March 2013

TRANSFORMING THE UK'S RESPONSE TO HIV

NAT

COMMISSIONING HIV TESTING SERVICES IN ENGLAND

A practical guide for Commissioners

Developed as part of the Halve It campaign

Halve It

EARLY TESTING SAVES LIVES

Contents

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FOREWORD

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

It is now understood that we need effective HIV testing with linkage to high quality HIV care in place if we are to have a real impact on the HIV epidemic. Getting HIV testing right will reduce late HIV diagnosis and this has multiple benefits. People with HIV will be able to maximise the positive impact of treatment and care, and live longer, healthy and productive lives. There will also be a reduction in HIV transmission as those diagnosed with HIV take steps to reduce their risk behaviours and commence anti-retroviral treatment, which significantly reduces their infectiousness. We know that the majority of new HIV transmissions in England are from people who are undiagnosed. Reducing the prevalence of undiagnosed HIV infection is therefore a public health priority, and HIV testing is our most effective tool to meet this challenge.

The prevalence and substantial individual and societal costs of late HIV diagnosis explain its inclusion as a key indicator in the Public Health Outcomes Framework. It is still the case that nearly half of people diagnosed with HIV in England are diagnosed late - after the point at which they should have started treatment and a number of years since they were infected. We still have much to do and we can do better. Public Health England has identified HIV and Sexual Health as a health impact priority. We are committed to working with partners across the system to accelerate our collective progress towards reducing new HIV infections and improving the health and wellbeing of those living with HIV. Key among our priorities will be to encourage system-wide scale up of HIV testing and linkage to care among those at greatest risk while ensuring that everyone is informed and empowered to take steps to prevent HIV.

This toolkit on the commissioning of HIV testing services, developed by NAT (National AIDS Trust), will make a welcome contribution to further developing our HIV testing and reducing local late diagnosis rates. I heartily commend it to the attention of all commissioning bodies. I say ‘all’ advisedly. The new NHS and Public Health architecture has at its heart a vision of collaboration and complementarity between different parts of the health system. HIV testing is the responsibility of local authorities, of Clinical Commissioning Groups and of the NHS Commissioning Board. This 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. This toolkit both signposts commissioners to the wide and rich range of data held by Public Health England on HIV testing and diagnosis, and also gives case studies of HIV testing initiatives which have been successful and are worth considering. It is good to hear that NAT plans to refresh this toolkit on a regular basis to ensure newer examples of best practice, as well as up-to-date evidence and data, are included in the resource. 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 numbers of people with HIV who are diagnosed late.

HOW THIS TOO

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 in the new system

From April 2013 responsibilities for the commissioning of HIV testing are shared amongst 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
- commission to a shared vision of need and a shared strategic approach.

The table at Appendix 2 sets out the commissioning (and related policy and planning) structure for HIV testing services.

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. It reflects the commissioning cycle (figure 2) 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 assessing need, identifying best practice and relevant evidence and reviewing current practice to identify gaps.

Section D helps the commissioner to develop high level outcomes to act as a driver to improve health. Section E asks commissioners to think about evaluation of the quality, efficiency and effectiveness of the services commissioned before they are commissioned rather than after, in order to identify the right information that will be needed in a formal evaluation. Section F asks for an appropriate data set to be formulated in order to collect the right information on both patients and services.

