HIV in Milton Keynes
Prevention, Diagnosis and Care
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EXECUTIVE SUMMARY

Introduction

A rapid Health Needs Assessment looking at HIV prevention, diagnosis and care services was undertaken with the aim of understanding the needs of the population of Milton Keynes and making recommendations to inform related commissioning and service design.

Milton Keynes has seen a year on year rise in the number of residents with a positive HIV diagnosis and is now defined as an area of high (HIV) prevalence by the Health Protection Agency.

Locally, efforts have been made to target populations where a higher prevalence of HIV is evident. Past initiatives in Milton Keynes have included a specialist outreach worker whose remit was to establish and operate condom distribution schemes, promote and operate HIV Quick Testing and raise awareness amongst the community. Some of this work continues but requires a more integrated, coordinated and strategic approach to ensure targeted prevention education and enhanced diagnostic testing reaches those individuals most at risk.

Methodology

The Department of Health (2007) Sexual Health Needs Assessment ‘How to’ Guide was used as a framework for undertaking this assessment. Rapid needs assessments review the needs of risk groups within a population. They use existing reports, surveys, demographic and service data to build an understanding of need and demand. Key informants provide additional information, especially in relation to specific risk groups where existing data provide limited or no information. A thorough analysis of all data is carried out to identify gaps or duplicated effort in relation to service provision with the aim of understanding limitations of existing initiatives and highlighting where services and health improvement programmes could be reconfigured to improve health outcomes.

Early on a core ‘expert’ group was convened to contribute to and support the process. This group, led by a Senior Health Improvement Specialist, included a Health Protection Specialist, Local Authority Commissioner, HIV and Sexual Health Consultants, HIV Lead Nurse and HIV Social Work Team Manager. The Survey of Prevalent HIV Diagnosis (SOPHID) and existing service user data informed the quantitative component of this work. The qualitative phase of intelligence gathering commenced with a meeting involving wider stakeholders followed by the opportunity for stakeholders to comment by email and in one to one discussions.

The Core group identified three areas to be considered within this HNA: HIV prevention, diagnosis and social care issues for individuals following diagnosis. Work around the care of people diagnosed with HIV was being undertaken by the Local Authority with findings and recommendations shared. The needs of specific groups were considered under each of these headings with particular consideration given to data (availability and data needs), mapping (of existing services and gap
analysis); Best practice (guidance and proven best practice around HIV prevention, treatment and care). Stakeholder views and expressed need were also considered.

**Stakeholder Views**

A stakeholder roundtable event and follow up discussions highlighted issues that are summarised below and detailed more fully within the document.

- Limited HIV prevention education provided locally and some mixed messages around different aspects, none of which was formally commissioned.
- Expressed concerns around stigma and accessing diagnostic services, particularly in primary care.
- Access to diagnostic services is limited. HIV tests should be offered more routinely to at risk groups and rapid HIV testing more widely available.
- Formal condom distribution schemes targeting adult men who have sex with men and sub Saharan African communities should be commissioned and outreach schemes implemented for these groups.
- Innovative marketing techniques utilising smart phones would be a useful health promotion/marketing tool.
- The need for ‘expert’ organisations with experience of implementing successful initiatives to increase uptake of HIV testing, increasing protective behaviours to work with target groups.

**Recommendations**

A comprehensive list of recommendations around prevention, diagnosis and care of individuals with HIV is listed at the end of this document.

From this list, the following recommendations, which have implications for commissioning for services and related health improvement programmes should be prioritised.

**Local Authority**

It is vital that Milton Keynes Local Authority continues to apply an internal ring fence to the former AIDS Support Grant.

A scheme should be put in place to offer free formula milk and formula feeding kits to HIV positive pregnant women for up to one year following the birth of their child.

The Commissioning Plan for HIV should be in line with all of the recommendations within this document.

**National Health Service**

In line with HPA guidance, all new GP registrants in Milton Keynes should be offered a HIV test upon registration.
In line with Health Protection Agency guidance, commissioners should work to introduce a CQUIN at Milton Keynes Hospital aiming to offer HIV tests to all individuals having blood samples taken.

In line with guidance, all Milton Keynes residents accessing termination of pregnancy should be offered an HIV test.

Local Support Organisations

Outreach, prevention, education and advisory work around HIV must be undertaken in line with national guidelines and evidence base

Local work to promote annual HIV testing for MSM and to reduce stigma and concerns around testing should be prioritised.

In order to better understand sexual health issues for MSM in Milton Keynes, efforts should be made to engage more local MSM in the (SIGMA research) Gay Men’s Sex Survey.
1. Introduction

Milton Keynes has seen a year-on-year rise in the number of individuals within its population with a diagnosis of HIV and is now defined as an area of high (HIV) prevalence by the Health Protection Agency.

The aim of this rapid health needs assessment is to:

- Provide an overview of existing HIV prevalence and service provision, considering prevention, diagnosis and care services around HIV in Milton Keynes
- Understand the needs of the population and identify gaps in provision, with a view to informing related commissioning of service design and health improvement programmes.
- Set out clear recommendations relating to HIV prevention, diagnosis and the social care of individuals with HIV.

2. Background

Better Prevention, Better Services, Better Sexual Health – The National Strategy for Sexual Health and HIV was published by the Department of Health in July 2001 setting out a 10 year programme to tackle sexual ill-health and modernise sexual health services in England.

The Strategy identified the following aims related to HIV

- Reduce the transmission of HIV and STIs
- Reduce the prevalence of undiagnosed HIV and STIs
- Reduce the stigma associated with HIV and STIs

And included the following related targets

- To reduce by 25% the number of newly acquired HIV infections and gonorrhoea infections by 2007.
- By the end of 2004, all GUM clinic attendees should be offered an HIV test on their first screening for sexually transmitted infections with uptake of at least 60% required by 2007
- A reduction by 50% of the number of previously undiagnosed HIV infected people who remain unaware of their infection after their first visit to GUM clinic
- Uptake of antenatal HIV test by pregnant women to be at least 90% by 2002.

Since this time numerous strategy and guidance documents relating to HIV have been published. Most recently the House of Lords Select Committee on HIV and AIDS (2011) published related recommendations to which the Department of Health (2011) responded. Many of the recommendations and related responses concern national issues such as vaccine research. Those that are relevant to local areas are
detailed along with the current local situation in appendix 1. They support the call for increased prevention and diagnostic initiatives in Milton Keynes.

Milton Keynes has a local sexual health strategy (2010-2013) that identifies the following actions relating to HIV:

- Ensure a co-ordinated approach to sexual health promotion and prevention across sexual health, teenage pregnancy and HIV
- Ensure local services meet national recommended standards for HIV by reviewing against current standards
- Evaluate HIV and syphilis quick test outreach initiatives
- Review HIV testing uptake in general practice and consider need to take a more strategic approach to increasing this.
- Continue work to promote HIV testing, raise awareness of risk factors and testing facilities and work towards reducing stigma
- Work to enhance professional understanding of HIV
- Undertake a workforce skills needs analysis to fully understand baseline skill of primary care and other staff’s needs in terms of training and development relating to contraception (LARCS), STIs and HIV.

