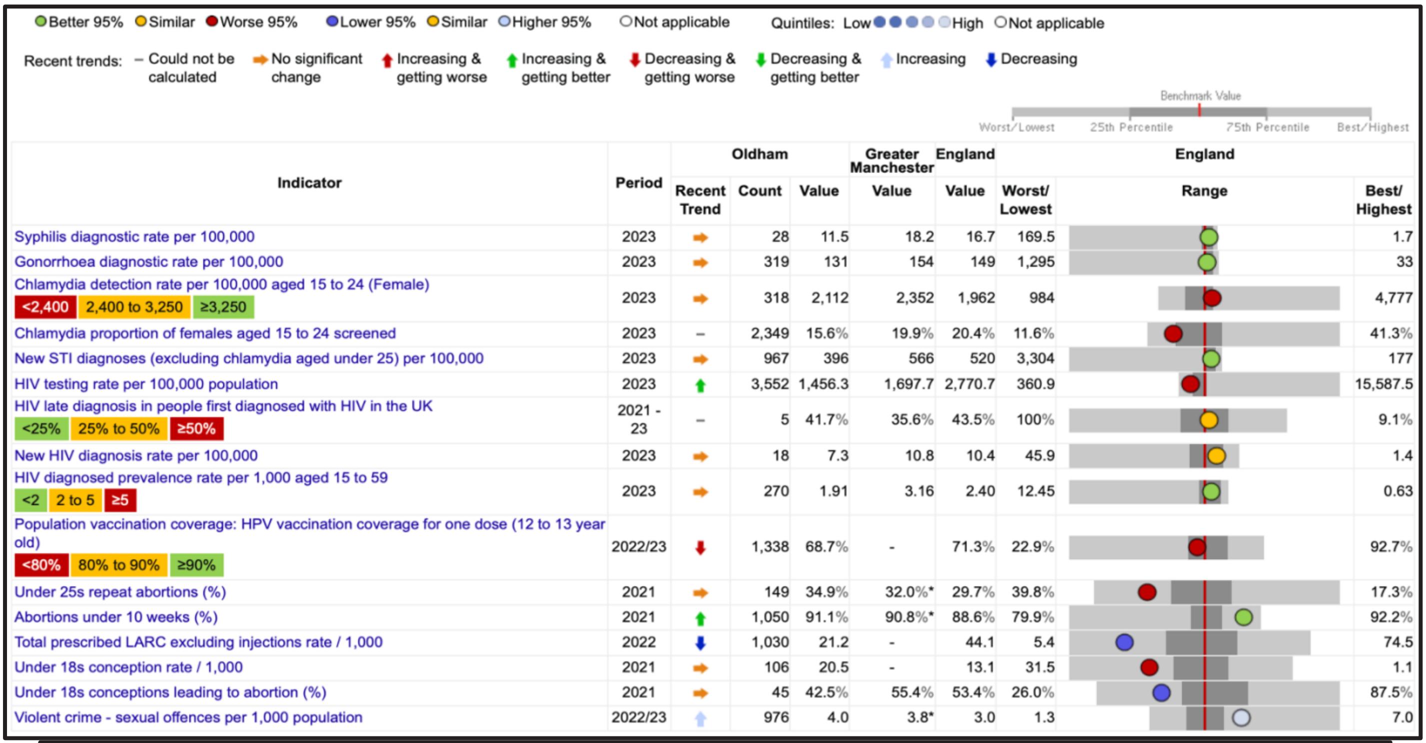
Project details

Project Name	Opportunistic HIV testing in primary care
Fellowship Dates	February 2024 - January 2025

Introduction

The practice I work at is in central Oldham, and its population is in the most deprived decile in the UK, according to the Index of Multiple Deprivation (2019). Key risk factors for having a high HIV prevalence in a population include patients who are new to the UK, younger patient populations, higher prevalence of TB and a high rate of childbirth, as well as a high deprivation index. My population has all of these. However, on review of my populations' HIV prevalence, I found it to be relatively low compared to GM and the wider UK. As a result of this, there is low awareness around HIV and less motivation to test people or talk about the disease; in an area with so many health inequalities already, this looks like something we have going for us, something we are doing right. But is that the whole story?



🟢Better 95% 🟡Similar 🔴Worse 95% 🔵Lower 95% 🟡Similar ○Higher 95% ○Not applicable Quintiles: Low ● ● ● ● ○ High ○Not applicable

Recent trends: – Could not be calculated ➡ No significant change ⬆ Increasing & getting worse ⬆ Increasing & getting better ⬇ Decreasing & getting worse ⬇ Decreasing & getting better ⬆ Increasing ⬇ Decreasing