OLKIT WORKS

Figure 1
The ABC Commissioning For Outcomes Model

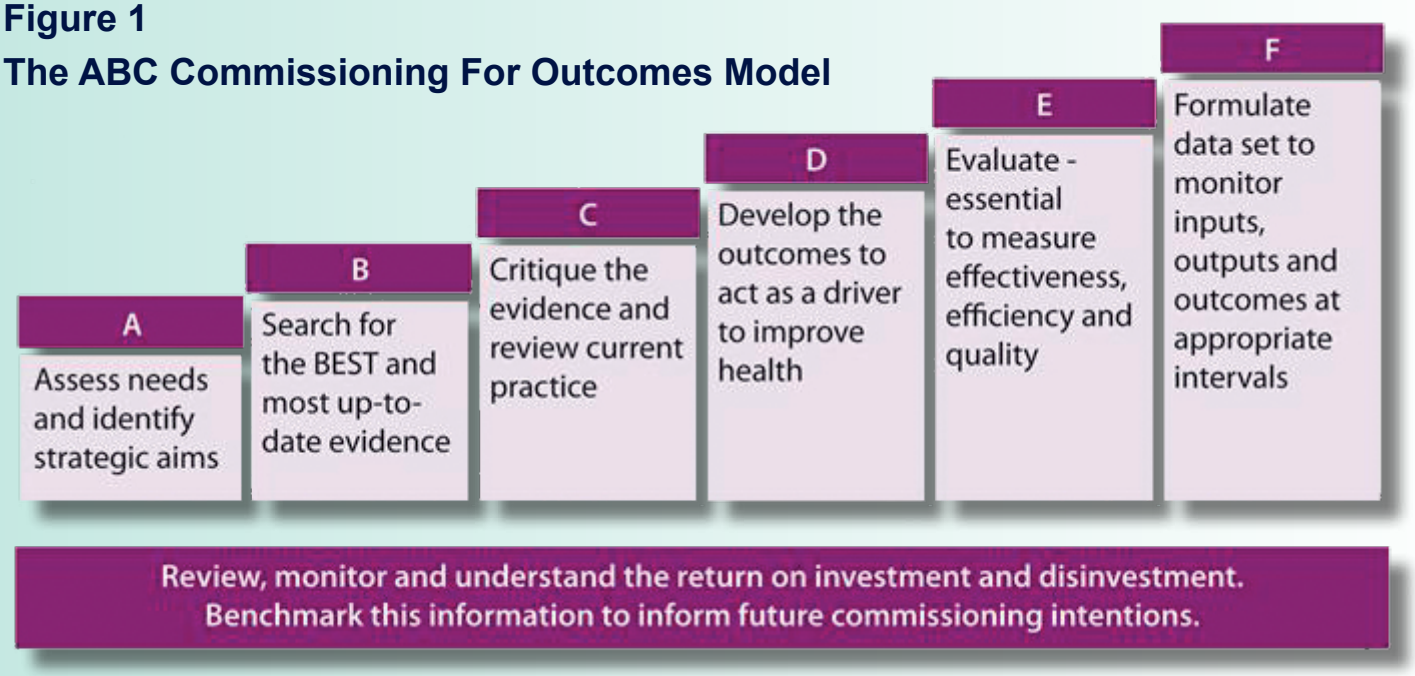
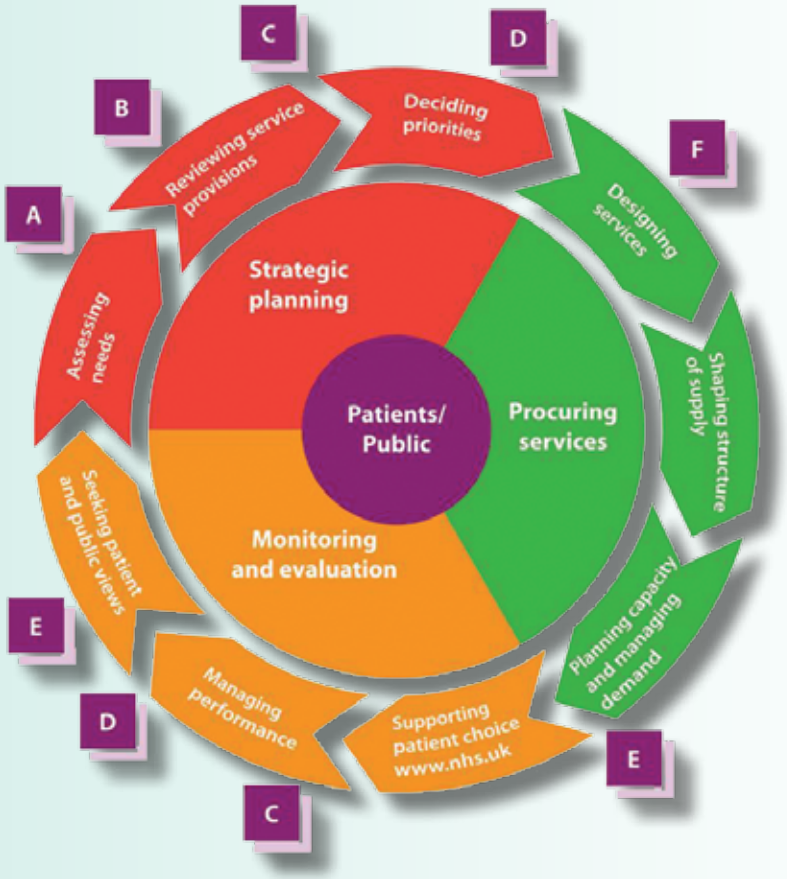


Figure 2
The Commissioning Cycle



HIV TESTING IS

Why effective commissioning of HIV testing is essential

To prevent further infections

Diagnosing those with HIV promptly has a significant role in reducing the spread of HIV in the local population. Most HIV transmissions are from people with HIV who are as yet undiagnosed, so reducing this undiagnosed fraction is an important HIV prevention strategy.