3. Data sources

Data around HIV is primarily available from the Survey of Prevalent HIV Infections Diagnosed (SOPHID) which began in 1995. SOPHID is a cross-sectional survey of all individuals with diagnosed HIV infection who attend for HIV-related care within the NHS in England, Wales, and Northern Ireland within a calendar year.

In recognition that some individuals infected with HIV and living in the UK have not yet been diagnosed, the HPA estimate the number of people living with HIV from multiple sources of information including SOPHID, the Unlinked Anonymous Prevalence Monitoring Program (UAPMP), the National Survey of Sexual Attitudes and Lifestyles II (NATSAL) and census data.

The following SOPHID data tables are available by PCT of residence although their usage is restricted to health care professionals working within the NHS and so they cannot be replicated in detail within this report:

- Numbers of diagnosed HIV-infected individuals seen for care by most advanced clinical stage, gender and age group.
- Numbers of diagnosed HIV-infected individuals seen for care by probable route of HIV-infection, sex and survey year.
- Numbers of diagnosed HIV-infected individuals seen for care by ethnic group, sex and survey year.
- Numbers of diagnosed HIV-infected individuals by index of multiple deprivation** and survey year.
- Numbers of diagnosed HIV-infected individuals seen for care by site of treatment and survey year.
- Number of infants who received HIV-related care because they were born to HIV-infected women in the survey year, but who are uninfected or whose
Numbers of diagnosed HIV-infected individuals seen for care by Local/Unitary Authority and postal district of residence.
Numbers of diagnosed HIV-infected patients by middle super output area (MSOA) of residence.
Numbers of diagnosed HIV-infected individuals seen for care by most advanced clinical stage and level of anti-retroviral therapy.
Numbers of diagnosed HIV-infected individuals seen for care by last CD4 count and level of anti-retroviral therapy.

The following information is also available by Strategic Health Authority of Residence:

Numbers of diagnosed HIV-infected individuals seen for care by site of treatment and survey year.
Number of infants who received HIV-related care because they were born to HIV-infected women in the survey year, but who are uninfected or whose infection status was indeterminate (at least 98% of indeterminate infants will subsequently be confirmed as uninfected), by site of treatment and survey year.
Numbers of diagnosed HIV-infected individuals seen for care, by Primary Care Trust of residence and survey year.
Numbers of diagnosed HIV-infected individuals seen for care seen, by Local Authority/Unitary Authority of residence and survey year.
Numbers of diagnosed HIV-infected individuals seen for care by route of infection, ethnic group and gender.
Number of diagnosed HIV-infected individuals seen for care by site of treatment and PCT of residence.

In addition, within this report, Genitourinary Medicine Clinic Activity Dataset (GUMCAD) data, data from the Sexual Health Observatory and Health Protection Agency are referred to. Where data queries existed, individual organisations were approached for confirmatory data. Information on support service usage was sourced from service commissioners.

4. Demographic Profile of Milton Keynes

Milton Keynes is a relatively new borough covering 10,000 hectares of largely rural north Buckinghamshire. The population is not evenly distributed as there is a higher density of people living in the central, new city area and fewer people living in the small towns, villages and rural areas at the periphery. Milton Keynes has been identified as a growth area and is expected to accommodate a further 48,850 dwellings between 2006 and 2026. Government figures show an overall picture of average affluence, but there are pockets of urban and rural deprivation. The population of Milton Keynes is growing rapidly having increased by 13.5% between 2001 and 2010 compared to just 5.5% for England and Wales as a whole.
In 2010 there were an estimated 241,500 people living in Milton Keynes. The ratio of males to females is similar with 50.2% of the population male and 49.8% female. (MKI 2011).

4.1 Age Distribution

Milton Keynes population age profile is younger than for England as a whole. The median age (2009) was 36 (compared to 38 in England). More than half of the population are aged 36 or younger.

By 2026 the borough’s population will have changed. The average will be around 40 years. The number of over 60 year olds will experience a very large increase.

4.2 Deprivation

Milton Keynes enjoys high levels of employment and relative affluence, however there are significant pockets of deprivation and poverty. When assessing the degree of deprivation of a population the Index of Multiple Deprivation (IMD 2007) is used. Ward averages may disguise pockets of extreme deprivation, but provide a useful summary. Nationally, there are 5 bands of deprivation ranging from the 20% least deprived to the 20% most deprived wards. The wards in NHS MK have been ranked accordingly.

Figure 1: Milton Keynes borough age structure 2009

![Age Structure 2009](image)

Figure 2: Milton Keynes Borough projected age structure 2026

![Projected Age Structure 2026](image)
Milton Keynes has a local authority rank of 211 where one is the most deprived with seven lower super output areas being within the 10% most deprived in England. The ward averages of IMD 2007 are illustrated in Table 1 with the most deprived ward at the top of the table and the most affluent ward at the bottom of the table. Woughton Ward is within the 20% most deprived wards in the country whilst Olney Ward is within the 10% least deprived.