Indicator	Period	Oldham			Greater Manchester	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Syphilis diagnostic rate per 100,000	2023	➡	28	11.5	18.2	16.7	169.5	🟢	1.7
Gonorrhoea diagnostic rate per 100,000	2023	➡	319	131	154	149	1,295	🟢	33
Chlamydia detection rate per 100,000 aged 15 to 24 (Female) <2,400 2,400 to 3,250 ≥3,250	2023	➡	318	2,112	2,352	1,962	984	🔴	4,777
Chlamydia proportion of females aged 15 to 24 screened	2023	–	2,349	15.6%	19.9%	20.4%	11.6%	🔴	41.3%
New STI diagnoses (excluding chlamydia aged under 25) per 100,000	2023	➡	967	396	566	520	3,304	🟢	177
HIV testing rate per 100,000 population	2023	⬆	3,552	1,456.3	1,697.7	2,770.7	360.9	🔴	15,587.5
HIV late diagnosis in people first diagnosed with HIV in the UK <25% 25% to 50% ≥50%	2021 - 23	–	5	41.7%	35.6%	43.5%	100%	🟡	9.1%
New HIV diagnosis rate per 100,000	2023	➡	18	7.3	10.8	10.4	45.9	🟡	1.4
HIV diagnosed prevalence rate per 1,000 aged 15 to 59 <2 2 to 5 ≥5	2023	➡	270	1.91	3.16	2.40	12.45	🟢	0.63
Population vaccination coverage: HPV vaccination coverage for one dose (12 to 13 year old) <80% 80% to 90% ≥90%	2022/23	⬇	1,338	68.7%	-	71.3%	22.9%	🔴	92.7%
Under 25s repeat abortions (%)	2021	➡	149	34.9%	32.0%*	29.7%	39.8%	🔴	17.3%
Abortions under 10 weeks (%)	2021	⬆	1,050	91.1%	90.8%*	88.6%	79.9%	🟢	92.2%
Total prescribed LARC excluding injections rate / 1,000	2022	⬇	1,030	21.2	-	44.1	5.4	🔵	74.5
Under 18s conception rate / 1,000	2021	➡	106	20.5	-	13.1	31.5	🔴	1.1
Under 18s conceptions leading to abortion (%)	2021	➡	45	42.5%	55.4%	53.4%	26.0%	🔵	87.5%
Violent crime - sexual offences per 1,000 population	2022/23	⬆	976	4.0	3.8*	3.0	1.3	○	7.0

Figure 1: Sexual and reproductive health profiles in Oldham compared to GM and England for 2023. From https://fingertips.phe.org.uk/profile/sexualhealth/data#page/1/gid/8000057/pat/126/ati/502/are/E08000004/iid/90742/age/1/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/car-do-0

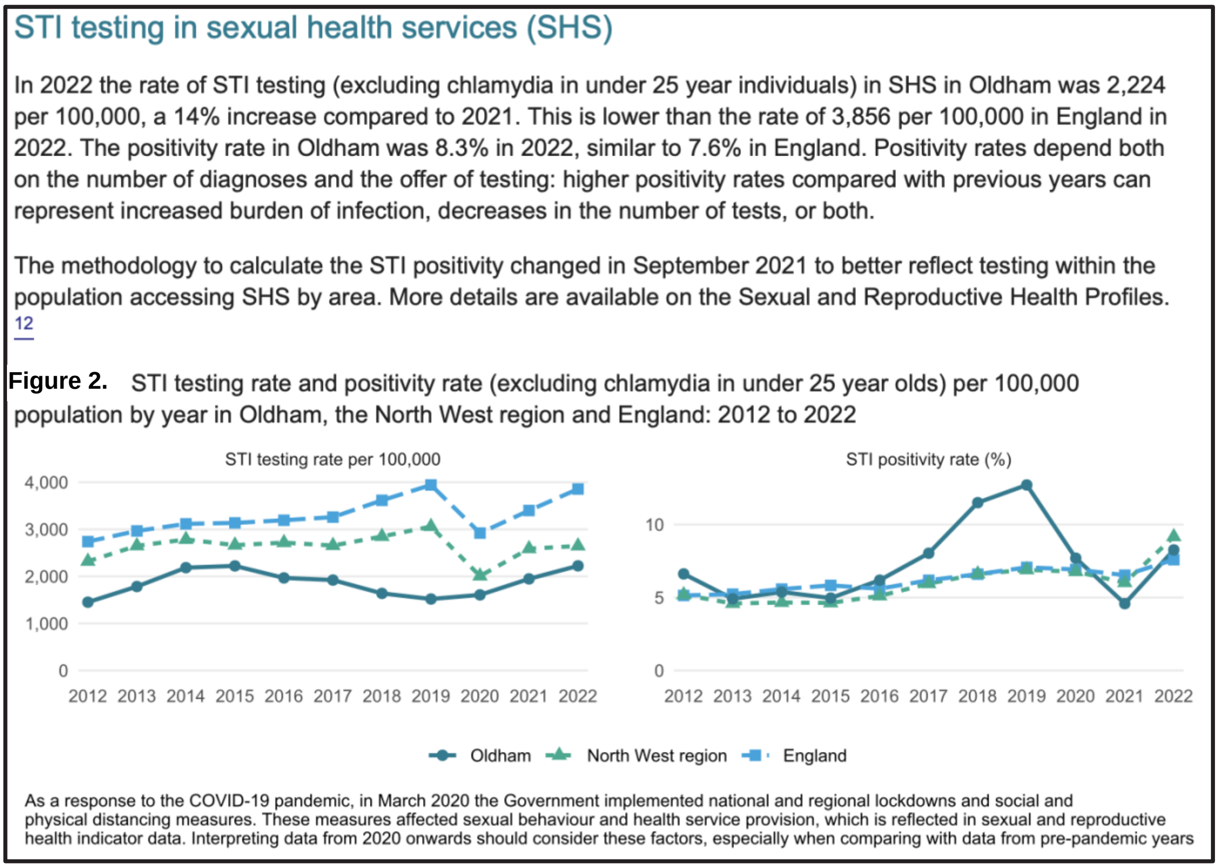
According to data above (fig 1) from the Department of Health and Social Care's fingertips website, there are a few tell-tale signs of deprivation. Starting with the bottom half of the table, violent crime and sexual offences are above the GM and England average, as well as repeat abortions and conception rate in under 18s. There is also a poor uptake of long-acting contraception (LARC) and HPV vaccinations compared to the rest of the country. LARC uptake in particular is dismal – 21% compared to England's 44. However, the top half of the chart doesn't look too bad. HIV, syphilis and gonorrhoea diagnostic rate is all below the national average. HIV prevalence in ages 15-59 in Oldham is **1.91 per 1000**, compared to 3.16 in GM.

