Whittington Health NHS

HIV Testing and Referral
Clinical Guideline

Subject:	HIV Testing and Referral
Policy Number	IPC/Micro 20
Ratified By:	Clinical Guidelines Committee
Date Ratified:	Original (Jan 2011) update reviewed by the IPCC
Version:	2
Policy Executive Owner:	Dr Richard Jennings
Designation of Author:	Consultant, Infectious Diseases & Acute Medicine and Divisional Director of ICAM
Name of Assurance Committee:	Infection Prevention and Control Committee
Date Issued:	January 2014
Review Date:	January 2017
Target Audience:	Doctors, Nurses, Pharmacists, Laboratory Scientists
Key Words:	HIV, HIV testing, Sexually Transmitted Infection, STI, Immunocompromise, Screening

Version Control Sheet

Version	Date	Author	Status	Comment
1	January 2011	Dr Richard Jennings	In-active	
2	August 2013	Dr Richard Jennings	Draft	New template, minor changes to email addresses, addition of references and policy monitoring tool. Not issued.
2	December 2013	Dr Ben Killingley	Active	Updating of contact details, addition relating to Donor testing

➢ Criteria for Use

This guideline is applicable to adult patients (16 years and over), both inpatients and outpatients.

- It lists those patients who should be offered a test for HIV (this list is not exclusive – any patient can be offered a test for HIV).
- It outlines the essential pre-test counselling and documentation that it is required.
- It explains how to refer HIV positive patients on to specialist HIV services.

➢ Background/Introduction

The prevalence of HIV in the local communities served by Whittington Health is among the highest in the UK (an estimated 8.1 per 1000 people in Islington, and 6.6 per 1000 people in Haringey are HIV positive) (Ref 1).

The two largest groups at risk of HIV infection are men who have sex with men (MSM) and people from high prevalence countries (mainly sub-Saharan Africa) (Ref 3).

Statistically, in the UK, black African people are forty times more likely to be HIV positive than white British people (Ref 2).

Approximately one-third of people with HIV in the UK are undiagnosed (Ref 4, 5). Undiagnosed patients present late, with severe complications of HIV infection. Late presentation is one of the most important causes of death in HIV positive patients, accounting for approximately one-third of HIV-attributable deaths (Ref 6). These deaths are preventable with earlier diagnosis.

The burden of late diagnosis falls disproportionately heavily on patients from high-prevalence countries (mainly sub-Saharan Africa) – 42% of black African patients are not diagnosed until HIV treatment should already have been started (Ref 2).

National and local audits, including audit at Whittington Health, show that many patients who are eventually diagnosed with HIV have had multiple previous healthcare contacts in which demographic or clinical indicators for HIV testing were missed by healthcare workers.

Diagnosing the undiagnosed is a key way in which individual patient's prognoses can be improved, and HIV transmission in the community can be reduced.

➢ Inclusion/Exclusion Criteria

The following patients should be offered a test for HIV:

1) **All patients from countries where the prevalence of HIV is >1%*.** These are (2010):

   - All of Sub-Saharan Africa
   - Thailand
   - Russia and the Ukraine

- Jamaica and the other Caribbean islands
- Guyana

2) **Men who have sex with men (MSM)**

3) **Intravenous Drug Users (IVDU)**

4) **All patients diagnosed with a sexually transmitted infection (STI)**

5) **Patients who have had sex with partners who are in the categories above, or with partners who have HIV**

6) **Patients with Clinical Indicator Diseases**

See Appendix 1 for a full list of Indicator Diseases.

Important ones to remember are:

- Bacterial Pneumonia
- Tuberculosis
- Intracranial infection or space occupying lesion
- Unexplained dementia
- Unexplained chronic diarrhoea
- Unexplained chronic weight loss
- Hepatitis B or C infection
- Lymphoma
- Unexplained thrombocytopenia, neutropenia or lymphopenia
- Unexplained lymphadenopathy
- Mononucleosis-like syndrome (fever, sore throat, +/- rash, atypical lymphocytosis)

An up to date list of high-prevalence countries can be found at http://www.unaids.org/documents/20101123_2010_HIV_Prevalence_Map_em.pdf (Ref 7).