### Table 1: Ward Level Averages of IMD 2007

<table>
<thead>
<tr>
<th>Ward</th>
<th>Average IMD percentile</th>
<th>Average income percentile</th>
<th>Average employment percentile</th>
<th>Average education, skills &amp; training percentile</th>
<th>Average housing and services percentile</th>
<th>Average crime percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milton Keynes</td>
<td>14.6</td>
<td>14.6</td>
<td>14.6</td>
<td>14.6</td>
<td>14.6</td>
<td>14.6</td>
</tr>
<tr>
<td>Eaton Manor</td>
<td>28.4</td>
<td>28.4</td>
<td>28.4</td>
<td>28.4</td>
<td>28.4</td>
<td>28.4</td>
</tr>
<tr>
<td>Campbell Park</td>
<td>29.1</td>
<td>31.1</td>
<td>43.0</td>
<td>46.0</td>
<td>54.0</td>
<td>59.4</td>
</tr>
<tr>
<td>Kemberton</td>
<td>29.5</td>
<td>31.3</td>
<td>44.0</td>
<td>46.2</td>
<td>56.0</td>
<td>60.1</td>
</tr>
<tr>
<td>Bletchbury</td>
<td>62.3</td>
<td>82.0</td>
<td>82.0</td>
<td>82.0</td>
<td>82.0</td>
<td>82.0</td>
</tr>
<tr>
<td>Blakemore</td>
<td>52.4</td>
<td>74.0</td>
<td>85.0</td>
<td>95.0</td>
<td>95.0</td>
<td>95.0</td>
</tr>
<tr>
<td>Bletchley &amp; Fenny Stratford</td>
<td>54.0</td>
<td>61.0</td>
<td>81.0</td>
<td>91.0</td>
<td>91.0</td>
<td>91.0</td>
</tr>
<tr>
<td>Cowley</td>
<td>65.0</td>
<td>73.0</td>
<td>91.0</td>
<td>91.0</td>
<td>91.0</td>
<td>91.0</td>
</tr>
<tr>
<td>Whitley</td>
<td>64.1</td>
<td>70.0</td>
<td>82.0</td>
<td>82.0</td>
<td>82.0</td>
<td>82.0</td>
</tr>
<tr>
<td>Tidewater</td>
<td>64.8</td>
<td>72.0</td>
<td>82.0</td>
<td>82.0</td>
<td>82.0</td>
<td>82.0</td>
</tr>
<tr>
<td>Furzton</td>
<td>67.0</td>
<td>71.0</td>
<td>83.0</td>
<td>83.0</td>
<td>83.0</td>
<td>83.0</td>
</tr>
<tr>
<td>Bletchley</td>
<td>63.1</td>
<td>60.0</td>
<td>66.0</td>
<td>66.0</td>
<td>66.0</td>
<td>66.0</td>
</tr>
<tr>
<td>Walton</td>
<td>72.9</td>
<td>70.0</td>
<td>75.0</td>
<td>75.0</td>
<td>75.0</td>
<td>75.0</td>
</tr>
<tr>
<td>Whorlton</td>
<td>71.7</td>
<td>74.0</td>
<td>64.0</td>
<td>64.0</td>
<td>64.0</td>
<td>64.0</td>
</tr>
<tr>
<td>Woughton</td>
<td>71.6</td>
<td>73.0</td>
<td>68.0</td>
<td>68.0</td>
<td>68.0</td>
<td>68.0</td>
</tr>
<tr>
<td>Olney</td>
<td>68.7</td>
<td>78.0</td>
<td>94.0</td>
<td>94.0</td>
<td>94.0</td>
<td>94.0</td>
</tr>
</tbody>
</table>

**IMD 2007 Colour Key:**
- **Red:** Within 10% most deprived in England, on average
- **Orange:** Within 20% most deprived in England, on average
- **Green:** Within 30% most deprived in England, on average
- **Blue:** Within 10% least deprived in England, on average

**Source:** Milton Keynes Social Atlas, 2008

### 4.3 Ethnicity

In 2011 the ONS published mid year population estimates for 2009. This found 19.4% of Milton Keynes population to be non white British compared to 17.7% for the whole of England.

The population breakdown is detailed in the table 1 below:

### Table 2: Population ethnicity comparison 2009

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Milton Keynes</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>White: British</td>
<td>190,500</td>
<td>82.8</td>
</tr>
<tr>
<td>White: Irish</td>
<td>2,900</td>
<td>1.1</td>
</tr>
<tr>
<td>White: Other White</td>
<td>8,100</td>
<td>3.6</td>
</tr>
<tr>
<td>Mixed</td>
<td>5,700</td>
<td>1.8</td>
</tr>
<tr>
<td>Asian or Asian British: Indian</td>
<td>8,200</td>
<td>2.7</td>
</tr>
<tr>
<td>Asian or Asian British: Pakistani</td>
<td>4,300</td>
<td>0.7</td>
</tr>
<tr>
<td>Asian or Asian British: Bangladesh</td>
<td>1,800</td>
<td>0.7</td>
</tr>
<tr>
<td>Asian or Asian British: Other Asian</td>
<td>1,800</td>
<td>0.7</td>
</tr>
<tr>
<td>Black or Black British: Black Caribbean</td>
<td>2,600</td>
<td>1.2</td>
</tr>
<tr>
<td>Black or Black British: Black African</td>
<td>5,000</td>
<td>1.5</td>
</tr>
<tr>
<td>Black or Black British: Other Black</td>
<td>700</td>
<td>0.2</td>
</tr>
<tr>
<td>Chinese or Other Ethnic Group</td>
<td>4,900</td>
<td>1.6</td>
</tr>
</tbody>
</table>
Chinese or Other Ethnic Group:

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Ethnicity by % of total population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chinese</td>
<td>3,000</td>
</tr>
<tr>
<td>Chinese or Other Ethnic Group: Other</td>
<td>1,900</td>
</tr>
<tr>
<td>Total Population</td>
<td>236,700</td>
</tr>
<tr>
<td>Total Non-White British</td>
<td>46,000</td>
</tr>
</tbody>
</table>

The 2010 PLASC Survey (Pupil leave annual school census) provides a similar estimate of overall ethnicity within Milton Keynes but suggests a greater increase in the Sub Saharan African population than the ONS estimates. This is significant for this Health Needs Assessment as this group have a higher prevalence of HIV compared to the general population.

Table 3: 2010 Pupil Leave Annual School Census

5. A Picture of HIV

5.1 HIV – the national picture

HIV continues to be one of the most serious communicable diseases nationally and globally. Although there is still no cure, people diagnosed with HIV are living much longer, following the introduction of highly active anti-retroviral therapy (HAART) in the mid 1990s.

Proper treatment and management of HIV is among the most cost effective interventions available because despite high drug costs the dramatic impact on survival, quality of life and reduction in onward transmission of infection is significant.
Since the first reported cases of AIDS in 1981, there have been more than 115,000 people diagnosed with HIV in the United Kingdom of whom 27,000 have developed AIDS and almost 20,000 have died (HPA 2011). In 2009, 65,319 people were known to be living with HIV in the UK, an increase of 61,110 from 2008. However, this is just the number of people who have been tested and diagnosed as HIV positive and in 2009 an estimated 886500 people were estimated to be living with HIV in the United Kingdom, a quarter being unaware of their infection (HPA 2010). Figure 1, below shows the actual number and estimate number of adults living in the UK in 2009 (HPA 2010).

Nationally the populations with the highest incidence and prevalence of HIV are men who have sex with men and people of Sub Saharan African origin (HPA 2010).

5.2 HIV – in Milton Keynes

The number of HIV infected diagnosed individuals resident in Milton Keynes has been increasing year-on-year since monitoring began. The numbers of Milton Keynes residents diagnosed as living with HIV at the end of 2010 was 386 (SOPHID 2011). With a rate of 2.34 per 1,000 (15-59 year old residents) having a diagnosis of HIV, Milton Keynes is defined as an area of high HIV prevalence. A map of the high prevalence areas as defined by the Health Protection Agency (2010) is over the page.
Map of United Kingdom highlighting geographical areas with high HIV prevalence.

Figure 4 shows the gradual increase in the numbers of Milton Keynes residents diagnosed with HIV since 2001. By the end of 2010, 386 people resident in Milton Keynes had been diagnosed with HIV and were accessing care.