This difference is important, because it changes the way we manage patients in these areas. Local authorities with a diagnosed HIV prevalence of between 2 and 5 per 1,000 people aged 15 to 59 years are categorised as having a **high prevalence** according to the World Health Organisation (WHO). WHO/NICE guidelines state that we should be screening **all** patients in these areas for HIV in primary care – see below.

> *"NG60 1.1.9 - In areas of high and extremely high prevalence, also* ***offer and recommend HIV testing to everyone*** *who has not previously been diagnosed with HIV and who:*
>
> *-**registers** with the practice or*
>
> *-is undergoing **blood tests for another reason** and has not had an HIV test in the previous year. [new 2016]"*
>
> *From https://www.nice.org.uk/guidance/ng60/chapter/recommendations#high-prevalence*

So according to the data above, Oldham does not meet these criteria. We don't need to worry, because prevalence is low. However, how and where is HIV prevalence data collected? If, prior to the start of my project, my practice was testing only 4% of eligible patients for HIV per year, where is this data coming from? Prevalence is the proportion of a population who have a specific characteristic in a given time period. But what if that population has never been tested?

Figure 2 (below) illustrates the issue. HIV, along with other sexually transmitted infection (STI) data is primarily collected at sexual health services or SHS, sometimes called GUM clinics. So the prevalence figure we have in figure 1 is calculated by working out the number of people who attended a GUM clinic that year, and out of that who was tested and how many tested positive. If nobody attended, the prevalence rate would be zero. Figure two and in particular the graph on the left, demonstrates that in Oldham, attendance at GUM clinics is almost half that of England. What might the prevalence be if we could test everyone in Oldham? Would it be above or below the national average? Would it push us into having a 'high' prevalence and warrant extra testing? We won't know unless we start testing more people.



STI testing in sexual health services (SHS)

In 2022 the rate of STI testing (excluding chlamydia in under 25 year individuals) in SHS in Oldham was 2,224 per 100,000, a 14% increase compared to 2021. This is lower than the rate of 3,856 per 100,000 in England in 2022. The positivity rate in Oldham was 8.3% in 2022, similar to 7.6% in England. Positivity rates depend both on the number of diagnoses and the offer of testing: higher positivity rates compared with previous years can represent increased burden of infection, decreases in the number of tests, or both.

The methodology to calculate the STI positivity changed in September 2021 to better reflect testing within the population accessing SHS by area. More details are available on the Sexual and Reproductive Health Profiles. 12

Figure 2. STI testing rate and positivity rate (excluding chlamydia in under 25 year olds) per 100,000 population by year in Oldham, the North West region and England: 2012 to 2022

As a response to the COVID-19 pandemic, in March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 onwards should consider these factors, especially when comparing with data from pre-pandemic years

I wanted to introduce opportunistic HIV testing for all patients aged between 15 and 65 at my GP practice. That way, we could see what the actual prevalence was and therefore the needs of our population, and tailor our management appropriately to them. To achieve this, I had to ensure the plan was specific to my practice population. It had to be convenient, cost effective, non-stigmatising and easy to understand by patients but also staff. To ensure its success, I really needed staff on board too. We are a large practice, with 12 thousand patients, 6 GPs, 5 nurses and 3 HCAs, so I knew I needed everyone get involved, rather than just me ordering some extra tests here and there. In an increasingly stretched and overwhelmed service, this is a significant challenge.

Background: a brief history of HIV

HIV (human immunodeficiency virus) is an infectious disease that is passed on through blood, semen, vaginal fluid, anal mucus and breast milk. If left untreated, HIV is often asymptomatic, but eventually it can damage the immune system to the extent that it leads to something we call late-stage HIV, or AIDS (acquired immunodeficiency syndrome) (1).

In the 1980s and early 90s, most people with HIV were eventually diagnosed with AIDS, which was almost always fatal and had a prognosis of weeks to months. The impact of this not just in the UK, but globally, was huge. For example, in 1994, AIDS was the leading cause of death for all Americans aged 25-44 years old. (2).

Now, thanks to modern antiretroviral treatment, very few people develop serious HIV-related illnesses. Medical evidence has shown that people on effective HIV treatment can't pass HIV on. They lead normal lives and have the same, if not sometimes a longer, life expectancy than those without HIV. This principle is known as 'U=U' – undetectable = untransmissible.

The breakthrough of successful HIV treatment means that the potential outcome of being tested has also changed. Instead of delivering bad news and a poor prognosis, a positive HIV test now means that you can start treatment and become undetectable and untransmissible. In doing this, not only are you taking control of your own health, but also you are part of the goal to zero transmission, by preventing the spread of this virus to others.

This led to a huge push in HIV diagnosis and treatment, particularly in classically at-risk populations, such as gay men. Now in this group, awareness is at an all-time high, testing is undertaken more regularly, and transmission rates are lower than ever.

Essentially, now people know that they can survive and thrive with a diagnosis of HIV, they are more willing to have regular testing, and clinicians can and should be more willing to regularly test people, without having to worry about what the results will bring.

These breakthroughs have changed the shape of this epidemic and provided new challenges. For example, in 2022, for the first time in a decade, the number of new HIV diagnoses among heterosexuals was higher than for gay and bisexual men, according to new figures for England from the UK Health Security Agency. This highlights the need to test not only at-risk groups, but everyone for HIV, if we want to meet the UK goal to eradicate all new HIV cases by 2030. We cannot leave any population behind.