➢ Clinical Management: Pre-test Counselling and Communicating the HIV Result

Pre-test discussion.

The pre-test discussion should be documented in the notes: the content of the discussion and the patients consent or refusal to test should be recorded.

Written consent is not required.

The two issues that should always be discussed when offering a HIV test are:

- The benefit to the individual patient
- How the result will be communicated to the patient.

Any specific concerns that the patient raised must also be addressed.

In general, lengthy pre-test counselling is not necessary.

A sexual history need not be taken prior to HIV testing. The usefulness of a sexual history should be judged on a patient by patient basis. If the patient is being offered a HIV test because they come from a high-prevalence country, a sexual history is not independently necessary, and may be counter-productive.

Discussion about HIV testing are often a good opportunity to give safe sex advice at the same time.

A robust arrangement must always be in place to communicate the result to the patient who may have left hospital before the result if available.

➢ **Further information: Disclosing the Result, Testing Without Consent, Urgent Testing, Donor testing and Referral to Specialist HIV Services**

HIV TESTING WHEN CONSENT CANNOT BE OBTAINED

- If a patient lacks capacity to consent to HIV testing, either permanently or temporarily (for instance, because they are unconscious), HIV testing may be carried out where this is in the best interests of the patient. If the patient has appointed an attorney, or left a valid advance statement, these must inform the decision. Cases where HIV testing without consent is considered should be discussed with the consultant in charge, and with a Microbiology or Infectious Diseases Consultant.

URGENT HIV TESTING

- If the HIV test is clinically urgent, a result can be made available within a few hours and, if necessary, this can be done out of hours. All such cases must be discussed with the Microbiology SpR or Consultant on-call.

SUSPECTED ACUTE SERO-CONVERSION

- If the patient is suspected of having an acute HIV ser-conversion illness (for instance, a mononucleosis-like syndrome, with fever, sore throat, +/- rash, atypical lymphocytosis), this must be made clear on the HIV request form and discussed with the laboratory, as the choice of tests performed on the sample may be affected.

DONOR TESTING AFTER OCCUPATIONAL EXPOSURE TO BLOOD OR OTHER BODY FLUIDS

- HIV testing of a Donor (the source) involved in an occupational exposure to blood or other body fluids may be carried out with the consent of the Donor – see Policy for the management of occupational exposures to blood and other body fluids at http://whittnet/document.ashx?id=5802

REPEAT HIV TESTING

- Patients who have tested negative but who have had possible exposure to HIV in the previous 3-6 months (the "window-period", during which HIV infection may have occurred by the HIV test may not yet be positive).

- Men who have sex with men (who are advised to be tested once a year, or more often if potential exposure occurs).

- Intravenous Drug Users (who are advised to be tested once a year, or more often if potential exposure occurs).

DISCLOSURE OF THE HIV TEST RESULT

- Great care must be taken to maintain patient confidentiality at all times.

- Patients should be asked if they are willing for the HIV test to be disclosed to their General Practitioner, and the advantages of doing this should be explained to the patient.

- If the HIV test is positive, partner-notification should also be discussed with the patient. The timing and nature of the discussion will depend on the individual case. Such discussions should be documented and the relevant details should be included in the referral to HIV specialist ongoing care.

- Partners of HIV positive patients who themselves wish to be tested should be assisted to achieve this.

REFERRAL FOR HIV SPECIALIST CARE

- Newly diagnosed inpatients should be discussed at the time of diagnosis with either the Infectious Diseases Consultants (Dr Richard Jennings/Dr Ben Killingley) or a Microbiology Consultant.

- If urgent clinical advice is needed out of hours, or if inpatient transfer to the HIV team at UCLH is being considered, patients should be discussed with:

  09:00 – 21:00 The HIV SpR on-call at University College Hospital (UCLH), who can be contacted on 07908 439 891.

  21:00 – 09:00 The HIV Consultant on-call at UCLH, who can be contacted via the UCLH switchboard.

