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Audit of first-time sexual health service attendees who do not have an HIV test

BASHH National Clinical Audit 2024

Background and aim

Background:

The UK government has committed to the elimination of HIV transmission by 2030. To achieve this, individuals living with undiagnosed HIV infection will need to be identified through testing and commenced on ART, thereby eliminating the risk of further onward transmission.

The aim of the audit is:

- To understand how sexual health services handle people who don't have an HIV test at their first visit
 - *Survey of Sexual Health services – completed once per service*
- Explore why they don't get tested and what arrangements are in place for the follow up of this group of individuals.
 - *Case note review of those not tested at first attendance – last 40 individuals between February 2023 – January 2024*

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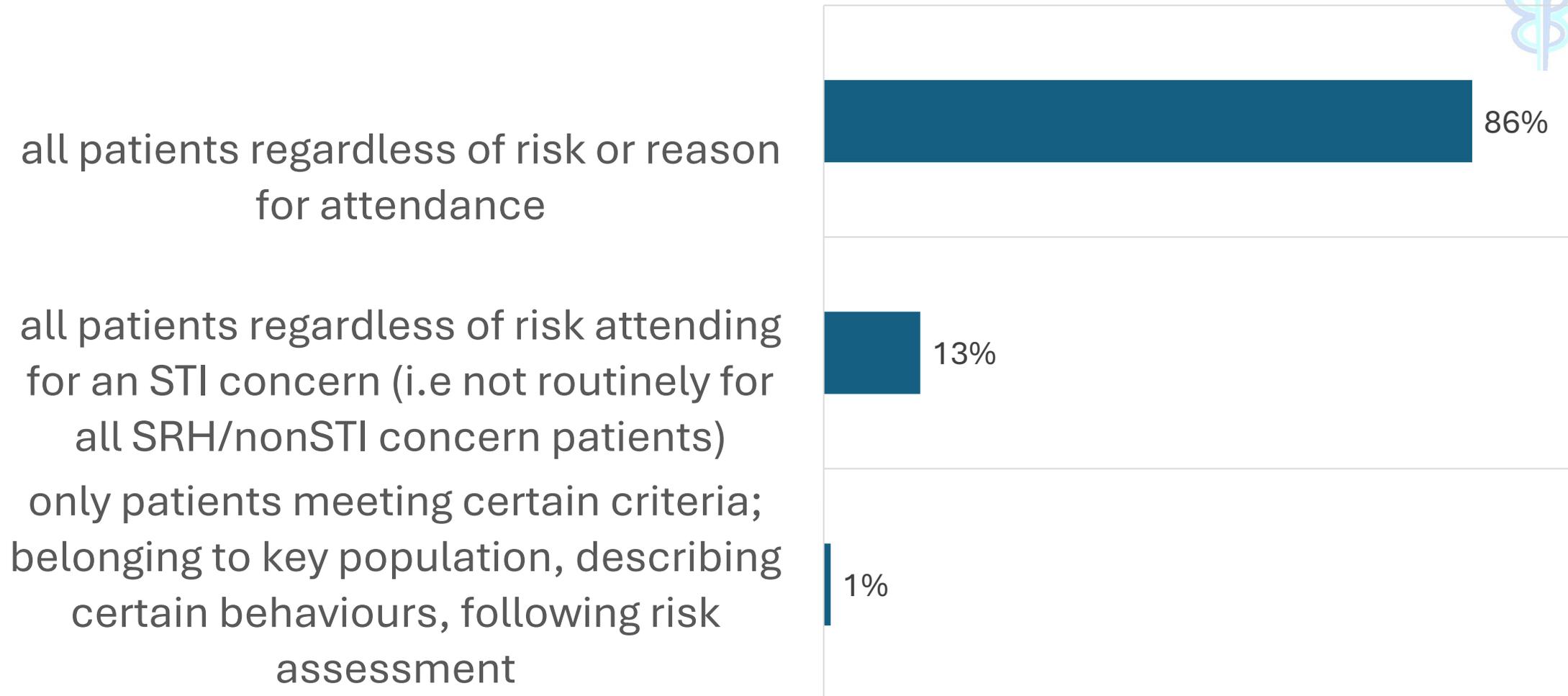
Survey of Sexual Health services