As mentioned above, my practice population has a lot of 'silent indicators' for HIV, such as poverty, being new to UK, poor use of sexual health services, and high teenage pregnancy and abortion rates (4). We cannot achieve U=U if we don't test everyone. We cannot say an area has a low prevalence if nobody is presenting to be tested. I don't want to demonstrate that the prevalence is different from what we think – it probably isn't. But we need more data so that we can have some idea of what is going on in our population and to get this data, we need to collect it in a way that is convenient for them and without stigma. That is fairer health for all.

(1) https://www.tht.org.uk/hiv/about-hiv
(2) https://www.apa.org/pi/aids/youth/nineties-timeline#:~:text=The%20Epidemic%20Grows&text=In%201991%2C%20the%20red%20ribbon,ages%2025%2D44%20years%20old.
(3) UK health security agency via https://www.tht.org.uk/news/heterosexual-hiv-diagnoses-overtake-those-gay-men-first-time-decade
(4) https://fingertips.phe.org.uk/static-reports/sexualhealth-reports/2024/E08000004.html?area-name=Oldham

Method

Firstly, I needed to ascertain how to roll out my project at my practice. Prior to this fellowship, I probably would have just guessed, but I have learned a lot this year about public health and tailoring your methods to the specific needs of your population. Therefore, despite my enthusiasm for making large posters with red ribbons on and 'HIV' written in huge letters across them, I restrained myself and decided to collect some opinions about what would be best.

As part of running baby and postnatal clinics every week, I had a bit more time to have more informal discussions with my patients in the at-risk age group. I also spoke to our in-house translators, who are key not just at the practice but members of the local community. This helped me to learn more about what would be the best way to implement this kind of testing at my practice in a culturally sensitive way.

The ethnic backgrounds of practice population are around 60% Pakistani or British Pakistani, 20% Romanian and 20% non-white other, according to fingertips data. Many of my patients are unkeen to discuss sexual health, transmittable diseases or even vaccinations, partly due to cultural stigma but also due to lack of trust of the health service in general. I also knew from studying data about attendance at GUM clinics, that ours is about half that of the Greater Manchester average. However, our patients were willing to attend their routine health checks, and often would ask unprompted for a set of blood tests or additional 'check ups' when asymptomatic, because this is part of a normal health service in their countries of origin. Therefore, I decided to add HIV testing into all routine blood tests being undertaken at the practice, rather than as a separate sexual health screen, or a specific appointment. This is also important as we are, like many GP practices around the country, having significant problems with patient access at the moment, so being able to integrate this into an existing appointment rather than try and create new ones was crucial.

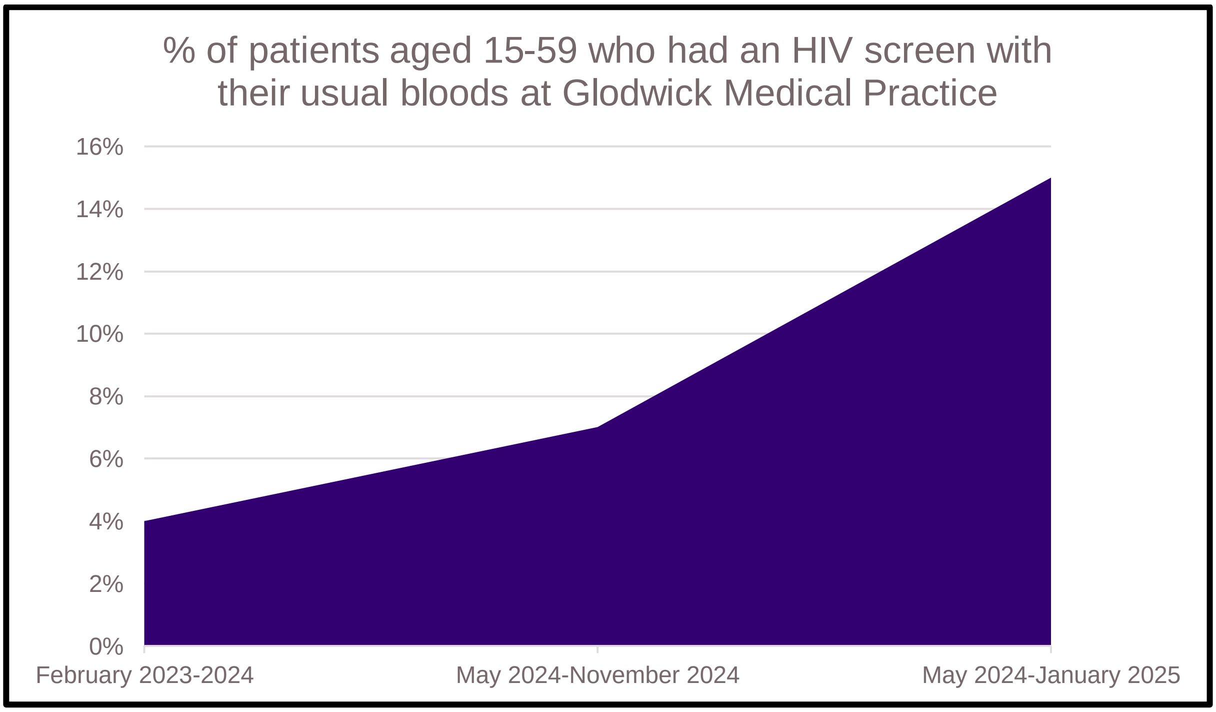
My initial ideas about posters that had red ribbons on them, using some graphic from the Terence Higgins trust about 'U=U' and 'stop the stigma' and 'HIV awareness day' etc, would probably be suitable in a practice in central Manchester, or in London where I trained as a doctor. But after speaking to patients and staff at my practice, I changed them completely to make them plain and informative, rather than flashy and trying to encourage testing. They simply stated the facts with our practice logo on, of course in the 4 commonly spoken languages at our practice. This way, they were informative without being in your face or pushy. I used the same approach to create laminated tokens to put in each practice room, to give to patients to read whilst they were having their blood tests done, in order to give them further and more targeted information. I realised that from staff, I needed up to date knowledge and enthusiasm about HIV, and from patients we needed trust and consent.