- **For all newly-diagnosed patients, a referral must be made for ongoing HIV outpatient care. <u>For inpatients, this referral must be made prior to discharge.</u>** If the patient is happy to be followed up at UCLH, then a written referral should be made to the UCLH HIV Team via email, at mmc-hiv.referral@nhs.net. In addition to the clinical details, the referral must include all the contact details, including the mobile number, that the patient is willing for the HIV team to use to contact them. Referrals should be copied to the Infectious Diseases Consultant, Dr Ben Killingley (ben.killingley@nhs.net)

➢ Contacts (inside and outside the Trust including out-of-hours contacts)

Infectious Diseases Consultants: Richard Jennings ext 3509 or via switch, Ben Killingley ext 4800 or via switch
Microbiology Consultant ext 3894/5082 or via switch
Microbiology SpR ext 5085 or bleep 3069
Microbiology Laboratory ext 5087
On-call Microbiology Laboratory Scientist Mob: 07911139159
UCLH HIV Registrar on-call 07908-439-891 09:00-21:00
UCLH HIV Consultant on –call – via UCLH switchboard
UCLH HIV Referral: mmc-hiv.referral@nhs.net

➢ References (evidence upon which the guideline is based)

Health Protection Report Volume 2 Number 38; 19 Sept 2008
Health Protection Agency; Sexually transmitted infections in black African and black Caribbean communities in the UK: Nov 2008 report
Health Protection Agency; HIV in the United Kingdom, 2009 Report
UK National Guidelines for HIV Testing 2008 http://www.bhiva.org/HIVTesting2008.aspx
Health Protection Agency (HPA), Centre for Infections. The UK Collaborative Group for HIV and STI Surveillance.
Testing Times. HIV and other sexually transmitted infections in the United Kingdom: 2007.
http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1203084355941
BHIVA Mortality Audit 2006
http://www.bhiva.org/documents/ClinicalAudit/FindingsandReports/MortalityAudit.ppt
http://www.unaids.org/documents/20101123_2010_HIV_Prevalence_Map_em.pdf
Increasing the uptake of HIV testing among men who have sex with men - NICE Public Health Guidance PH34 March 2011
http://publications.nice.org.uk/increasing-the-uptake-of-hiv-testing-to-reduce-undiagnosed-infection-and-prevent-transmission-among-ph34
Increasing the uptake of HIV testing among black African communities living in England - NICE Public Health Guidance PH33 March 2011
http://publications.nice.org.uk/increasing-the-uptake-of-hiv-testing-to-reduce-undiagnosed-infection-and-prevent-transmission-among-ph33

APPENDIX 1

Clinical Indicator Diseases for Adult HIV Infection

Respiratory

Tuberculosis
Bacterial pneumonia
Pneumocystis
Aspergillosis

Neurology

Cerebral toxoplasmosis
Aseptic meningitis /encephalitis
Primary cerebral lymphoma
Cerebral abscess
Cryptococcal meningitis
Space occupying lesion of unknown cause
Progressive multifocal leucoencephalopathy
Guillain Barré syndrome
Transverse myelitis
Peripheral neuropathy
Dementia
Leucoencephalopathy

Dermatology

Kaposi's sarcoma
Severe or recalcitrant seborrhoeic dermatitis
Severe or recalcitrant psoriasis
Multidermatomal or recurrent herpes zoster

Gastroenterology

Persistent cryptosporidiosis
Oral candidiasis
Oral hairy leukoplakia
Chronic diarrhoea of unknown cause
Weight loss of unknown cause
Salmonella, shigella or campylobacter
Hepatitis B infection
Hepatitis C infection

Oncology

Non-Hodgkin's lymphoma
Anal cancer or anal intraepithelial dysplasia
Lung cancer
Seminoma
Head and neck cancer
Hodgkin's lymphoma
Castleman's disease

Gynaecology

Cervical cancer
Vaginal intraepithelial neoplasia
Cervical intraepithelial neoplasia Grade 2 or above

Haematology

Any unexplained blood dyscrasia including:
• thrombocytopenia
• neutropenia
• lymphopenia

Ophthalmology

Cytomegalovirus retinitis
Infective retinal diseases including herpesviruses and toxoplasma
Any unexplained retinopathy

ENT

Lymphadenopathy of unknown cause
Chronic parotitis
Lymphoepithelial parotid cysts

Other

Mononucleosis-like syndrome (primary HIV infection)
Pyrexia of unknown origin
Any lymphadenopathy of unknown cause
Any sexually transmitted infection

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval

		Yes/No	Comments
1.	**Does the procedural document affect one group less or more favourably than another on the basis of:**		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	No	
4.	**Is the impact of the procedural document likely to be negative?**	No	
5.	**If so can the impact be avoided?**	N/A	
6.	**What alternatives are there to achieving the procedural document without the impact?**	N/A	
7.	**Can we reduce the impact by taking different action?**	N/A	

If you have identified a potential discriminatory impact of this procedural document, please refer it to the Director of Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact the Director of Human Resources.