109 valid responses

Covering 126 Sexual Health Services

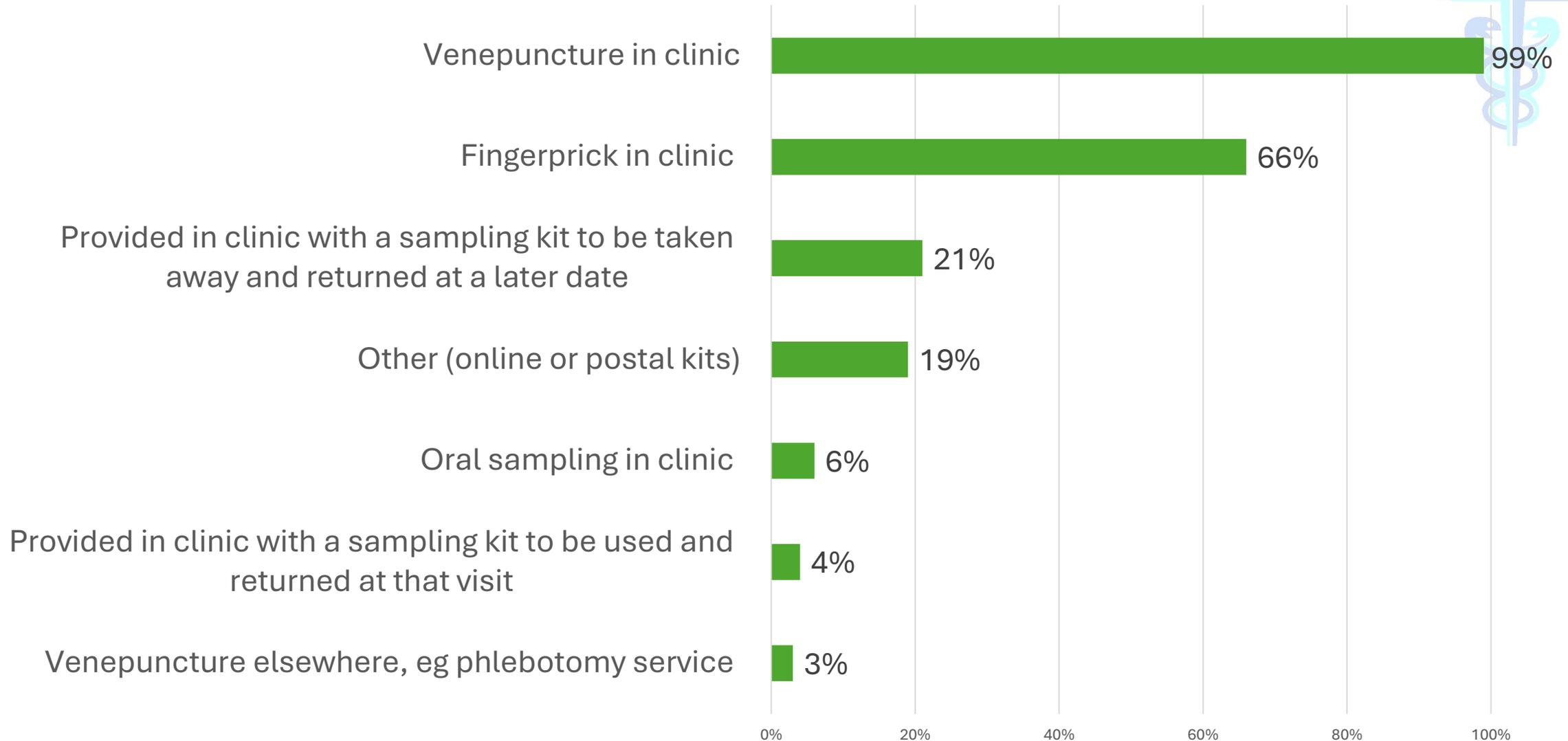


Clinic policy regarding who should be offered an HIV test on first attendance



How services provide or arrange sampling for HIV testing for individuals with STI related health needs

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Self-sampling kits – 24% (26) of services provide self-sampling kits to be returned directly to the service



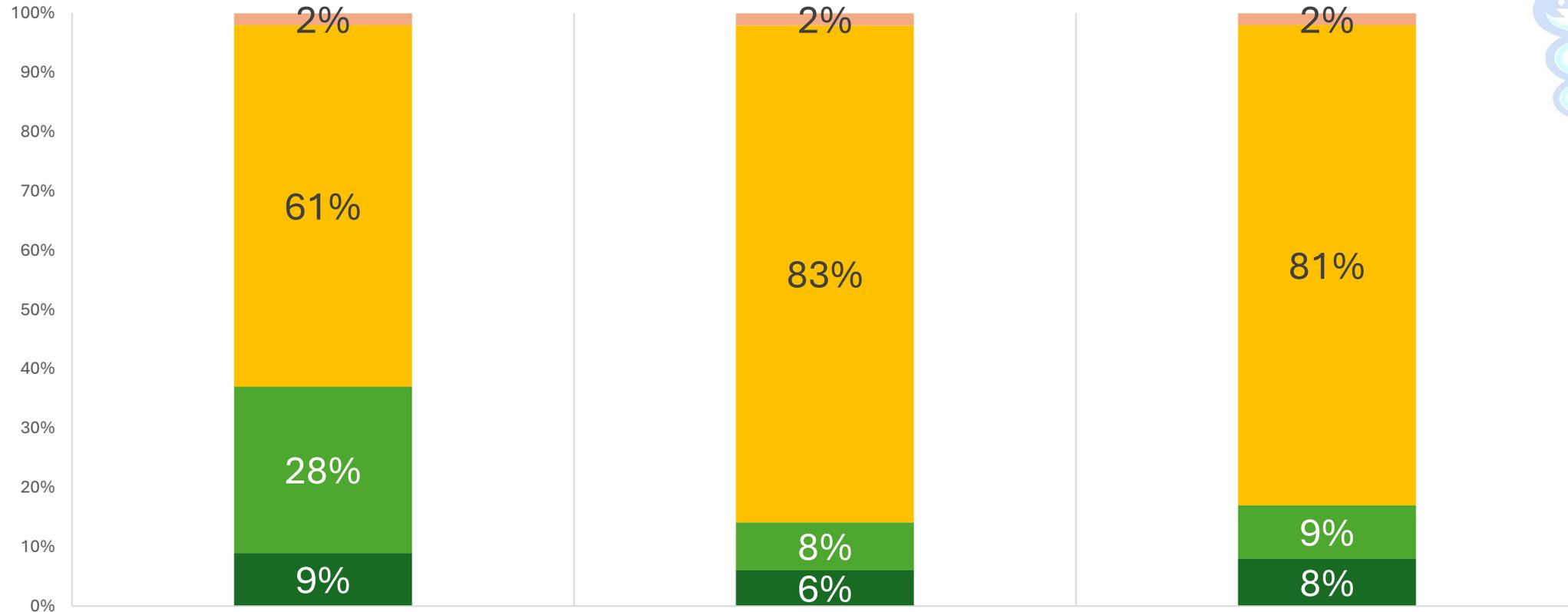
Does everybody routinely get the full four tests (chlamydia, gonorrhoea, syphilis and HIV)?