SOURCE: SOPHID Data, HPA
Table 4: The probable route of infection of diagnosed HIV infected individuals living in Milton Keynes

<table>
<thead>
<tr>
<th>Probable route of infection</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex between men</td>
<td>9</td>
<td>17</td>
<td>18</td>
<td>32</td>
<td>43</td>
<td>47</td>
<td>55</td>
</tr>
<tr>
<td>Injecting drug use</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Sex between men and women</td>
<td>124</td>
<td>155</td>
<td>176</td>
<td>220</td>
<td>249</td>
<td>265</td>
<td>305</td>
</tr>
<tr>
<td>Blood/blood products recipient</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Mother to child (0 - 14) transmission</td>
<td>7</td>
<td>10</td>
<td>11</td>
<td>13</td>
<td>15</td>
<td>12</td>
<td>16</td>
</tr>
<tr>
<td>Other/not known</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>*</td>
<td>*</td>
<td>&lt;5</td>
</tr>
</tbody>
</table>

* Figure not detailed as would reveal <5 number elsewhere
<5 is reported when the number of cases is between one and five in order to prevent deductive disclosure.

SOURCE: SOPHID Data, HPA

The majority of cases were attributed to sex between men and women (79%). Seventy four percent of the individuals diagnosed define their ethnicity as ‘black African’. Fourteen percent of cases were attributed to men who have sex with men.

It is very difficult to project the future burden of HIV within the population as this will be affected by the increasing population size, ethnic diversity and the impact future prevention and early diagnosis initiatives may have. However, assuming no change in population size or service provision, the graph below gives an indication of potential numbers, based on the last ten years trend.

Graph 4: Actual and projected rise in HIV infected persons and means of transmission 2006 - 2015

source: NHS Milton Keynes Public Health Information Team - 2011
5.3 HIV and Specific Groups

5.3.1 Population wide

In the UK the majority of HIV infections diagnosed within the heterosexual population are amongst those born abroad (predominantly in Sub-Saharan Africa). However, as graph 5 shows, diagnosis amongst heterosexuals who probably acquired their infection in the UK has risen in recent years.

Graph 5: New HIV diagnosis acquired heterosexually: UK 1981 - 2010. HPA.

In Milton Keynes heterosexual sex is the primary probable route of infection amongst the population diagnosed with HIV, with more than 70% of this population giving their ethnicity as Black African.

Locally and nationally it is recognised that the burden of HIV infection is greatest amongst the Sub-Saharan African and MSM populations. National evidence that heterosexual transmissions are increasingly being attributed to infection acquired from within the UK suggest we need to be mindful to ensure that all sexually active people are aware of HIV and understand prevention issues. Generally this work will take place in the routine promotion of safer sexual practices (condom use, STI screening, negotiation skills) but in addition whole population campaigns should be rolled out, where possible in line with national drivers. This work should include and be adapted and disseminated to micro populations within Milton Keynes such as the prison population, traveller population as appropriate.

5.3.2 Children and Young People (Infections acquired through mother to child transmission (vertical transmission))

To date, mother to child transmission of HIV accounts for 1983 new diagnosis of HIV nationally. In 2009 there were 94 mother to child HIV transmissions (HPA 2010).
The implementation of routine antenatal testing in 2000 has supported the diagnosis of HIV positive pregnant women enabling interventions to be put in place to reduce the possibility of vertical transmission.

The World Health Organisation (2007) states that if a HIV positive pregnant woman (and those involved in her care) are unaware of her status there is a 1 in 4 chance (25%) of her baby being infected by HIV. However antiretroviral therapy (ART) antenatal, during delivery and for the infant, delivering the baby by caesarean section and avoiding breastfeeding can reduce rates of mother to child transmission to around 1%.

In Milton Keynes, 16 individuals living with HIV have their diagnosis attributed to mother to child transmission (SOPHID 2011). On average 12 HIV positive mothers give birth in Milton Keynes each year (SOPHID 2011) but the majority of cases are managed so that HIV is not transferred to the baby (Roy 2010).

Lewis (2011) considered the needs of children and families in Milton Keynes. Through discussion with service users and providers she raised the following issues and concerns:

- Parents may withhold information about their own status from their family
- Children may be carers of HIV positive parents bringing both the burden of care and issues of stigma
- Parents may choose to withhold information about their children’s HIV status from the child
- HIV positive parents who have children whose status is unknown often find it difficult to have their child tested for HIV and may choose to withhold testing from their child.
- Where young people are unaware of their status concerns were expressed about the possibility of horizontal transmission.
- The transition from child to adult services can be difficult and it is important to ensure services are in place to promote support this transition and support safer lifestyle choices.

Breastfeeding

Whilst breastfeeding carries significant health benefits and should be promoted to the general population it is also known that HIV can be transmitted during breastfeeding. In 2006, the Royal College of Paediatrics and Child Health estimated avoidance of breastfeeding to reduce the risk of vertical transmission by up to 15%.

Stakeholder representatives have continually expressed concerns around HIV positive women continuing to breastfeed their babies despite advice to discontinue. Reasons identified for this centre around the prohibitive cost of bottle feeding equipment and formula, particularly for women who have no recourse to public funds. Cultural norms and concerns around disclosure of status is also a factor - a woman’s decision not to breastfeed may be viewed negatively or the woman may be concerned that not breastfeeding might reveal her HIV positive status.
5.3.3 Sub Saharan African population

Outside of the UK some regions of the world have a particular high prevalence of HIV. In Sub Saharan Africa HIV prevalence differs by country. Overall, 5% of the adult population (15 – 59 years) have been diagnosed with HIV (AVERT 2009).

Nationally, one third of new HIV diagnoses were amongst the Sub Saharan African Population. In 2009 approximately 30,188 Black Africans were living with HIV in the UK, 23,288 of whom were recorded as accessing health services and 6,055 were estimated to be undiagnosed (HPA 2010).

2011 SOPHID data for Milton Keynes found 285 (74%) of residents living with HIV were from the Sub Saharan African population.

As mentioned earlier, demographic data shows Milton Keynes has an increasing population of individuals who describe their ethnicity as ‘black African’. Given that this population have both the highest prevalence of HIV and tend to have a higher late diagnosis rate it is important to work with this community to promote prevention, early testing and tackle stigma and to fully understand the barriers to achieving this.

