



1 in 4 people with



HIV

in the UK do not know they have it



Screening in GP practices

To provide the best care for you, it is normal for us to offer screening for HIV and also hepatitis B & C to all new patients aged 16-65.

Promotional Material Developed specifically for this pilot by BHA Leeds Skyline

**Blood-Borne Virus Screening in Primary Care Pilot
Evaluation
Executive Summary**

Report Author: Nina Putnis, Public Health Registrar, Adults and Health, Leeds City Council
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Introduction

This pilot implemented across selected Leeds general practices sought to introduce HIV, Hepatitis B and C (HBV/HCV) screening into new patient registration. The Sexual Health Team in Leeds City Council was successful in their bid to obtain funding from the Elton John AIDS Foundation and Public Health England (PHE) to implement HIV screening in practices with estimated high HIV prevalence. This funding was supplemented by the three Leeds Clinical Commissioning Groups (CCGs) in order to include HBV/HCV, enabling it to be reframed as a Blood-Borne Virus (BBV) screening pilot. The pilot was launched on 20th November 2015. This evaluation takes a whole systems approach to assess how screening was implemented, how it progressed and assess outcomes in the first 12 months.

Headlines

3,748 people - 18% of 20,615 eligible¹ new patients - were screened for BBV, ranging from 0–67% of eligible new patients per practice.

There were a total of 49 positive cases diagnosed in the first 12 months - 11 HIV, 30 HBV and 8 HCV. This represents a total yield of 13.1 per 1000 screens (2.9 per 1000 HIV tests, 8 per 1000 HBV tests and 2.1 per 1000 HCV tests).

Testing in participating practices increased by almost 250% compared to the year prior to the pilot².

Cost per diagnosis is estimated at £1060 which, despite excluding project management costs, is likely to represent significant savings long-term.

If practices were supported in increasing screening across the city to rates achieved by some practices in this pilot (65%) and **assuming the yield stayed the same**, 176 new diagnoses would have been made in the 12 months, with likely significant beneficial impacts across the city.

Summary of Findings

This pilot achieved mixed outcomes, with an overall screening rate lower than anticipated yet with a high rate of positivity. In addition, some practices screened almost up to the target of 70% of their new patients. These outcomes illustrate that screening at new patient registration is not only possible, but has the potential for significant beneficial outcomes. The individuals diagnosed with a condition through this pilot can now access the appropriate care, with probable improvements to their prognoses and a reduction in their risk of transmitting these conditions to others.

This evaluation identifies some **key avoidable barriers to screening**. It discusses how issues such as staff turnover, lack of communication, type of new patient registration, approach to screening and staff confidence can impact on a practice's ability to screen their new patients. It considers patient responses and concerns around delivering positive results. These issues are in turn considered in the recommendations, which outline how the planning stages, workforce development and intra-city partnerships could be improved in order to improve screening rates and better support patients. If these recommendations are implemented, subsequent increases in screening have the potential to confer significant benefits, with these impacting on individuals diagnosed with a new condition, their families and communities and on the health of the city as a whole.

¹ 16-65 year olds

² 1 screen= 3 tests. Data is from 8 months of the pilot compared to the corresponding 8 months in the year prior.

Setting the Scene

- Leeds overall has a 'high' (>2 per 1000 people) HIV prevalence and a high rate of 'late' diagnosis³. 38 Leeds GP practices were mapped to be in areas of estimated >2 or >5 per 1000 HIV prevalence⁴. There are significant risk factors for all BBVs across the city.
- At 12 months, 29 of these practices across 33 sites were involved in the pilot. They provide services to 224,958 patients and registered 20,159 new patients over these months. 56 staff members from those practices attended training, with staff reporting a significant increase in their knowledge and confidence offering tests.

Key Findings

Why did some practices screen more patients?