- Currently around a quarter of people with HIV in the UK don't know they have it, and research estimates that it is this undiagnosed minority who are responsible for around 50% of new infections.[2-3]
- According to the HPA, about two-thirds of the MSM with HIV in the UK who are deemed to be infectious are undiagnosed.[4]

Earlier HIV diagnosis reduces onward transmission of HIV among the population.

This is because:

- People tend to adapt sexual behaviours to reduce risk following diagnosis.[5]
- Effective treatment significantly reduces transmission risk (see 'Position statement on the use of antiretroviral therapy to reduce HIV transmission BHIVA/EAGA' January 2013).[6]

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 a significant proportion of HIV transmissions take place during this period.

S ESSENTIAL

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

In 2011 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/mm^3). Being diagnosed late is on average equivalent to having had HIV without knowing it for at least five years.[7]

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.[8]

- Late HIV diagnosis is strongly linked to increased rates of morbidity, chronic illness and hospital admission.[9-10]
- Late diagnosis (CD4 cell count <350 cells/mm^3) leaves an individual ten times more likely to die within a year of diagnosis.
- Two thirds of those with HIV who died in 2010 were diagnosed late.[11]
- An individual diagnosed very late (CD4 <200 cells/mm^3) with HIV is thought to have a life expectancy at least ten years shorter than somebody who starts treatment at CD4 350 cells/mm^3.[12]

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/mm^3 (Indicator 3.4).

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,
- sickness absence,
- self-reported well-being,
- mortality from causes considered preventable,
- mortality from all cardiovascular diseases,
- mortality from cancer,
- mortality from liver disease, and
- mortality from respiratory diseases (late HIV diagnosis increases risk of mortality for all these specific conditions).

HIV TESTING IS

The NHS Outcomes Framework is also relevant since indicators include 'preventing people from dying prematurely', 'health-related quality of life for people with long-term conditions', 'employment of people with long-term conditions' and 'emergency admissions for acute conditions that should not usually require hospital admission'[13]. HIV is a long-term condition and 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 the HPA, "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"[14].
- 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.[15]
- 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.[16]
- NICE also estimate 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.[17]
- Reduced rates of late diagnosis (and therefore chronic illness or morbidity) will reduce 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.[18]

S ESSENTIAL

To reduce health inequalities

The NHS Commissioning Board 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. The HPA reported in 2011 that HIV prevalence is 30 times higher in these two groups than in the general population.[19] 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 2011 was at 68% and amongst black African women was 61%, compared with the overall average of 47%.[20]

The most deprived areas of the country also have the highest HIV prevalence.[21]

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.

A ASSESS

Much essential HIV data information for your local authority area can be provided by Public Health England (PHE) - a key source of evidence and expertise. As of April 2013 Public Health England will take over relevant functions previously undertaken by the Health Protection Agency (HPA). There will be 15 local Public Health England Centres (PHECs) distributed in four regions. Whilst we refer in this toolkit to Public Health England it is probable during this process of transition that some of the resources and links cited still refer to the HPA.

Key online resources include:
Diagnosed HIV prevalence in Local Authorities (LAs) in England, 2011

Local authorities in England where the prevalence of diagnosed HIV infection exceeded two adults per 1,000 population (aged 15-59 years) in 2011

Sexual Health Profiles Performance Map for late HIV diagnosis

More detailed breakdown of data within your local authority area can be accessed by talking with your regional and local PHECs: HPA – Local Services

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

Questions to consider

Do you know the rate of late diagnosis (CD4 cell count <350 cells/mm^3) and very late diagnosis (CD4 <200 cells/mm^3) in your local area, and how they compare with national and regional averages?

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.

Do GPs and acute medicine clinicians in your local area know the symptoms of primary HIV infection and why it is important to make a diagnosis at this early stage of infection?

S NEED

In some lower prevalence areas (i.e. less than 2 per 1000 diagnosed with HIV) late diagnosis rates may not be statistically significant (see the HPA Sexual Health Profiles Performance Map). 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/mm^3) which often involves failures in local health services offering an HIV test at earlier presentations.