A previous Health and Social Care Needs Assessment (Livingstone et al, 2004) exploring the needs of black Africans in Milton Keynes, recommended that a post be created within the PCT looking at health issues for this growing community, with particular emphasis around HIV. Choosing Health monies were utilised to fund a post which had a specific remit around sexual health and HIV prevention, including the development and delivery of community based HIV testing, co-ordinating culturally appropriate related campaigns, and increasing community capacity. Particular emphasis was placed on working with faith communities. The post was one of many made redundant following a PCT financial review in 2010. An evaluation of the successes of the post and continued need found it to have been successful in establishing community based targeted HIV testing (although there are issues around the suitability of times of clinics) and a targeted condom distribution scheme but limited success around engaging with communities and faith leaders. It is felt that this post would always have been restricted through being undertaken by a single postholder situated within a commissioning organisation with a broad focus and that engagement with faith leaders and community leaders could be compounded by its sole focus being sexual health. The National African HIV Prevention Programme is a national organisation which develops national campaigns around HIV prevention for the African community – their resources could be adapted to meet local information needs and delivered by a local ‘expert’ organisation.

Milton Keynes has a relatively high late (HIV) diagnosis rate. A recent audit (Kozakis 2011) found that (in line with national findings) in Milton Keynes the Sub Saharan African population were most likely to receive a late diagnosis. The issue of late diagnosis is discussed later in the section - diagnosis.
5.3.4 Men who have sex with men

Nationally men who have sex with men remain the group most disproportionately affected by and at risk of HIV. Since reporting began, over 51,500 HIV new diagnoses have been reported amongst MSM in the UK (HPA 2011). Figure shows the increasing number of new HIV diagnosis amongst MSM in the UK since 1981.

Figure 6: Annual New HIV diagnosis amongst men who have sex with men in the UK. (HPA 2011)

![Graph showing increasing number of HIV diagnoses among MSM](image)

In Milton Keynes currently 55 (14.2%) of diagnosed cases of HIV are attributed to sex between men (SOPHID 2011).

It is possible to surmise the number of MSM expected to be HIV positive within a population using estimates for the average number of MSM and expected prevalence. Assuming in the ‘average’ male adult population approximately 3% will be MSM (HPA 2011) we can estimate that Milton Keynes has 2,792 residents who are MSM. Nationally between 3.1 and 4.5% 15 - 59 year old MSM are estimated to be HIV positive. This is a very rough estimation and is by no means an absolute figure but if we apply this to the Milton Keynes population we could expect between 86 and 126 HIV positive MSM residents. We know of 55.

As MSM represent one of the groups where rates of HIV are highest nationally it is recommended that MSM test annually for HIV.

It is difficult to be sure about the uptake of testing locally as although total test request numbers from individual GP practices can be determined from pathology there is no historic data from within GP practices to determine how many MSM request or are offered a HIV test.

Most recent available data (HPA 2010) shows that of 181 residents of Milton Keynes accessing sexual health clinics in 2010 who classified themselves as MSM, 96% took up the offer of an HIV test.
The most recent annual Gay Men’s Sex Survey (SIGMA research 2010) found 43% of Milton Keynes MSM to report they had never tested for HIV and 16.7% had tested more than 12 months previously. In addition 53% reported last having had anal sex with a male partner without using a condom. These results should be treated with caution due to the low numbers (just thirty-six) participating but do give an indication of the low numbers of MSM locally who may be accessing testing at recommended frequency and indicate that prevention education and risk awareness work could be increased. There is a plethora of information from national organisations (Terrence Higgins Trust) that could be adapted to meet local information needs and delivered by a local ‘expert’ organisation.

5.3.5 IV Drug Users (IDU’s)

Around 5,500 individuals who probably acquired their HIV infection through intravenous drug users have been diagnosed in the UK to date (HPA 2011). Nationally, prevalence of HIV amongst the IDU population remains below 2%. The introduction of needle exchange schemes in the UK has had a significant impact in reducing transmission of HIV amongst this group with more than half of diagnosis now being amongst IDU’s who acquired their infection abroad.

In Milton Keynes the number of cases of HIV attributed injecting drug use has remained static (around 5 individuals). This is largely attributed to the success of the local needle exchange scheme which had more than seven thousand client contacts last year (Pharmaceutical Needs Assessment 2010).

Stakeholder discussion around IDU’s highlighted the importance of ensuring drug treatment services are linked into and are able to test or support referral to HIV testing services.

6. Stigma & Discrimination

HIV is a condition that is particularly stigmatised with concerns around discrimination impeding disclosure and deterring individuals from accessing related prevention, diagnostic and care services.

This stigma and discrimination is compounded by the fact that HIV continues to be most prevalent in minority groups who are already at increased risk of discrimination. The added burden of HIV can exacerbate issues such as social exclusion.

The Equality Act (sexual orientation) Regulations 2007 has made it unlawful for health & social care staff to discriminate unfairly against lesbian, gay and bisexual people. In addition people with HIV now have the same legal protection as people with other long term conditions such as multiple sclerosis and cancer. An amendment to the Disabilities Discrimination Act (2005) means that it is now illegal to discriminate against people with HIV in employment, education and the provision of services.
Despite the above changes to law, work with stakeholders found that individuals seeking or wishing to seek support from healthcare professionals around HIV could be reluctant to do so due to concerns around confidentiality and discrimination. This was felt to be compounded by local clinicians and healthcare staff lacking confidence in raising issues around HIV or lacking current knowledge around the subject.

7. Service Provision

7.1 Prevention

Primary prevention of HIV transmission is possible through health promotion, screening, antenatal screening, needle exchange programmes, post exposure prophylaxis and good protective practice in healthcare settings.

The following prevention services are provided in Milton Keynes:

Condom Distribution Schemes

Currently a number of condom distribution schemes operate aiming to provide free and easily accessible condoms to groups most at risk of sexually transmitted infections, including HIV. Brook East of England are formally commissioned to operate a scheme to provide free condoms to under 25 year olds. For a fixed term Shika Tamaa Support Services (STaSS) are operating a scheme targeting the Sub Saharan African population. Condoms and lube are provided free by the NHS to a local nightclub targeting the gay community, however, this is not a formally commissioned scheme.

Post Exposure Prophylaxis

In Milton Keynes Post Exposure Prophylaxis (PEP) for HIV is delivered in line with Milton Keynes Hospitals ‘Management of Occupational and Non Occupational Exposures to Blood Borne Viruses Policy’. For the general population PEP is available from the Accident and Emergency Department and GUM clinic at Milton Keynes Hospital.

Needle Exchange Scheme

This scheme, operating from pharmacies and specialist drug services in Milton Keynes had more than seven thousand client contacts last year (Pharmaceutical Needs Assessment 2010).

HIV Prevention education

Brook East of England are commissioned to deliver general STI prevention and education messages to under 25 year olds. HIV is discussed as part of their general awareness raising education.

There is no other formally commissioned HIV prevention/education work undertaken in Milton Keynes.
7.2 HIV testing and diagnosis

Nationally, HIV testing is offered routinely to all patients attending antenatal clinics and Genitourinary Clinics. Consequently, the majority of HIV testing occurs within these settings.