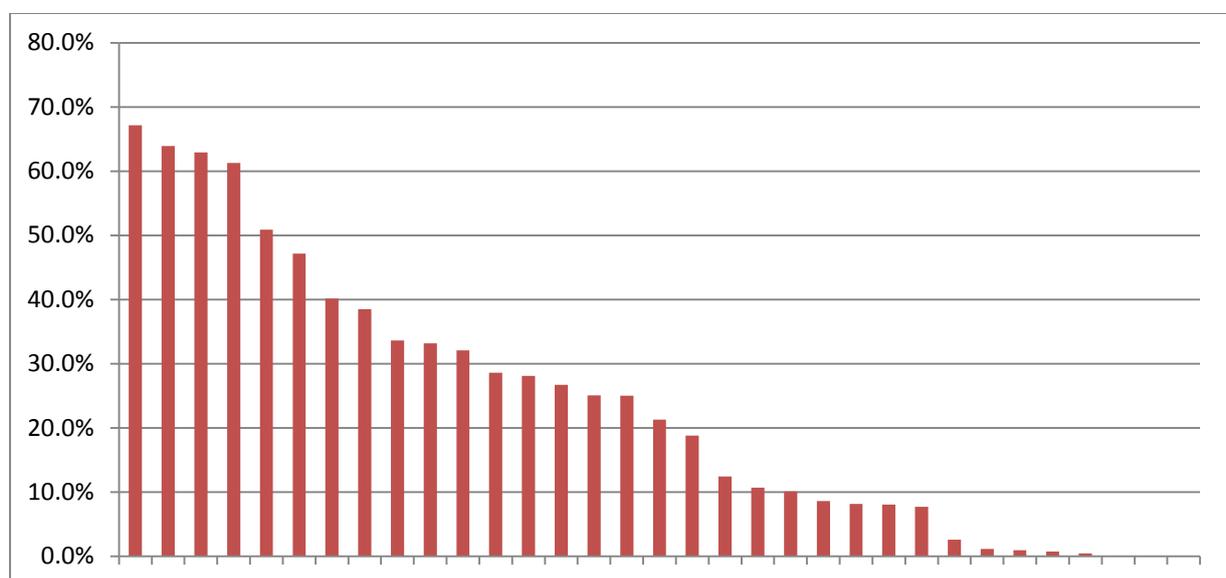


Figure 1: Variation in screening rates across the participating practices across 12 months, where each space for a red bar represents a practice

- Practices varied significantly in terms of key attributes. However, the only attributes that made statistically significant and practical impact on screening were background HIV prevalence, with practices in higher prevalence areas screening more patients, and type of patient registration with practices that provide face-to-face new patient health checks achieving higher rates. Other factors such as deprivation, demographics of new patients and smaller number of registrations may have had a small further positive impact on the ability or motivation of practices to screen.
- Screening was not initiated in all practices at the start of the pilot. This was likely exacerbated by time constraints in planning and implementation stages including insufficient involvement of individual practices and CCGs at these points, meaning that full potential outcomes are likely not realised within the 12 months of this evaluation.
- Numbers of new patients registering at practices fluctuate throughout the year. Screening rates per practice have fluctuated significantly over the 12 months.

³ <350mm³ CD4 count at diagnosis

⁴ >2 and >5 per 1000 are deemed by PHE to be 'high' or 'extremely high' prevalence (PHE/NICE, 2016)

- Communication to practices was a key problem throughout both the pilot and the evaluation, exacerbated by staff turnover and vacancies within practices. This was the key finding in those practices that did not screen any patients as they had very poor or no knowledge of screening and of participation in the pilot.
- Reception staff felt concerned and lacked confidence in offering screens, exacerbated by a lack of attendance at training. This may, in turn, have adversely affected patient responses to screening.
- Language and approach are important when offering screening to patients. Screening was often not offered as 'opt out', with this seemingly coinciding with lower screening rates and likely impacting on uptake.
- Potential for cross-sector collaboration was not fully recognised, missing key opportunities for partnership across the third sector, NHS and Local Authority

Who was screened?