Do you understand the specific geographical and community HIV testing needs in your local area for example:

- Variations in HIV prevalence between Middle Super Output Areas (MSOA) within your local authority area?

- For a given MSOA where HIV prevalence is higher than 2 per 1,000, do you know which groups such as gay and bisexual men/ African & Caribbean communities and/or people who inject drugs represent those with the highest levels of HIV?

Do you know where your local residents are testing for HIV and where people are being diagnosed HIV positive?

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

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 and in the Joint Health and Wellbeing Strategy (JHWS)?

More detail on assessing need can be found in the Appendix to this Toolkit

B CONSIDER B

Best evidence for the testing and diagnosis of people with HIV

Consider best evidence including:

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

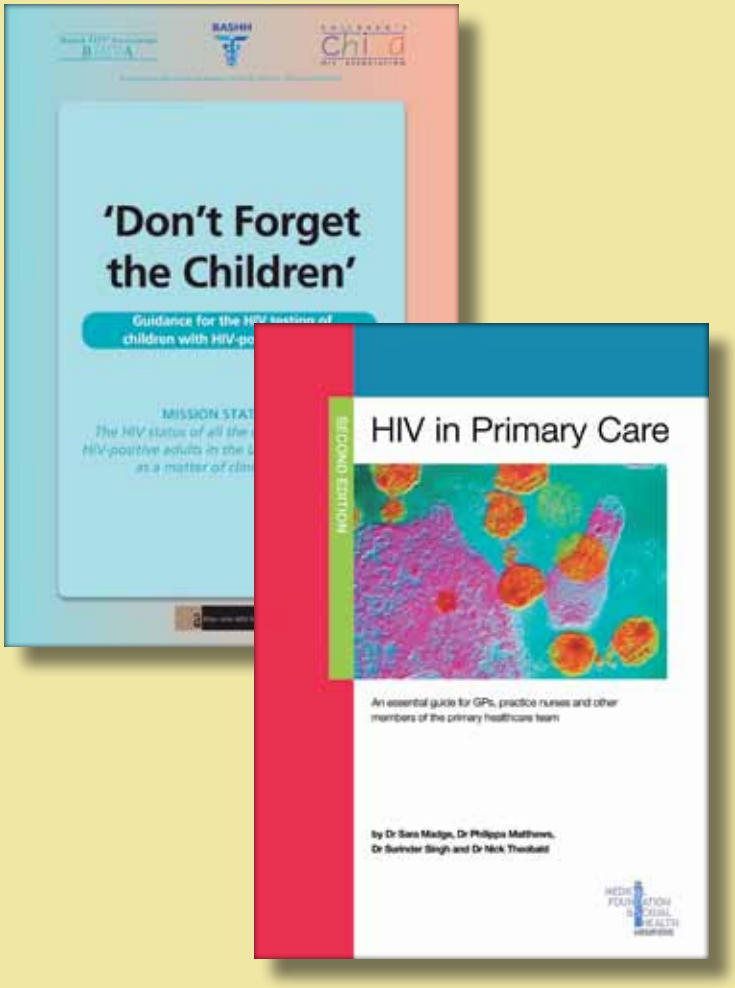
Public Health England resources on implementing national HIV testing guidance

- HPA: Time to Test for HIV: Expanded healthcare and community HIV testing in England, Sept 2011.
- HPA: Evidence and resources to commission expanded HIV testing in priority medical services in high prevalence areas, April 2012

BEST EVIDENCE

Other guidance with content on HIV testing

- BHIVA: Standards of Care for People Living with HIV 2013, December 2012
- 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.
- UK National Screening Committee: Infectious Diseases in Pregnancy Screening Programme - Programme Standards, Sept 2010.
- BASHH: 2012 Partner Notification statement, July 2012.
- BASHH/MEDFASH: Standards for the management of STIs, Jan 2010.
- BHIVA/CHIVA 'Don't forget the children' - Guidance for the HIV testing of children with HIV positive parents, July 2009.
- MEDFASH Standards for psychological support for adults living with HIV, Nov 2011.



Resources for primary and secondary care clinicians on HIV testing

- MEDFASH: HIV in Primary Care, May 2011.
- MEDFASH: HIV for non-HIV specialists, 2008.
- MEDFASH: Tackling HIV testing: increasing detection and diagnosis, Oct 2009.

C REVIEW CURR

Consider the following questions and actions when reviewing services:

What lessons for HIV testing and diagnosis are being learned from look-backs for those diagnosed very late (CD4 <200 cells/mm^3)? Are such look-backs happening as recommended in the BHIVA Standards of Care?