Routinely gets the full four	81%
Risk based assessment	8%
Based on patient preference	8%
Other	4%

In an individual is provided with a self-sampling kit for chlamydia/ gonorrhoea but not for syphilis/HIV, how is the HIV test is coded

HIV test offered and declined (SHHAPT code: P1B)	52%
Not done	26%
Other	13%
Don't know	9%

There is a mechanism for recalling or referring individuals to other services in the following scenarios:



An HIV test was offered but the individual declined

HIV testing was considered not appropriate

HIV testing was not offered

■ Yes for all

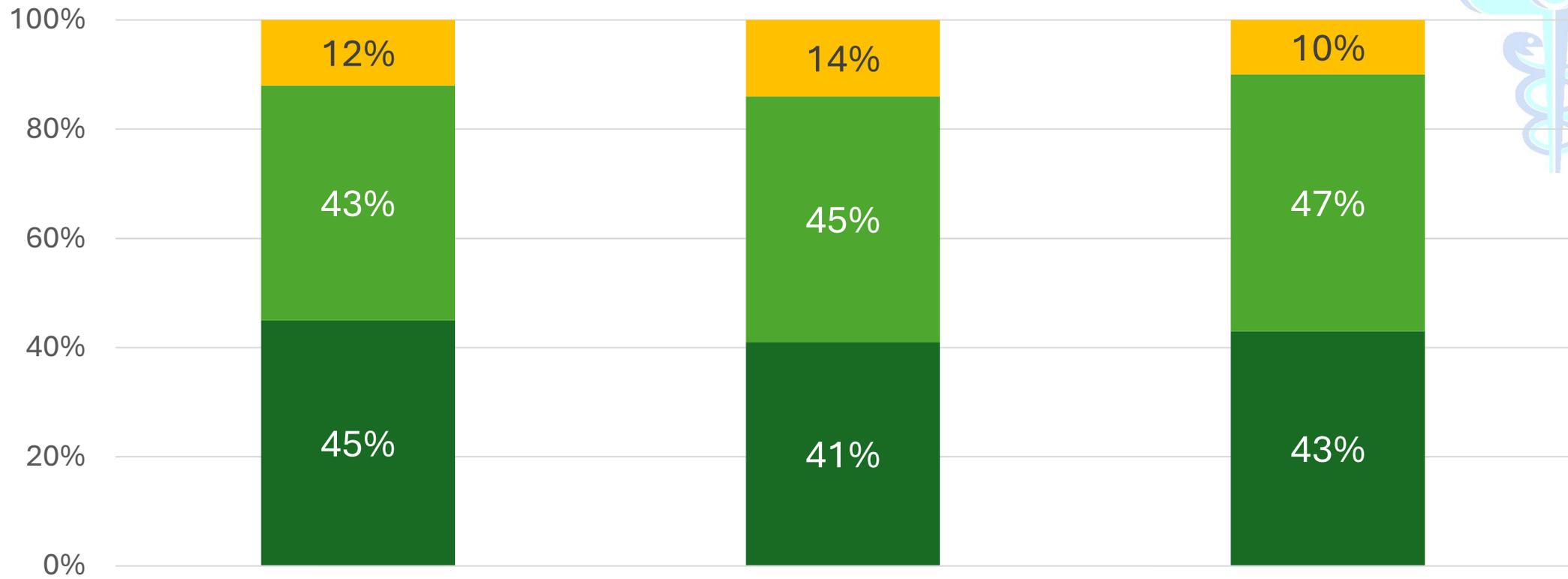
■ Yes but only those assessed as higher risk

■ No

■ Don't know



Is it service policy to:



To record reason/s for any GUM attender not offered HIV testing?

To record reason/s for any GUM attender considered not appropriate for HIV testing?

To record reasons/ given by GUM attender declining an HIV test?

■ Yes, this is policy

■ Not formal policy but usually done

■ No

Processes and monitoring

Does the service have any of the following monitoring in place?

Service produces regular internal reports/KPIs on HIV testing performance	81%
Regularly review HIV testing uptake coverage among GUM attenders	78%
Key performance indicators (KPIs) or targets for improving uptake of HIV testing*	65%

Population groups these targets apply: All groups (79%), MSM (18) plus those from African communities, heterosexuals, and areas of high prevalence.



Processes and monitoring

Does the service have any of the following processes in place?