- Testing across all 3 conditions increased to 17,010 tests in the first 8 months of the pilot, compared to 6860 in the corresponding 8 months in the pre-pilot year⁵. This is an increase of almost 250%. 80% of these additional tests in the pilot year are accounted for by screening, meaning the remaining tests may indicate an increase in testing in practices overall.
- Age, gender and ethnicity are all characteristics that potentially affect whether a patient is screened or declines screening. Almost 70% of new patients were aged 16-35, about half were women and under 40% identified as 'White British'. Proportionally fewer younger patients were screened, fewer women and fewer individuals with a 'White British' background. This could have been because of these individual attributes or because of attributes of practices where screening was lower.
- Where data is known, the majority of individuals diagnosed with a condition were born outside the UK. Many individuals were diagnosed late. Non-attendance at secondary care was a significant issue and requires further investigation to establish whether this was exacerbated by method of diagnosis.
- Clear pathways and processes to manage positive results were lacking, especially managing non-compliance and managing families and contacts. Protocols for non-attendance were unclear.
- Despite screening potentially being acceptable to patients, feedback demonstrated that not all patients understood its purpose and this may have contributed to feelings of fear and lack of support after diagnosis. This may have been exacerbated by language barriers and relate to findings that some staff members may have insufficiently explained the screening to patients.
- There were issues with monitoring and coding in primary care. This may have resulted in some under-estimation of key outcomes due to incorrect recording, and therefore extraction, of data.

⁵ Laboratory tests are rounded to the nearest factor of 10

Recommendations

This report concludes that BBV screening in new patient registration is feasible and has the potential for significant positive health impacts for communities with high HIV prevalence. Taking a city-wide approach, these recommendations highlight achievable steps that could improve screening rates, outcomes and acceptability to staff and patients alike. These recommendations have been grouped into three headings and include both operational steps for those working in primary care, and strategic points for those working across an area or city.

Logistics – Planning and Communication

1. Ensure *each* practice has *tailored* and documented implementation and continuity plans developed in collaboration with practice staff and in place prior to the pilot start date.
2. Develop robust communication strategies both to and within practices, ensuring regular updates and a feedback loop mechanism.
3. Where possible, embed screening into face-to-face new patient registration appointments with clinical staff, but recognise it is not the only factor required to maximise screening.
4. Allow a longer duration in order to embed screening into normal processes and to be able to assess its full potential.
5. Use traditional methods of health promotion and awareness raising to support practices, ensuring that these are available in the appropriate languages for the participating patient populations and taking into account change in these populations.

Workforce

1. Ensuring that reception staff are trained, confident and knowledgeable of screening and HIV/HBV/HCV is a vital step in successful implementation and normalisation of screening.
2. Ensure staff understand the balance between the importance of offering screening as ‘opt out’, yet ensuring patients have sufficient information to make an informed decision and are prepared for potential positive results.
3. Advise staff of the benefits of universal screening, where screening can be presented to patients as routine and ‘normal’.
4. Plan for staff turnover and further training needs. Consider, for example, a new staff starter pack
5. Recognise how a lack of confidence and concerns of staff may project onto patients, exacerbating potential stigma and subsequent negative responses to screening.

Partnerships

1. Take into account how the organisational boundaries of the Local Authority and the NHS impacts on planning, implementation, communication, monitoring and managing problems as they arise.
2. Recognise the mutual benefit that could arise from co-working with CCGs, utilising CCG links and relationships with primary care and sharing knowledge and awareness about local prevalence, risks and the importance of prevention.
3. Harness the opportunity for cross-sector collaboration, utilising third sector services and specialist knowledge, working with primary care and in partnership with Local Authorities and CCGs. Recognise the potential this presents for improvements to patient access and support.
4. Develop a pathway for managing positive cases with secondary care, explicitly planning for the management of non-attendance and incorporating family and contacts of those diagnosed.

PHE/NICE (2016) HIV testing: increasing uptake among people who may have undiagnosed HIV (joint NICE and Public Health England guideline) – published: 1 December 2016, available online at: <https://www.nice.org.uk/guidance/ng60>

The full evaluation report can be accessed by request to:

Nina.Putnis@nhs.net or Hannah.Sowerbutts@leeds.gov.uk