Free National Health Service HIV testing in Milton Keynes is offered at:

- Milton Keynes Genitourinary Clinic (GUM)
- Level 2 Sexual Health Services (Brook MK and the STAR Clinic)
- All pregnant women are offered HIV testing as a routine part of their antenatal care
- All GP practices are able to offer HIV testing to their patients
- Hospital Departments will undertake a HIV test when HIV is considered to be part of the differential diagnosis
- Rapid result HIV Quick Tests are available in two GP practices in Milton Keynes and are open to all. These clinics carry out approximately one hundred and fifty quick tests annually with approximately 3% positivity. They are not formally commissioned and are currently managed internally by PCT staff.

In Milton Keynes uptake of HIV testing antenatally is high and in line with recommended levels.

GUM clinics offer HIV testing to all individuals presenting for a sexual health screen as well as confirmatory testing (where results elsewhere have indicated a probable positive). In 2009, 1981 Milton Keynes residents were offered HIV testing at a GUM clinic with 84.2% taking up the offer. Table 4 below shows a breakdown

Table 4: Percentage uptake of HIV amongst Milton Keynes residents in GUM clinics – 2009

<table>
<thead>
<tr>
<th>Gender/sexual orientation</th>
<th>Number taking up test</th>
<th>Number offered test</th>
<th>Percent uptake</th>
<th>England Percent uptake</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>1668</td>
<td>1981</td>
<td>84.2</td>
<td>74.9</td>
</tr>
<tr>
<td>MSM</td>
<td>181</td>
<td>193</td>
<td>93.8</td>
<td>88.5</td>
</tr>
<tr>
<td>Heterosexual men</td>
<td>1455</td>
<td>1724</td>
<td>84.4</td>
<td>78.7</td>
</tr>
<tr>
<td>Women</td>
<td>1668</td>
<td>1981</td>
<td>84.2</td>
<td>74.9</td>
</tr>
</tbody>
</table>

Source: sexual health balanced scorecard

There is evidence that GP practices and hospital departments are offering HIV tests to their patients with approximately 1700 of these tests being carried out annually (MK Lab data 2010). There is no formal arrangement in place with GP practices or Milton Keynes Hospital to determine the exact level of testing for specific at risk groups.
National Guidance around HIV Testing and Diagnosis

In 2008 the British HIV Association and British Association of Sexual Health and HIV recommended areas with a prevalence of HIV above 2 in 1,000 (diagnosed 15 - 59 year old population) e.g. Milton Keynes, should expand the offer of routine HIV testing to all adults registering in general practice and for general/medical hospital admissions.

In 2010 the HPA reiterated this recommendation with their publication ‘Time to Test’ reporting on eight projects they funded in high HIV prevalence areas in 2009. Overall positivity for the projects was 5 per 1,000 tests (the cost effectiveness threshold for expanding HIV testing programmes in the United States of America) and found the routine offer of HIV testing in primary care and hospital settings to be feasible and acceptable to staff and patients.

Most recently NICE (2011) have issued guidance to increase the uptake of HIV testing amongst men who have sex with men and black Africans, recommending that in high prevalence areas like Milton Keynes, HIV testing is offered to adults routinely upon GP registration and for general hospital admissions. In addition Guidance also states that HIV testing should be offered to women seeking termination in areas of high prevalence (BHIVA 2008).

Late Diagnosis

It is estimated that around 22,000 people in the UK have HIV but do not know it, with one in four of all HIV infections being undiagnosed (HPA 2009). Without treatment HIV results in destruction of the body’s immune system and a progressive increase in illness.

Early diagnosis and early access to antiretroviral treatment lowers the level of virus in the individual’s body improving outcomes for that individual. As well as benefits for the HIV positive person prompt diagnosis has other benefits. An HIV positive individual using antiretroviral treatment will have a reduced level of infectiousness and having received a diagnosis encourages individuals to take appropriate precautions to reduce onward transmission. Contact tracing that takes place following a positive diagnosis provides opportunities to diagnose other individuals. Treatment of HIV positive pregnant women along with careful management at delivery reduces the likelihood of transmission to the baby.

Late diagnosis is defined as a diagnosis where the CD4 cell count is less than 350per mm within 3 months of diagnosis.

In Milton Keynes, along with increasing numbers of diagnosed cases of HIV, in 2009 (2010 data awaited) as table 5 shows, 69% of samples tested were defined as late diagnosis.
Table 5: HPA data for late diagnosis in the SE of England

<table>
<thead>
<tr>
<th>SHA</th>
<th>PCT Name</th>
<th>2009</th>
<th>&lt;350</th>
<th>%LateDX</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Central</td>
<td>Berkshire East PCT</td>
<td>44</td>
<td>21</td>
<td>47.7%</td>
</tr>
<tr>
<td>South Central</td>
<td>Berkshire West PCT</td>
<td>44</td>
<td>23</td>
<td>52.3%</td>
</tr>
<tr>
<td>South Central</td>
<td>Buckinghamshire PCT</td>
<td>25</td>
<td>14</td>
<td>56.0%</td>
</tr>
<tr>
<td>South Central</td>
<td>Hampshire PCT</td>
<td>51</td>
<td>32</td>
<td>62.7%</td>
</tr>
<tr>
<td>South Central</td>
<td>Isle Of Wight PCT</td>
<td>Sample &lt;5</td>
<td>33.3%</td>
<td></td>
</tr>
<tr>
<td>South Central</td>
<td>Milton Keynes PCT</td>
<td>29</td>
<td>20</td>
<td>69.0%</td>
</tr>
<tr>
<td>South Central</td>
<td>Oxfordshire PCT</td>
<td>23</td>
<td>9</td>
<td>39.1%</td>
</tr>
<tr>
<td>South Central</td>
<td>Portsmouth City Teaching PCT</td>
<td>10</td>
<td>6</td>
<td>60.0%</td>
</tr>
<tr>
<td>South Central</td>
<td>Southampton City PCT</td>
<td>17</td>
<td>7</td>
<td>41.2%</td>
</tr>
<tr>
<td>South Central</td>
<td>England</td>
<td>246</td>
<td>133</td>
<td>54.1%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4548</td>
<td>2333</td>
<td>51.3%</td>
</tr>
</tbody>
</table>

Along with the difficulties late diagnosis can present to the HIV positive individual, there are significantly increased statutory costs associated with late diagnosis. The cost of treating someone diagnosed with a CD4 count of less than 350 per mm (over 3) of blood is more than two and a half times higher than someone diagnosed in the early stages (Krentz and Gill 2010). Although the difference between the total costs narrows after five years, they remain higher for those diagnosed later than those diagnosed earlier. The financial value of preventing a single onward transmission was estimated to be between £500,000 and £1 million (in health benefit and treatment costs) in 2001.