To flag the record of any GUM attender who declines HIV testing with need for this to be discussed at next attendance	16%
To advise any GUM attender who declines HIV testing in clinic to seek this from a community/voluntary provider	25%
To contact GUM attenders who decline HIV testing (eg phone call from health advisor or other clinician)?	6%
Regularly to review uptake and reasons for not testing for HIV in MDT or similar?	24%

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Case note review of those not tested at first attendance –

last 40 individuals between February 2023 – January 2024

3382 valid responses

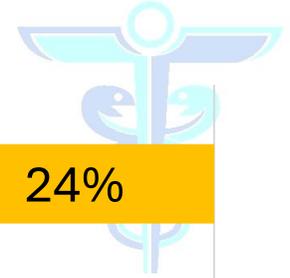
Covering 125 Sexual Health Services

Sample characteristics

	Number	%
Gender*		
Female (including trans)	1587	47%
Male (including trans)**	1790	53%
Other or declined	5	0.1%
<i>*95% were the same gender as their birth sex, 4% not recorded and 1% trans or gender non-conforming</i>		
<i>**61% of males were heterosexual and 37% MSM. 2% unknown</i>		
Age		
Under 16	57	2%
16-19	423	13%
20-24	715	21%
25-29	608	18%
30-34	534	16%
35 or older	1043	31%

Sample characteristics

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Was the individual known to have:

One or more partners from a high HIV prevalence group (ie from a high prevalence country, or with a history of injecting recreational drugs)



A history of sex work (ie providing sexual services for money)?



A history of injecting recreational drugs?



One or more partners with diagnosed HIV infection?



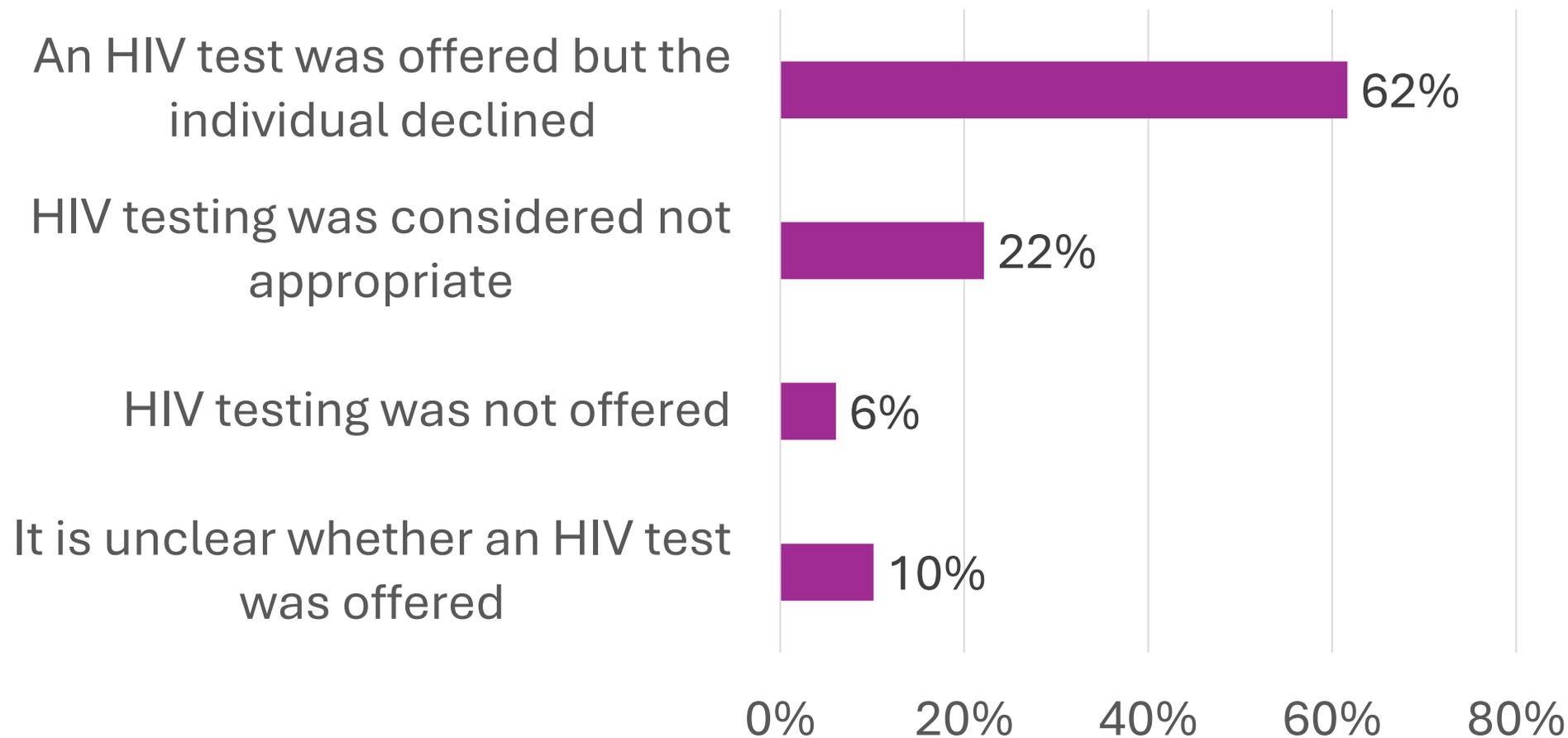
0% 20% 40% 60% 80% 100%

■ Yes ■ No ■ Not recorded

Of those with one or more partners with diagnosed HIV infection (20), 25% (5) had no detectable HIV viral load, 40% (8) were not known and 35% not recorded (7).