In order to increase knowledge and enthusiasm for staff then, I created an 'HIV pub quiz' for my practice staff to gauge what their current knowledge and beliefs were in HIV, and take things from there. I found that generally, up to date knowledge of HIV (ie that it was treatable, that you could be undetectable and that if so, you cannot pass it on etc) was quite poor, but enthusiasm to learn far outweighed it. Everyone who completed the quiz went to a teaching session with me, where we discussed the answers, I gave a concise update about some of the more up to date knowledge, and then they could ask any questions they wanted. They then received an HIV awareness red ribbon to wear on their lanyards at work as a prize. A few people contributed suggestions to help with the project too. The admin lead suggested we send out a blanket accurx text to all patients in that age group to let them know about the screening, which we sent out that same day.

See the appendix for examples of the pub quiz, practice posters and patient leaflets.

Results

So far, there have been two main changes since the project started. One of these is measurable – the rate of HIV testing is increasing significantly. I know this both from looking at the data since the launch of opt out testing in July, and from my own work as a GP at the practice; we file all blood results, and I am getting a good few HIV tests to file each day, where before I had none! On reviewing the data for the last time in January, I found our testing coverage had almost quadrupled from 4% to 15% of patients. Although this is a win, we have a long way to go yet to get everyone tested!



The other outcome is more difficult to measure, but it is that of staff enthusiasm and feeling more like a team. When I launched my project at the practice, I was unusually nervous – I felt people might not be too keen to help with it and that they might feel it was just another hoop to jump through. We are a relatively new GP practice, formed from a merger of two failing practices, with permanent staff only really starting in February this year, so we didn't know each other all that well yet.

However, when I explained my project, why I think it is important, and that it isn't mandatory/part of QOF/something we should already be doing, but something special for our practice to try out, everyone was very enthusiastic. I had lots of questions, particularly from older staff members, surrounding HIV stigma and how we would manage that in a consultation; I had nurses and HCAs keen to take part now that I had given them blanket permission to request an HIV test without GP approval; the admin lead even had all my posters and leaflets printed, laminated and put up that same day. I was not completely sure why this happened, and I was taken aback it – but I am very happy about it and I think maybe we just all needed something to focus on together and demonstrate that we can improve things for our patients. For me personally, it showed that the enthusiasm and willingness for change and improvement is there, we just needed something to all throw our weight behind as a team. This was particularly important for me and where I work, because there were and are lots of other things that need to change over time and I have become a big part of implementing this, so now I know that firstly it is possible, and secondly who my key people are to help me with this in the future.

Conclusion

I have really enjoyed doing my project and have learned so much along the way. I would have loved to see a higher testing coverage than we have, but realistically in a newly formed practice with a lot of access issues and with the multiple pressures on primary care at the moment, I think it's important to take the increase as a win. I am also so happy about how enthusiastic everyone was to help out and to listen to and participate in my teaching sessions. These were something I enjoyed and hope to be able to roll out to other neighbouring practices in the future, which is really exciting, as I really want to be able to bring everyone's knowledge of HIV more into the 21st century. This will, in its own small way, help in our area to bring about the 'HIV time's up' campaign, which is the joint Government and Terence Higgin's Trust charity campaign to have no new cases of HIV by 2030.

There were, of course, many difficulties I came across with implementing this project. Firstly, the whole project relies on a member of staff remembering to manually order an HIV test. We have order sets for things like a liver screen, or cardiovascular/diabetic annual reviews, but none of these have HIV on and no matter what we tried, we could not add it onto these. Therefore, if someone simply forgot to tick the box to do an HIV test, that patient wouldn't get one, and it would look the same as if they had refused a test. Also in the lab, an HIV test comes under microbiology, therefore requiring a whole extra tube of blood to be taken, which requires extra administrative faff, money, and also means that we cannot simply call the lab at the end of a day and add on a load of HIV tests – something we would be able to do if it were, for example, a renal function blood test. Part of the reason for these is the stigma around testing for HIV. We used to have to spend 5 minutes counselling a patient about a test, which meant nobody wanted to do it and a lab wouldn't routinely accept an add on test – it had to be done separately. However this is now out of date, and HIV tests are consented in the exact same way as every other blood test, so it's really frustrating that lab and IT systems have not caught up with this. I think this contributed greatly to our figures not being closer to 100% - I know I had days where I forgot to tick the extra HIV test box, and I am running the project! I am still liasing with the IT and lab systems in order to try and make this process slicker, and hope that this will help us to process more HIV tests in the future and have better testing coverage.

I think what has been of utmost important to me, not just for this project but the fellowship as a whole, has been having the time set aside to think creatively about problems, uncover deeper issues and be able to try to raise awareness and solve things. As GPs, we are under constant pressure to be time and money efficient – we see 25-30 patients in clinic, as well as assessing and acting upon the data of hundreds more, every single day. When the day ends and everyone is safe and accounted for, we breathe a sigh of relief and go home, only to do it all again tomorrow. As a result of this, we rarely have time to think about how to run things better, how to better serve our population, or even to notice patterns in our appointments/patient contacts that might help us to work better. Doing this fellowship has changed that for me.