What can you learn for HIV testing services from relevant stakeholders, users and professionals, from existing evaluation reports, and from communities most at risk of HIV? Can you reflect on positive and negative feedback on services, identified barriers to testing, for example?

Have providers achieved agreed inputs, outputs and outcomes as outlined in service specifications?

Access to care

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

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

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?

RENT PRACTICE

Sexual health clinics

Do your local residents have access to a sexual health clinic within 48 hours of contacting the service?

Are all sexual health clinics in your area offering on an opt-out basis an HIV test to all attendees not previously diagnosed HIV positive? Is the offer and uptake of testing being audited within each service?

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

Are all patients newly diagnosed with HIV having a discussion of partner notification within 4 weeks of diagnosis, with an update on outcomes/progress at 12 weeks from diagnosis?

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?

GPs

Are GP practices testing for HIV when clinically indicated and recommended according to national guidelines (see list of clinical indicator conditions as recommended by UK National Guidelines for HIV Testing?)

Are GP practices offering HIV tests to MSM and to people from African communities as recommended in NICE public health guidance?

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?

Secondary care services

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

Are secondary care specialties which treat clinical indicator conditions for HIV routinely testing for HIV as recommended by UK National Guidelines for HIV Testing?

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?

Healthcare professional training

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

Community testing services

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)?

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?

Effective commissioning

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?

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

More detail on reviewing current practice can be found in the Appendix to this Toolkit

D DEVELOP OUTCOMES

Develop outcomes to act as a driver to improve health

Examples of high-level outcomes are:

- Reduction in local late (and/or very late) HIV diagnosis rate (this should also have a preventive benefit over time) - data can be found in the Sexual Health Profiles Performance Map for late HIV diagnosis and in the Public Health Outcomes Framework Data Tool
- Reduction in local late diagnosis rate in specific communities with significantly poor late diagnosis rates - local data on MSM, women and heterosexual men can be found in the relevant Sexual Health Profiles Performance Maps
- Reduction in hospitalisation for HIV-related causes
- Increase in proportion of people from most at risk communities who have tested for HIV in the previous 12 months
- Reduction in HIV-related deaths
- Increase in proportion of people with HIV in employment.

Each service will have more process and outcome measures that are not indicated here.

E EVALUATE LO
HIV TESTING

To evaluate local HIV testing, consider the collection of data in the following format

Pre-implementation (ensure you have the right data set and it is agreed before starting)

Implementation (ensure that the data set is being collected, reported and reviewed continuously)

Post-implementation (identify an appropriate time to evaluate the service/ programme).

Minimum areas for evaluation should be:

- Effectiveness (the outcomes)
- Efficiency (number of HIV tests/HIV positive diagnoses and proportion of those diagnosed HIV positive who are promptly linked into care)
- Quality (service user/community experience and satisfaction, HIV testing accuracy).

FEEDBACK AND EXPERIENCES

We want to hear your experiences of commissioning or delivering HIV testing services.

We would also value your feedback on this resource so we can continue to improve it. Please click here or visit www.nat.org.uk/cge.aspx for a brief evaluation and feedback form - your views and experiences make a real difference.

OCAL

Effectiveness/outcomes - see section D

Efficiency - examples below

- Number of people diagnosed with CD4 count below 350, as a proportion of all diagnosed
- Number of people diagnosed with CD4 count below 200, as a proportion of all diagnosed
- Number of HIV positive diagnoses in each setting, and as a proportion of HIV tests undertaken
- Number of people tested as a result of partner notification, as a proportion of identified contacts, and per index patient
- Number of people diagnosed with HIV linked into treatment and care within 2 weeks of a positive result.

Quality - some examples below, but see also section C

- Service user knowledge and satisfaction surveys
- Are all relevant staff up to date with recommended HIV testing guidelines?
- Are GP practices testing for HIV? (get data e.g. from laboratories or look-back exercises)
- Is there a clear and agreed pathway for post-diagnostic psychological support from services providing HIV testing? Are people newly diagnosed with HIV being offered appropriate psychological support as set out in Standard 4 of the Standards for psychological support for adults living with HIV?
- What in different settings and services are the average and range of times between performing an HIV test and the result being available to the patient? (BHIVA Standards of Care 2013 indicate within 48 hours as 'preferable').