7.3 Treatment and Care

Milton Keynes residents diagnosed with HIV are able to access their treatment at their Centre of choice. Milton Keynes is lucky to have a local HIV service with a specialist HIV Consultant and nurse to whom individuals with a positive HIV diagnosis are referred. Increasingly Milton Keynes residents are choosing to access their treatment at Milton Keynes Hospital. In 2009, 68% of Milton Keynes residents who had been diagnosed with HIV were receiving treatment at Milton Keynes Hospital with others choosing to access their care and support elsewhere usually where their initial diagnosis/treatment commenced or close to work commitments.

Concerns have been raised by stakeholders about the need for paediatric patients to travel outside of Milton Keynes to specialist services elsewhere (see other information).

7.4 Care Services

Historically an ‘Aids Support Grant’ has been paid by Central Government to Local Authorities to enable Social Care Departments to draw up strategic plans to address the specific care needs of their local population with a diagnosis of HIV. On 1st April 2011 the Aids Support Grant (ASG) will be moved into the main formula grant paid to local authorities by the Department of Communities and Local Government and it will cease being a specific grant.
Currently Milton Keynes Council uses the Aids Support Grant to commission the following social care support services for people living with HIV:

- **Shika Tamaa Support Services (STaSS)**
  Provide advocacy, support, drop-in sessions, befriending services, signposting, and information and outreach services to individuals and families infected and affected by HIV.

- **City Counselling (H4 service)**
  Offers counselling sessions to people with HIV via drop in appointments and outreach from the STaSS offices.

- **Citizens Advice Bureau**
  Offers Information, advice and support regarding debt, benefits, legal and immigration issues.

Milton Keynes Council also provides funding for the following two full time posts:

- Social Worker – Hospital Social Work team
- Community Social Worker (HIV/AIDS) – Hospital Social Work team

All services provide regular monitoring information such as number of clients / families, demographic data and residential area to provide a clearer picture of people infected or affected by HIV in Milton Keynes to allow for better planned support services.

A previous piece of work (undertaken by the social work team and Milton Keynes council) looking specifically at service users views determined that care services were in line with the needs of service users but information about services for individuals with a new diagnosis was lacking and resulted in an information leaflet about services available for individuals with an HIV diagnosis.

The Joint Commissioning Team based at Milton Keynes Council is in the process of conducting a review of funds available from the AIDS support grant and related services to which this needs assessment will contribute.

8 Stakeholder and User Views

A Roundtable event focusing on HIV prevention, treatment and care of the highest risk groups was held with stakeholders providing services to these groups or HIV related services along with key influencers (religious leader and community leader representatives) in May 2011. The focus was to fully understand current provision and to identify gaps. The key issues highlighted at this meeting were then circulated more widely with an invitation to comment and add. A number of 1-1 discussions with key stakeholders followed in order to clarify issues raised.

In summary the stakeholder consultations highlighted the following:
8.1 Prevention

8.1.1 Men who have sex with men

With the exception of free condom provision from a local nightclub (targeting MSM) there are no co-ordinated or specifically commissioned MSM HIV prevention activities provided locally.

MSM not openly identifying as gay or bisexual may be a difficult group to target and accessing these groups will need to be considered innovatively.

Innovative technologies and existing forums were felt to have potential to publicise local issues.

The two highest prevalence groups (MSM and Sub Saharan African Communities) require very specific and expert support.

Although there is an under 25s condom distribution scheme and adhoc condom provision from a local nightclub targeting MSM generally would be preferable.

There is a lot of detailed information available for MSM which can be found if you look hard enough and lots of new ‘evidence’ around safe and not so safe sexual practices (i.e. new information about increased risk of HIV and use of Poppers) this information is not necessarily easily accessible – a system needs to be put in place to make sense of this information and make it more easily accessible.

More awareness of Post Exposure Prophylaxis is needed.

Concerns around potential stigma and reaction from professionals when accessing testing, disclosing HIV status or sexuality

8.1.2 Prevention - Sub Saharan African population

Local workers are aware of HIV positive women continuing to breastfeed against advice. Barriers include finance, as purchasing formula milk and bottle-feeding equipment can be a problem for some HIV positive mothers. Healthy start vouchers are available for those eligible for them, but a high number of HIV positive local mothers do not have recourse to public funds, in addition, there are concerns around disclosure.

For HIV positive mothers advised to bottle-feed there can be pressure to breastfeed from family members who may not be aware of the diagnosis (as above).

Prevention and diagnostic information needs to be in different languages and formats to take into account the diverse population within Milton Keynes

More information (particularly about how to get children tested where parents might have concerns) could be made available at Sure Start Centres and ante-natal clinics.

8.1.3 Prevention – all

Use of social media, twitter.facebook/chat rooms, Apps should be considered for prevention/education work.

National campaigns are needed to reach a wider audience. Some sections of the community/public might perceive HIV as something from the 1980s
Use of prominent figures e.g. footballers might help with promoting testing/practising safer sex.
Condoms are a key factor in the prevention message.

8.2 Diagnosis

The following issues around diagnosis were identified by stakeholder:

8.2.1 Diagnosis – MSM
Anecdotal evidence suggests local MSM (who can access them) may choose to use testing services outside of Milton Keynes as they are tailored very specifically to their wants and needs.
Reflecting the national evidence base, concerns were expressed around stigma and discrimination when accessing services and concerns about confidentiality, legal and practical issues, all of which were exacerbated by a lack of local information.
There is a lack of outreach HIV testing targeting MSM which would be desirable.
Offering HIV testing routinely in GP practices (as per national guidance) to all men would reduce concerns around stigma/discrimination and increase uptake.

8.2.2 Diagnosis – Sub Saharan African population
Access to community based quick testing is problematic. The timing of clinics is inaccessible to many as provision is primarily within working hours.
Community based testing should include a mobile ‘outreach’ component.
There needs to be further engagement with religious and community leaders.

8.2.3 Diagnosis – all
It would be preferable for rapid (quick/point of care) testing to be universally available (including at GUM).

8.3 Treatment
There are some concerns around the transition from paediatric services at Milton Keynes Hospital to adult services.

8.4 Care and support following diagnosis - All
Concerns were raised around the mental health impact of diagnosis which counselling alone will not support and queries over whether additional psychological support could be in place.
There are inherent financial issues for some individuals diagnosed with HIV which impact on housing and other issues.

These views have been considered, along with the evidence base, to define the recommendations made on page 25.
9. **Recommendations**

The following recommendations reflect the findings of this needs assessment. A number have already been implemented during the process of this Health Needs Assessment. Those that should be prioritised by commissioners are detailed in the Executive Summary.

**Prevention**

A. The outcome of the House of Lords Review of HIV Education should be used to inform health education/awareness raising needs locally. In the meantime, existing targeted information available nationally should be adapted and utilised locally and delivered by organisations with expertise in working with the ‘target’ population.

B. A scheme should be put in place to offer free formula milk and formula feeding kits to HIV positive pregnant women for up to one year following the birth of their child.

