HIV testing: Increasing the uptake of HIV testing among people at higher risk of exposure

NICE National Institute for Health and Care Excellence

Consultation on draft guideline – deadline for comments 5pm on 15/06/16 **email:** HIVtesting@nice.nhs.uk

	Please read the checklist for submitting comments at the end of this form. We cannot accept forms that are not filled in correctly. We would like to hear your views on the draft recommendations presented in the guideline and any comments you may have on the evidence reviews. We would also welcome views on the Equality Impact Assessment and economic report. We would like to hear your views on these questions: 1. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. 2. Would implementation of any of the draft recommendations have significant cost implications? 3. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice. **4.Do you think there will be a significant resource impact when implementing recommendations 1.2.1 (POCT) and 1.2.3 (Self-sampling)?:** If yes, NICE would like to undertake some additional work to estimate the resource implications and would like any data or information you have on the following: 4a. What is current practice (i.e. traditional testing via healthcare workers in clinics) and what will change by implementing the recommendations 4b. How this will increase numbers of tests offered including how many self-sampling kits may be taken and returned 4c. Unit costs of tests (both) or equipment/healthcare worker who would deliver/time to deliver test (POCT) 4d. Results i.e. proportion diagnosed with HIV, or increases in early diagnosis 4e. Estimated treatment costs and potential savings from early diagnosis. See section 3.9 of Developing NICE guidance: how to get involved for suggestions of general points to think about when commenting.

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Organisation name – Stakeholder or respondent (if you are responding as an individual rather than a registered stakeholder please leave blank):	Association of Directors of Public Health
Disclosure Please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry.	NA
Name of commentator person completing form:	Rulan Chatrath
Type	[office use only]

Comment number	**Document** (**full** version, **short** version or the **appendices**)	**Page number** Or **'general'** for comments on the whole document	**Line number** Or **'general'** for comments on the whole document	**Comments** Insert each comment in a new row. Do not paste other tables into this table, because your comments could get lost – type directly into this table.
1	Full	5	3	Need to be clear re tuberculosis services – is the expectation that everyone (even those with latent TB) should have an HIV test? Current practice is that people with active TB would be offered a test. If the former is expected, it needs to be clear (and the associated evidence base quoted).
2	Full	5	5-25	First bullet - high prevalence needs to be defined. It is suggested that in this bullet we are talking about high prevalence in the UK. However, the third bullet is then confusing "Is known to be from a country or community with a high prevalence of HIV" – this bullet needs to be clearer – which countries/communities? Also in bullet regarding high risk sexual practices, it is important to define these. The bullet that suggests anyone disclosing they have changed a sexual partner, is there evidence to support this? Men who have sex with men – PHE recommend testing every 3 months – but this guidance suggests only testing if a test has not been done in the last year. Missing groups = sex workers? Female contacts of men who have sex with men (these are in the UK National HIV testing

				guidelines) We particularly appreciate the updated and new recommendations on repeat testing for HIV; and the recommendation of an HIV test for all hospital admissions in high prevalence areas. However, there are reservations about testing everyone who attends hospital and is having blood tests and who lives in a high prevalence area. This isn't practical at the level of the catchment population of a hospital. This was looked into in Watford, and huge variation was found in prevalence across the hospital's catchment despite prevalence looking high on average. This could do with some qualification – based on age, or something more specific. Do we really want to test every elderly person going into hospital? This isn't much of an issue at the GP practice level where the catchments are smaller, but it is the same issue.
3	Full	6	28-29	What evidence is there for the effectiveness/cost effectiveness of community testing services at PSE sites, in third sector provider premises etc. A PHE evidence briefing suggested that community testing of this nature tended to exceed cost effectiveness thresholds, although it may have been more effective in some circumstances.
4	Full	7	22-24	"about the relatively poor specificity and sensitivity of POCT and the 24 need for confirmatory serological testing." This needs rephrasing, as many of the POCTs these days are quite sensitive and specific 3 months after exposure. What is more important is explaining the window period and getting individuals to test again (as per 1.2.7) Self-sampling provision – what evidence supports this?
5	Full	8	14-17	An expansion of the offer of a HIV test to more people in more settings is welcome, but it is important to be really clear about the frequency of testing and for which groups.
6	Full	9	16-18	"detail how and where to access local HIV testing services, including 17 services offering POCT and self-sampling, and sexual health clinics (where people do not have to give their real name)" It isn't helpful to tell people that they don't have to give their real name in GUM clinics – this is likely to reinforce stigma associated with HIV and STIs. Talking about privacy and confidentiality is fine.
7	Full	11	1-21	Previous comments. Also – people with negative tests need to know where they can get a full STI screen.
8	Full	15	General	According to the HIV in UK report 2015, 17% overall not 24% of people with HIV are estimated to be unaware of their diagnosis.
9	Full	16	General	It is noted that the Committee notes that the BHIVA testing guidelines still stand (with the exception of some of the HIV clinical indicator conditions), but this is not consistent with the risk groups identified in this guidance earlier (1.1.4 and 1.1.5). It may be that