F FORMULATE DATA SET

Formulate an appropriate data set

Data is key to driving improvements in care. It is essential that there is an appropriate data collection system built into the commissioning and procurement of services. To prevent duplication of data consider the following questions:

Have local services provided the PHE with relevant HIV testing and diagnosis data for all service users in the reporting period? (and are you aware of and using the data relevant to HIV testing and diagnosis which is meant to be reported to the PHE?)

Are secondary care specialties and GP practices which should be testing for HIV when people present with clinical indicator conditions providing information to their commissioners/the local authority on the proportion of those with the relevant clinical indicator condition who are tested for HIV, and the proportion of those tested who are found to be HIV positive?

What levers do you have to negotiate the information flow (e.g. will this be or is this in a service specification or contract)?

Endnotes

[1]For more information see 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, and the NICE Shared Learning database http://www.nice.org.uk/usingguidance/sharedlearningimplementingniceguidance/examplesofimplementation/eximpresults.jsp?o=384

[2]Health Protection Agency: HIV in the United Kingdom: 2011 Report, 2011.

[3]Marks G, Crepax N, Janssen RS: '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, 2006.

[4]Brown A, Delpech V, Presanis A, Murphy G, Gill N: 'The threshold for an ART secondary prevention effect on HIV transmission among MSM has not been reached despite high treatment uptake', presentation at HPA Conference, Warwick University, 2012.

[5]NAM: Preventing HIV, London, 2008; Fox J et al: 'Reductions in HIV transmission risk behaviour following diagnosis of primary HIV infection: a cohort of high-risk men who have sex with men', HIV Medicine, vol. 10, 2009.

[6]Position statement on the use of antiretroviral therapy to reduce HIV transmission BHIVA/EAGA January 2013

[7]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.

[8]UK CHIC: 'Impact of late diagnosis and treatment on life expectancy in people with HIV-1: UK Collaborative HIV Cohort (UK CHIC) Study', BMJ, 2011; 343:d606

[9]HPA: Evidence and resources to commission expanded HIV testing in priority medical services in high prevalence areas, Colindale, 2011.

[10]Stockle M, Elzi L, Rockstroh JH, Battegay M: 'Morbidity and mortality in HIV infection', Internist (Berl), 2012; Antinori, A. et al. 2011. Late presentation of HIV infection: a consensus definition'. HIV Medicine, 12(1), pp.61-64

[11]HPA: 'HIV in the United Kingdom:2011 Report' Colindale, 2010.

[12]UK CHIC: 'Impact of late diagnosis and treatment on life expectancy in people with HIV-1: UK Collaborative HIV Cohort (UK CHIC) Study', BMJ, 2011;343:d606

[13]NHS: The NHS Outcomes Framework 2013-14 2012

[14]HPA: Evidence and resources to commission expanded HIV testing in priority medical services in high prevalence areas, Colindale, 2011.

[15]NICE: 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, 2011.

[16]Ibid.

[17]Ibid

[18]NAT and THT: Poverty and HIV 2006-2009 p.16 2010

[19]Health Protection Agency: HIV in the United Kingdom: 2012 Report, 2012

[20]Ibid.

[21]Ibid.

Acknowledgements

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NAT remains solely responsible for the content of this HIV testing toolkit.

ELTON JOHN AIDS FOUNDATION

janssen

ViiV Healthcare

Abbreviations and acronyms

BASHH	British Association of Sexual Health and HIV
BHIVA	British HIV Association
CHIVA	Children's HIV Association
CQUIN	Commissioning for Quality and Innovation
EAGA	Expert Advisory Group on AIDS
HPA	Health Protection Agency
JHWS	Joint Health and Well-being Strategy
JSNA	Joint Strategic Needs Assessment
MEDFASH	Medical Foundation for HIV and Sexual Health
MSM	Men who have Sex with Men
MSOA	Middle Super Output Area
NAT	National AIDS Trust
NHS CB	NHS Commissioning Board
NICE	National Institute for Health and Clinical Excellence
PHE	Public Health England
PHEC	Public Health England Centre
PN	Partner notification
POCT	Point of Care Test
PYFU	Person-years of follow-up
SHIP	Sexual Health in Practice training
THT	Terrence Higgins Trust

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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.

TRANSFORMING THE UK'S RESPONSE TO HIV

NAT

SHAPING ATTITUDES
CHALLENGING INJUSTICE
CHANGING LIVES

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.

WWW.NAT.ORG.UK

www.lifewithHIV.org.uk – a resource for HIV positive people
www.HIVaware.org.uk – what everyone should know about HIV

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