As well as my HIV project, I have had a rethink about how we run our postnatal appointments. I now run my clinic alongside the nurse and send my patients directly into her room from mine for their first childhood vaccines. This has resulted in increased uptake of first jabs in our practice, a statistic that was shockingly poor before we started this. All my appointments are audited (by me) for if they are urgent, routine, if the patient attended, and importantly, if the appointment was needed or not and if not, where that patient should have been directed to instead. I also count the number of patients being seen more than once in ten days, and how many complaints I receive from patients about access to appointments in each clinical session. I have then used this data as part of a large access project for the whole practice, to demonstrate what we can change as a practice in order to make access to our appointments easier for the patients who need them, making both patients and clinicians happier and more efficient. I would never have had the time – or indeed perhaps even the idea – to do this without this fellowship. I now feel able to think outside the clinic room to the practice and population as a whole, and use this perspective to help improve things, hopefully for many more years to come!

Appendix 1 – HIV 'pub quiz' given out to staff, with correct answers added here in pink.

HIV questionnaire

What is HIV?

A virus - other examples include flu, chicken pox. A bug/germ which infects cells in the body. HIV infects immune cells - the ones which fight off infection.

What do the letters in HIV stand for?

Human immunodeficiency virus

What is AIDS and what does AIDS stand for?

Acquired immunodeficiency syndrome - an umbrella term for when someone who has HIV becomes very unwell with one or more illnesses as a result of the virus attacking their immune system. Just like when patients are on chemo or immunosuppressants, they are susceptible to a range of illnesses that a healthy person would not catch, ie TB, CMV, RSV, PCP etc.

How is HIV transmitted and how easy is it to catch from someone?

3 main ways: ALL types of sex, blood, breast milk. Can pass in utero and childbirth. Cannot catch it from saliva, urine, faeces, skin contact, bites, insects.

Is there treatment for HIV and if so, what is it?

Antiretroviral drugs. Often 1-2 pills per day. Annual check at GUM clinic.

What is the prognosis of HIV - is it curable? Treatable? Deadly?

Not curable (yet.) But is fully treatable - the drugs above suppress the virus to the point where it is undetectable in the blood and the person is completely well. When it is undetectable, it cannot be transmitted through ANY route. U=U

What is the life expectancy of someone with HIV compared someone who doesn't have it? ie longer? Shorter? How many years can you live with it before getting sick/dying?

Longer due to the above plus an annual health check - these patients now have a slightly above average life expectancy if treated in time!

Are there any conditions you would think of or any symptoms someone might have that would make you think we need to test someone for HIV?

Loads. Main ones: cancer incl lung, anal and cervical, ALL pneumonia, TB, herpes >1/12, oral candidiasis, lymphoma, shingles, hep b/c, seb derm, PUO, hep B, EBV, GBS, unexplained chronic diarrhoea/renal impairment/weight loss/ lymphadenopathy/leuco or thrombocytopenia, severe/atypical psoriasis, MS or mononeuritis, ITP, CMV. Take home is any of these in young person = needs HIV test. Anything unusual/recurrent/no clear cause - get an HIV test.

Do you think we are doing all these?

Overall message = it's really easy to treat, but not if we dont diagnose it - therefore testing is key.

Appendix 2: Practice poster translated into Urdu, Romanian and Punjabi with the help of our in-house translators. This was put up all over the practice.

HIV blood tests

HIV testing is now a routine part of health checks at our practice. If you would like to opt out of this, please speak to a member of staff at your next blood test appointment.

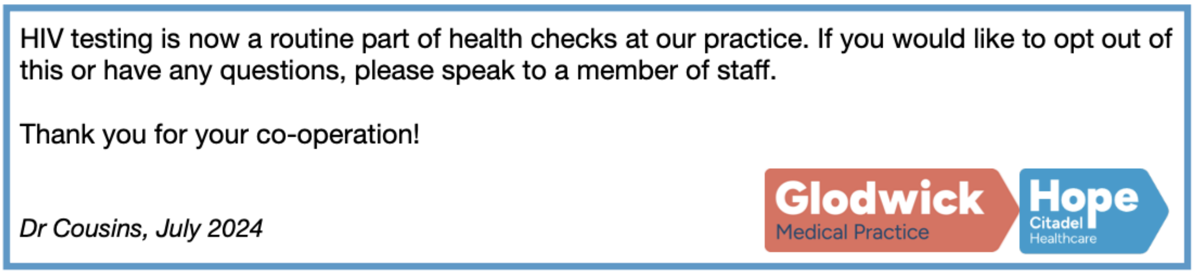
Testarea HIV este acum o parte de rutină a controalelor de sănătate la cabinetul nostru. Dacă doriți să renunțați la acest lucru, vă rugăm să discutați cu un membru al personalului la următoarea programare pentru analiza de sânge.