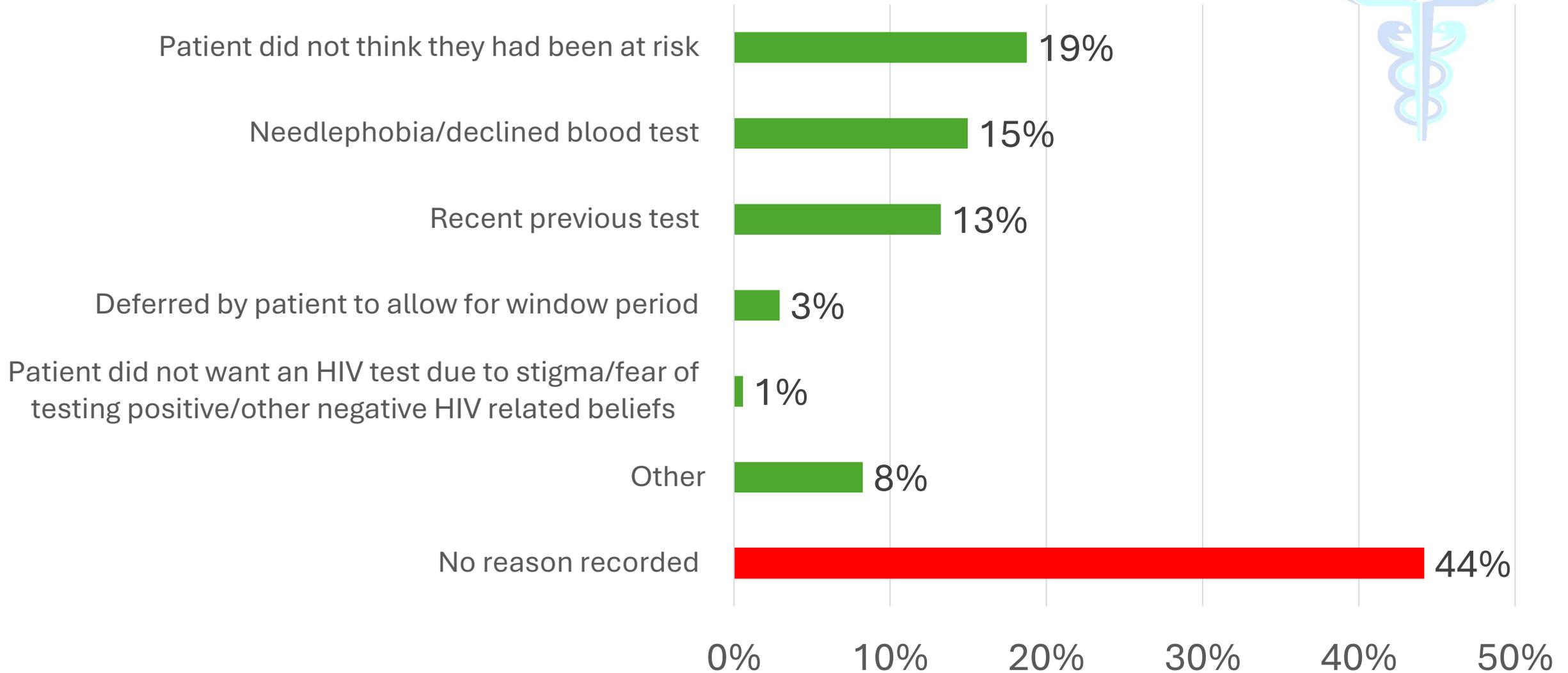
What was recorded about HIV testing during the relevant episode of care



For females, 31% of attendances was primarily for contraception/reproductive care with no STI-related concerns

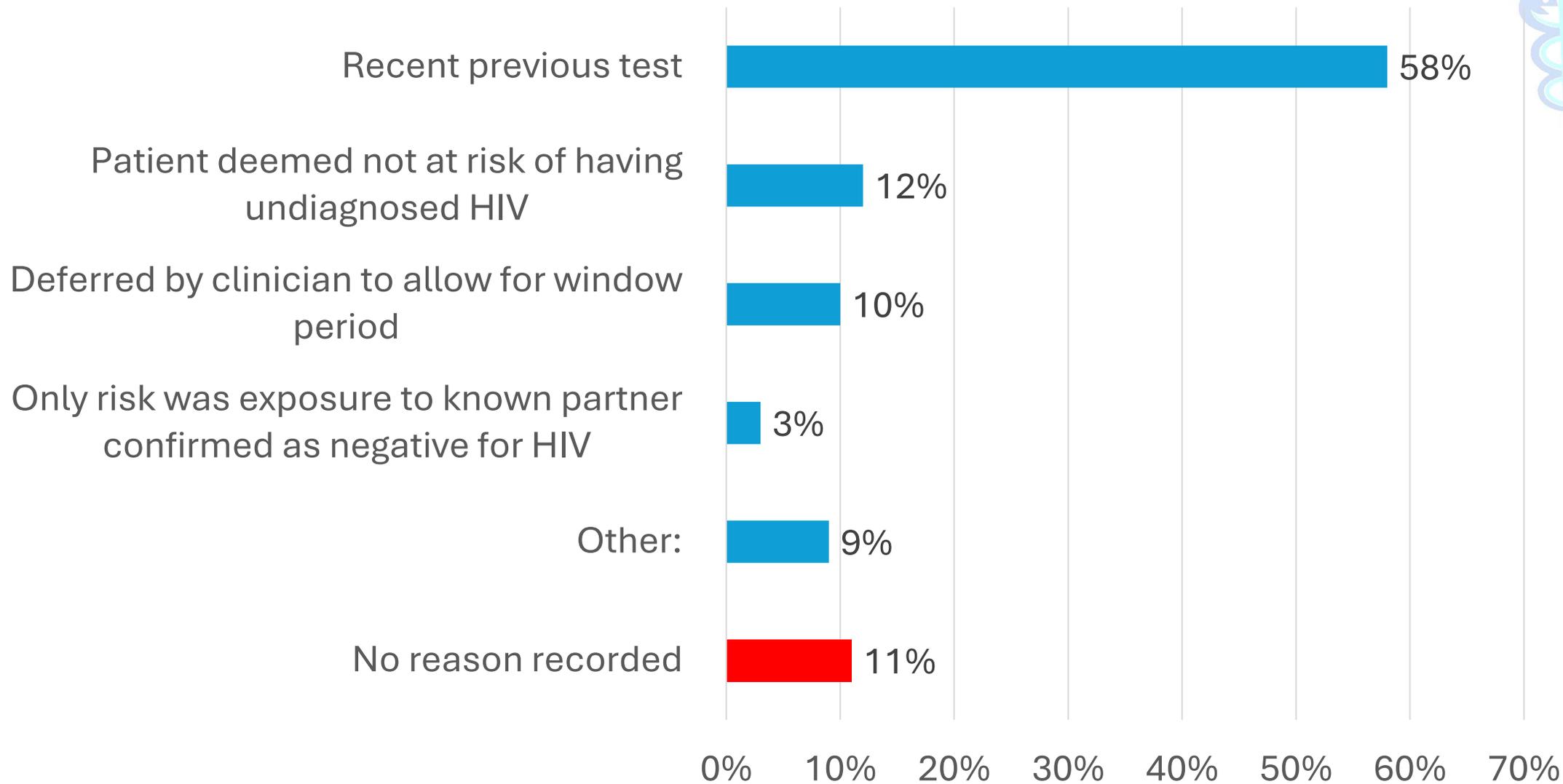
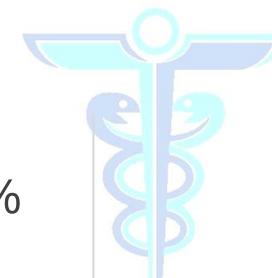
The reasons recorded for declining HIV testing