				NICE evidence has suggested changes to the risk groups? If not then they should be the same?
10	Full	17	General	The change of definition of high prevalence is interesting (which needs to be higher in the guidance) 4/1000 population. How was this arrived at? Also – although it is noted that GPs may not have time to offer tests in their appointments - Warwickshire are doing testing in practices, where nurses and HCAs do during registration checks. Haringey GPs do opportunistic testing
11	Full	General		The inclusion of the latest information and evidence of new HIV testing technologies and platforms, enabling more people to be tested by clinical staff, allied professionals, outreach workers, and by people themselves; through self-sampling testing kits is well-timed. However, there are multiple references to self-testing in the document. It isn't clear whether this means postal requested tests as opposed to taking your own sample face to face with a practitioner.
12	Full	1		The guidance states it is focused on people who live in areas or communities with a high prevalence – however, even in areas of relatively low prevalence elements of this guidance is very helpful and applicable and colleagues could certainly be implementing some of the recommendations.
13	Full	General		We welcome the new NICE guidance on increasing the uptake of HIV testing, which combines and updates PH33 (AFC) and PH34 (MSM) – there was duplication across these two guidelines previously, so bringing them together streamlines the action needed to increase HIV testing within these and other communities. The recommendations are themselves very clear and the new updates provide that extra clarity. We value the inclusion of digital platforms not only to promote HIV testing but also to encourage health seeking behaviour and system wide and individual behaviour change. However, the ones around secondary and emergency care and GPs may be quite hard to implement – and I wonder whether CCGs and NHS England (as Commissioners of these services) will see that they have a major role to play in ensuring implementation of these recommendations. The Commissioners will need to write it into contracts with KPI's. Perhaps their role could be highlighted, and joint working with LA public health and local sexual health services recommended. Examples of good practice would also be useful.
14	Full	7	20-27	The consultation asks specifically about whether there will be significant resource impact for implementing recommendations 1.2.1 (POCT), and 1.2.3 (self-sampling). From a low prevalence area point of view (North Yorkshire), these services are already provided as per the recommendations as part of a contract with the integrated sexual health service; therefore, there wouldn't be a significant resource impact within North Yorkshire. However, we would welcome a cost-calculator that would provide Local Authorities with the means to plan for implementation and provide crucial information on the cost implications of fully

				implementing these guidelines.
15	Full	6 7	28-29 22-24	It is important to consider extending access to HIV testing in rural areas and populations and in particular reaching at risk MSM groups who do not identify openly as "gay" men in their often small communities. Testing models in public sex environments are important in this case (6:28-29) as are access to online HIV home testing and sampling models (7: 22-24).

Insert extra rows as needed

Checklist for submitting comments

- Use this comment form and submit it as a Word document (not a PDF).
- Complete the disclosure about links with, or funding from, the tobacco industry.
- Include page and line number (not section number) of the text each comment is about.
- Combine all comments from your organisation into 1 response. We cannot accept more than 1 response from each organisation.
- Do not paste other tables into this table – type directly into the table.
- Underline and highlight any confidential information or other material that you do not wish to be made public.
- Do not include medical information about yourself or another person from which you or the person could be identified.
- Spell out any abbreviations you use
- For copyright reasons, comment forms do not include attachments such as research articles, letters or leaflets (for copyright reasons). We return comments forms that have attachments without reading them. The stakeholder may resubmit the form without attachments, but it must be received by the deadline.

You can see any guidance that we have produced on topics related to this guideline by checking NICE Pathways.

Note: We reserve the right to summarise and edit comments received during consultations, or not to publish them at all, if we consider the comments are too long, or publication would be unlawful or otherwise inappropriate.

Comments received during our consultations are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the comments we received, and are not endorsed by NICE, its officers or advisory Committees.