ایچ آئی وی ٹیسٹنگ اب ہماری پریکٹس میں صحت کی جانچ کا ایک معمول کا حصہ ہے۔ اگر آپ اس سے آپٹ آؤٹ کرنا چاہتے ہیں، تو براہ کرم اپنی اگلی بلڈ ٹیسٹ اپوائنٹمنٹ پر عملے کے کسی رکن سے بات کریں۔

HIV ਟੈਸਟਿੰਗ ਹੁਣ ਸਾਡੇ ਅਭਿਆਸ ਵਿੱਚ ਸਿਹਤ ਜਾਂਚਾਂ ਦਾ ਇੱਕ ਰੁਟੀਨ ਹਿੱਸਾ ਹੈ। ਜੇਕਰ ਤੁਸੀਂ ਇਸ ਤੋਂ ਹਟਣਾ ਚਾਹੁੰਦੇ ਹੋ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੀ ਅਗਲੀ ਖ਼ੂਨ ਜਾਂਚ ਮੁਲਾਕਾਤ 'ਤੇ ਸਟਾਫ ਦੇ ਕਿਸੇ ਮੈਂਬਰ ਨਾਲ ਗੱਲ ਕਰੋ।

Glodwick Medical Practice
Hope Citadel Healthcare

Appendix 3: Slips that were laminated and given out to patients at the time of their blood test, again in the 4 most commonly used languages at our practice. These were both a prompt for staff and patients and often facilitated open discussion.



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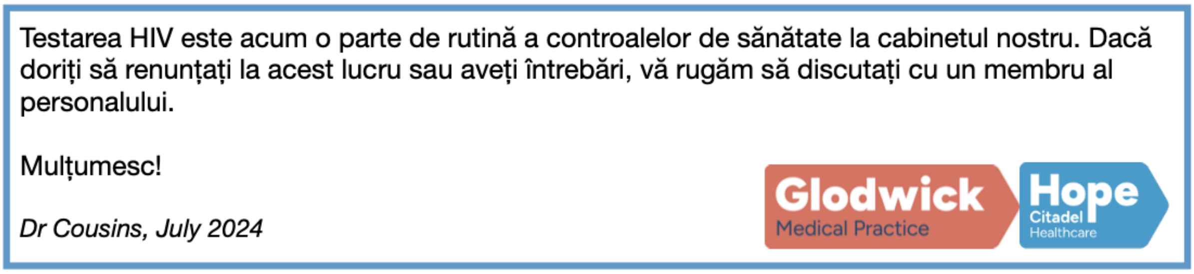
Thank you for your co-operation!

Dr Cousins, July 2024



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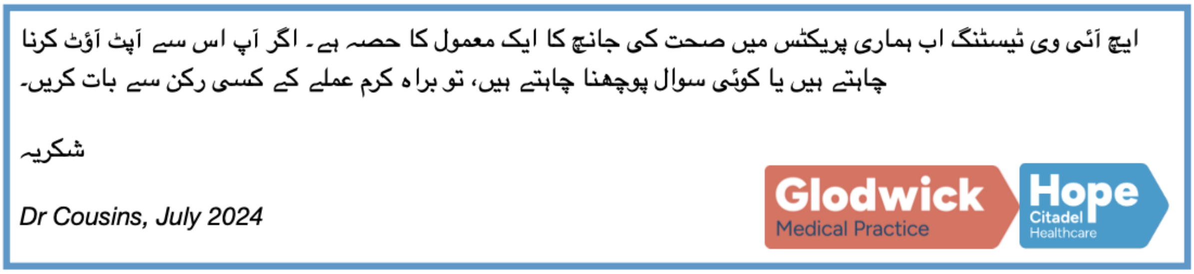
Mulțumesc!

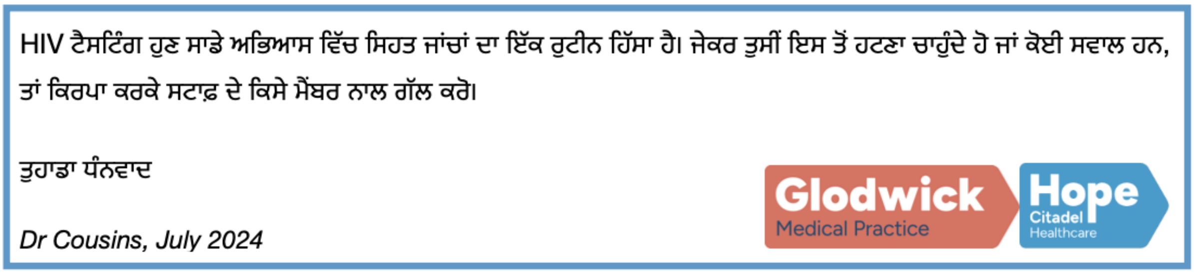
Dr Cousins, July 2024



ایچ آئی وی ٹیسٹنگ اب ہماری پریکٹس میں صحت کی جانچ کا ایک معمول کا حصہ ہے۔ اگر آپ اس سے آپٹ آؤٹ کرنا چاہتے ہیں یا کوئی سوال پوچھنا چاہتے ہیں، تو براہ کرم عملے کے کسی رکن سے بات کریں۔