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The reasons recorded for why HIV testing was considered not appropriate

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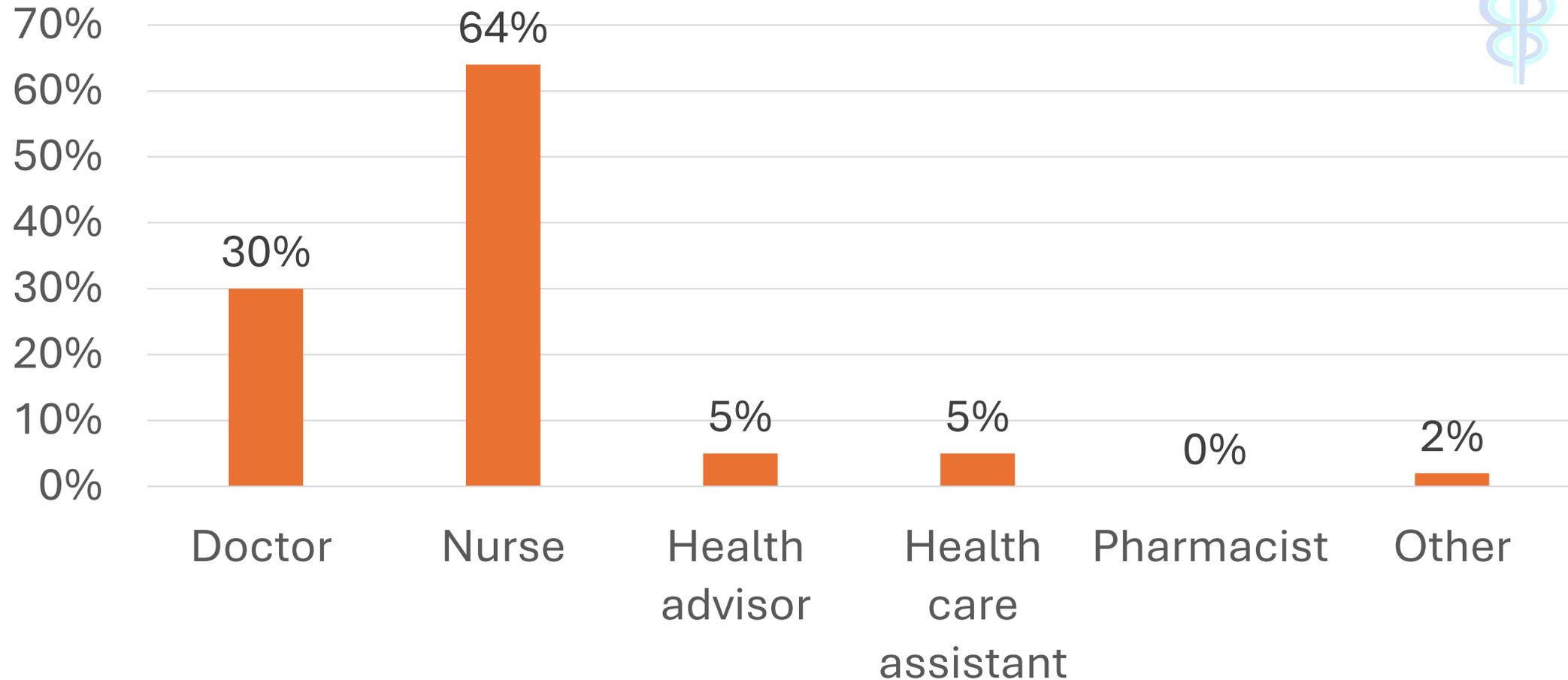
What SHHAPT code was recorded regarding HIV testing for the relevant episode of care