Checklist for the Review and Approval of Procedural Document

To be completed and attached to any procedural document when submitted to the relevant committee for consideration and approval.

	Title of document being reviewed:	Yes/No	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Is it clear that the relevant people/groups have been involved in the development of the document?	Yes	
	Are people involved in the development?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
5.	**Evidence Base**		
	Are key references cited in full?	N/A	
	Are supporting documents referenced?	N/A	
6.	**Approval**		
	Does the document identify which committee/ group will approve it?	Yes	
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Yes	
8.	**Document Control**		
	Does the document identify where it will be held?	Yes	
9.	**Process to Monitor Compliance and Effectiveness**		

	Title of document being reviewed:	Yes/No	Comments
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Yes	
	Is there a plan to review or audit compliance with the document?	Yes	
10.	**Review Date**		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so is it acceptable?	Yes	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Yes	

Executive Sponsor Approval			
If you approve the document, please sign and date it and forward to the author. Procedural documents will not be forwarded for ratification without Executive Sponsor Approval			
Name		Date	
Signature			
Relevant Committee Approval			
The Director of Nursing and Patient Experience's signature below confirms that this procedural document was ratified by the appropriate Governance Committee.			
Name		Date	
Signature			
Responsible Committee Approval – only applies to reviewed procedural documents with minor changes			
The Committee Chair's signature below confirms that this procedural document was ratified by the responsible Committee			
Name		Date	
Name of Committee		Name & role of Committee Chair	
Signature			

Tool to Develop Monitoring Arrangements for Policies and Guidelines

What key element(s) need(s) monitoring as per local approved policy or guidance?	**Who will lead on this aspect of monitoring?** **Name the lead and what is the role of the multidisciplinary team or others if any.**	**What tool will be used to monitor/check/observe/Assess/inspect/ authenticate that everything is working according to this key element from the approved policy?**	**How often is the need to monitor each element?** **How often is the need complete a report ?** **How often is the need to share the report?**	**What committee will the completed report go to?**
Element to be monitored	**Lead**	**Tool**	**Frequency**	**Reporting arrangements**
Testing for HIV in patients originating from a country where the prevalence of HIV is >1%	Ben Killingley, Consultant, Acute Medicine	A sample of 50 medical records will be selected for audit – these records will be chosen so that in all cases the patient is likely to originate from a country where the prevalence of HIV is >1% as indicated by either a) the ethnic origin as recorded on PAS or b) the patient's name. The notes will be audited to check that patients originating from high prevalence areas have been offered a HIV test.	Annually	The ICAM Acute Medical Emergencies Board (AMEB)
Consent to testing for HIV	Ben Killingley, Consultant, Acute Medicine	All patients testing positive for HIV in previous year will be identified from pathology database and included in the audit. Antenatal test patients will be excluded as antenatal testing is covered by a separate policy. Medical notes for all those included will be audited to check that the pre-test discussion has been documented in the notes and that the content of the discussion and the patients consent or refusal to test has been recorded.	Annually	The ICAM Acute Medical Emergencies Board (AMEB)

Referral of newly-diagnosed HIV	Ben Killingley, Consultant, Acute Medicine	All patients testing positive for HIV in previous year will be identified from pathology database & included in the audit. Medical notes for all those included will be audited to check that 1) All newly diagnosed inpatients have a record in the notes to show that they were discussed with an infectious diseases or microbiology consultant at Whittington Health, or with a HIV specialist at UCLH, and that where appropriate, patients already known to have HIV have been discussed with one of these specialists or with their usual HIV specialist in a different Trust. 2) For all newly-diagnosed patients, a referral has been made for ongoing HIV outpatient care.	Annually	The ICAM Acute Medical Emergencies Board (AMEB)