شکریہ

Dr Cousins, July 2024

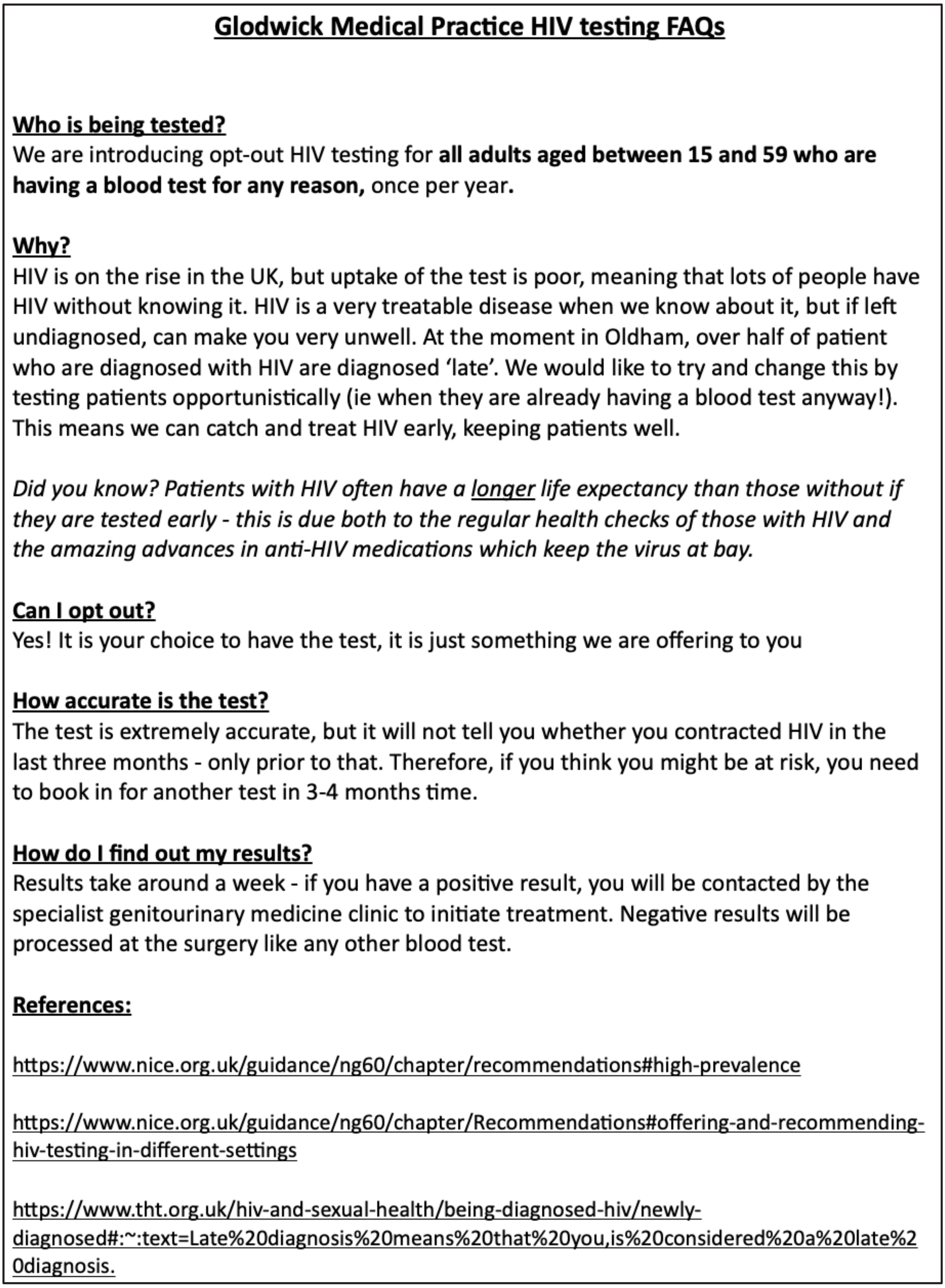


HIV ਟੈਸਟਿੰਗ ਹੁਣ ਸਾਡੇ ਅਭਿਆਸ ਵਿੱਚ ਸਿਹਤ ਜਾਂਚਾਂ ਦਾ ਇੱਕ ਰੁਟੀਨ ਹਿੱਸਾ ਹੈ। ਜੇਕਰ ਤੁਸੀਂ ਇਸ ਤੋਂ ਹਟਣਾ ਚਾਹੁੰਦੇ ਹੋ ਜਾਂ ਕੋਈ ਸਵਾਲ ਹਨ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਸਟਾਫ਼ ਦੇ ਕਿਸੇ ਮੈਂਬਰ ਨਾਲ ਗੱਲ ਕਰੋ।

ਤੁਹਾਡਾ ਧੰਨਵਾਦ

Dr Cousins, July 2024

Appendix 4: Testing FAQs. These were in every clinic room to facilitate discussion should a patient have any questions about the opt-out testing.



Glodwick Medical Practice HIV testing FAQs

Who is being tested?

We are introducing opt-out HIV testing for **all adults aged between 15 and 59 who are having a blood test for any reason,** once per year.

Why?

HIV is on the rise in the UK, but uptake of the test is poor, meaning that lots of people have HIV without knowing it. HIV is a very treatable disease when we know about it, but if left undiagnosed, can make you very unwell. At the moment in Oldham, over half of patient who are diagnosed with HIV are diagnosed 'late'. We would like to try and change this by testing patients opportunistically (ie when they are already having a blood test anyway!). This means we can catch and treat HIV early, keeping patients well.

Did you know? Patients with HIV often have a longer life expectancy than those without if they are tested early - this is due both to the regular health checks of those with HIV and the amazing advances in anti-HIV medications which keep the virus at bay.

Can I opt out?

Yes! It is your choice to have the test, it is just something we are offering to you

How accurate is the test?

The test is extremely accurate, but it will not tell you whether you contracted HIV in the last three months - only prior to that. Therefore, if you think you might be at risk, you need to book in for another test in 3-4 months time.

How do I find out my results?

Results take around a week - if you have a positive result, you will be contacted by the specialist genitourinary medicine clinic to initiate treatment. Negative results will be processed at the surgery like any other blood test.

References:

https://www.nice.org.uk/guidance/ng60/chapter/recommendations#high-prevalence

https://www.nice.org.uk/guidance/ng60/chapter/Recommendations#offering-and-recommending-hiv-testing-in-different-settings

https://www.tht.org.uk/hiv-and-sexual-health/being-diagnosed-hiv/newly-diagnosed#:~:text=Late%20diagnosis%20means%20that%20you,is%20considered%20a%20late%20diagnosis.