P1B HIV test offered and declined	55%*
P1C HIV test not appropriate	22%
REF3 Recent access to an online testing service	0.4%
None of the above	14%
Not applicable	7%
Not answered	1%

**There is a discrepancy apparent between what was recorded about HIV testing during the relevant episode of care and how it was coded for P1B, minimal noted for the others.*



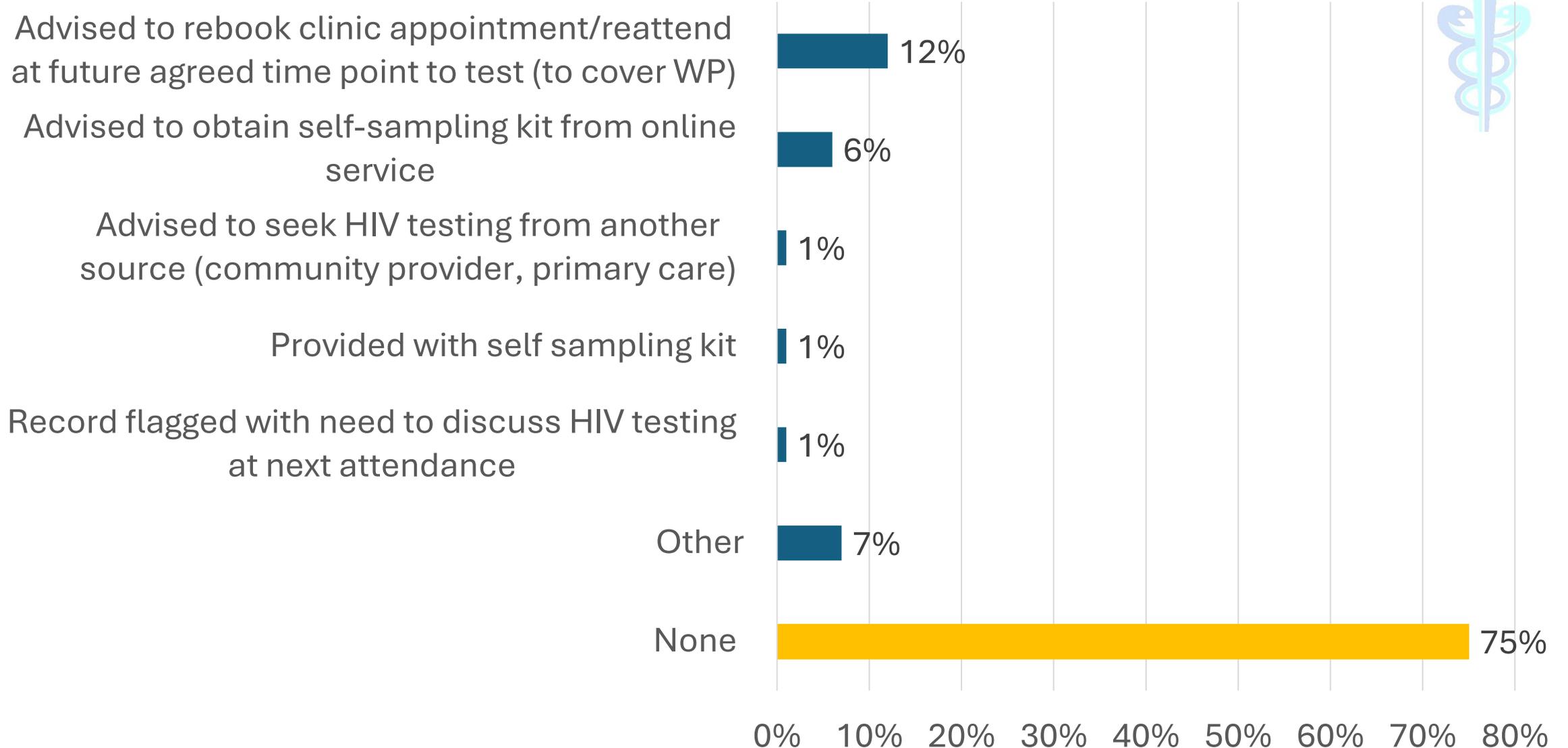
Which clinician(s) spoke with the individual during the face to face appointment



Other included; administration team (collecting postal kits), out reach workers, and nursing associate

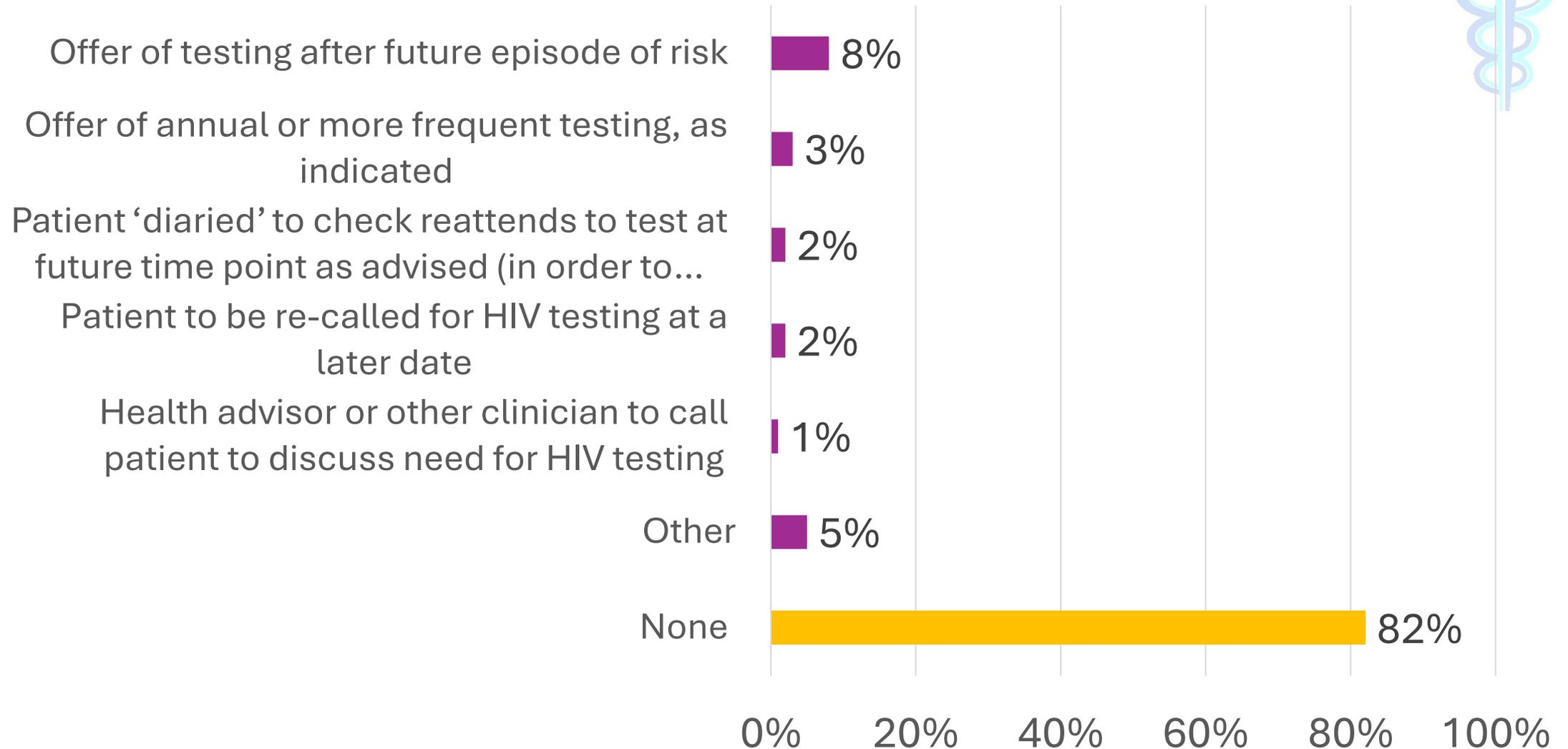
Documented actions undertaken relating to this episode of care (during the appointment or subsequently)

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Documented actions planned or recorded by the service in relation to HIV testing

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Key conclusions

- 86% of clinics will offer an HIV test to all patients regardless of risk or reason for attendance. As opt-out testing is being rolled out to A&E's, it was expected for this figure to be nearer 100%.
- Most services (99%) are able to undertake venepuncture in clinic, with two thirds able to provide fingerprick testing as well.
- Between 41-45% of services have policies in place for documenting the reasons why HIV testing is not offered, not appropriate or declined. Another 43-47% of services stated they usually document the reasons but this is not formal policy. However, 44% of cases did not have a reason recorded when the HIV test was declined.



Key conclusions

- Less than a quarter of services have processes in place to flag record of any GUM attender who declines for this to be discussed at the next attendance, advise the attender to seek testing from a community/voluntary provider, and regularly review uptake and reasons for not testing for HIV in MDT or similar. This was reflected in the casenote survey, with three quarters of attenders having no documented actions relating to the episode of care with regards to HIV testing.
- 81% of services have regular internal reports / KPIs on HIV testing performance. 78% regularly review HIV testing uptake among GUM attenders and 65% have KPIs for improving the uptake of HIV testing.
- In just under two thirds (62%) of cases, the individual declined a HIV test, with the most common reason recorded as they did not think they'd been at risk (19%), followed by needle phobia/declined blood test (15%) or just had a recent test (13%). In 22% of cases HIV testing was not considered appropriate by the clinician due to a recent previous test (58%), deemed not at risk (12%) and deferred to allow for window period (10%).

Recommendations

- All services to review HIV testing pathway with an aim to strengthening internal processes.
 - Consider review of barriers to implementation and address any gaps between expected and actual testing rates.
 - If not in place - develop formal policies regarding declining tests, including discussing declined tests at the next visit, alternative on-site testing options and community voluntary sector testing options.
 - Consider implementing electronic prompts to ensure reasons to declining HIV tests is recorded in all cases.
- Expand internal KPIs to regularly review HIV testing data and establish clear targets for improving uptake.
- Embed consistent messaging re: HIV testing within staff CPD and new staff induction.
- Encourage proactive discussions around HIV testing at each attendance.
- Develop targeted patient education materials to address misconceptions about HIV risk and testing.



Acknowledgements

Thank you to everyone who participated in the audit

National Audit Group: V Apea (Chair), N Astill, S Aung, M Bandara, J Bassett, A Blume, E Buitendam, S Davies, L Goodall, D Lebari, E Mccarty, K Michie, R Omer, N Pal, H Pollitt, M Ramogi, M Richardson, C Slater, A Sullivan, M Symonds, S Thomas, R Viney, S Warren, S Wielding, and H Wiggins