C. An organisation should be identified to support a scheme to work with HIV positive pregnant women who have concerns around disclosure and stigma if bottle-feeding.

D. Commissioners should work with providers of sex and relationships education (SRE) to ensure HIV prevention education and awareness is included within SRE provision.

E. Condom distribution schemes targeting MSM and the Sub Saharan African community should be reviewed and formally commissioned.

F. There is a need for work around HIV prevention, education and health promotion targeting the Sub Saharan African Community and organisations that work with these groups. This should be delivered in line with NICE Public Health Guidance.

G. There is a need for targeted work around HIV prevention, education and health promotion targeting the MSM communities. This should be delivered in line with NICE Public Health Guidance.

H. Work should be undertaken to ensure all sectors providing services for or working with MSM have current and factual information around HIV including promotion of annual HIV testing and condom distribution. This should be co-ordinated from one central point.

I. In order to better understand sexual health issues for MSM in Milton Keynes, efforts should be made to engage more local MSM in the (SIGMA research) Gay Men’s Sex Survey.

J. Local work to promote annual HIV testing for MSM and to reduce stigma and concerns around testing should be prioritised.
K. Links should be established with drug and alcohol services to ensure HIV prevention information and testing information is available to service users.

L. A social marketing campaign promoting condom use for the general population should be undertaken.

Testing and Diagnosis

M. In line with HPA guidance all new GP registrants in Milton Keynes should be offered an HIV test upon registration.

N. In line with British Association of Sexual Health and HIV (BAASH), British HIV Association (BHIVA) and British Infection Society (BIS) Guidelines all Milton Keynes residents accessing termination of pregnancy should be offered an HIV test.

O. Commissioners should work to introduce a CQUIN at Milton Keynes Hospital aiming to offer HIV tests to all individuals having blood samples taken.

P. Community/outreach based HIV testing should be formally commissioned. It should take place at more accessible times and in locations to meet the needs of the highest prevalence groups (Sub Saharan African Population and MSM).

Q. Existing providers of HIV tests should be promoted to MSM and providers should be mindful to the needs, concerns and barriers to testing for this group (including men who may not identify as ‘gay’).

R. GP practice and hospital staff should be offered training/education to support them to recognise individuals who may be at risk of being HIV positive, to promote HIV prevention and where appropriate broach and offer HIV testing.

S. A system should be put in place to enable commissioners to fully understand the level of requests for, offers of and uptake of HIV testing for specific groups within Milton Keynes GP practices.

T. In line with NICE Guidance formal strategies to increase uptake of HIV testing amongst MSM and amongst Sub Saharan African Communities should be in place.

U. Work with key influencers within the Sub Saharan Africa community to confirm anecdotal discussions around possible links between late diagnosis and new immigrants with the aim of investigating best practice in terms of increasing information for and allaying concerns of this population with regards to accessing testing for HIV.

V. Awareness raising for primary care staff around issues associated with HIV to include awareness of HIV prevalence in Milton Keynes, prompts for testing, and to address stigma issues and concerns raised by service users.
Treatment and Care

W It is vital that Milton Keynes Local Authority continues to apply an internal ring fence to the former AIDS Support Grant.

X Concerns expressed by stakeholders over the potential difficulties for children with HIV during the transition period from child to adult which should be explored further.

Y Ideally diagnostic and treatment services should be integrated and provided by one organisation. If this is not possible a seamless pathway with information sharing protocols must be in place in order for the two services to work together to ensure diagnosed individuals reach treatment services.
References


Krentz and Gill. 2010. Despite CD4 cell rebound the higher initial costs of medical care for HIV infected patients persist 5 years after presentation with CD4 counts less than 350. AIDS 2010. advance online publication CITED IN Halve It: HIV is a Public Health Priority. The Halveit Coalition.


Royal College of Paediatrics and Child Health. 2006. Reducing Mother to Child Transmission of HIV Infection in the United Kingdom. RCPCH


Appendix 1

House of Lords Select Committee on HIV and AIDS, Department of Health Response and Milton Keynes PCT current situation (2011)

<table>
<thead>
<tr>
<th>House of Lords Select Committee Recommendations</th>
<th>Department of Health response</th>
<th>Milton Keynes local related situation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prevention</strong></td>
<td>Prevention</td>
<td>Prevention</td>
</tr>
<tr>
<td>Should be at the forefront of the response to HIV and must be reflected in the Governments replacement of the 2001 sexual health strategy. More resources must be provided at international and local level. The Government should audit and monitor the use of resources provided</td>
<td>Will be a key part of the new Sexual Health Policy Framework. At local level it is for primary care trusts and from 2012 local authorities to decide their level of investment in HIV prevention, taking into account HIV prevalence and wider public health needs</td>
<td>There is limited HIV prevention work in place and this does not reflect the increasing HIV prevalence.</td>
</tr>
<tr>
<td><strong>Risky behaviour</strong></td>
<td>Risky behaviour</td>
<td></td>
</tr>
<tr>
<td>More needs to be done to reduce dangerous and risky behaviour that is leading to HIV infection. More funding is needed and a broader range of evidence based approaches are required. HIV prevention campaigns should be targeted to the two groups with highest HIV prevalence (MSM, SSA communities) and co-ordinated at national level. A range of intensive interventions including group and individual counselling work should be delivered for those who are most at risk of either contracting or passing on HIV</td>
<td>Reducing risk taking is not an issue unique to sexual health. Government agrees more needs to be done by all to address behaviour that increases the risk of HIV infection and will consider this further as part of the development of the new Sexual Health Policy Framework</td>
<td></td>
</tr>
<tr>
<td>HIV awareness should be incorporated into wider national sexual health campaigns to promote public health and prevent stigmatisation of groups at highest risk of infection. DH should undertake a new national HIV prevention campaign aimed at the general public to ensure HIV prevention messages are accessible to all. A full range of media should be utilised.</td>
<td>Government accepts the evidence base that MSM an SSA communities must remain the focus of HIV prevention programmes. Do not support he recommendation of need for a national campaign aimed at the general public</td>
<td>Prevention education for the general public concerning general STI and HIV prevention could centre around further promoting condom distribution schemes.</td>
</tr>
<tr>
<td>Nationally and locally work already taking place with faith leaders should be built on in order to enlist their support for effective and truthful</td>
<td>Government agrees that faith leaders and groups in some communities afford a valuable contribution to those communities.</td>
<td>Some limited work was undertaken by outreach worker. Work within toolkits should be included in local HIV prevention strategy.</td>
</tr>
<tr>
<td>Topic</td>
<td>Action</td>
<td>Notes</td>
</tr>
<tr>
<td>-------</td>
<td>--------</td>
<td>-------</td>
</tr>
<tr>
<td>Communication of HIV prevention messages. DH should ensure continued funding to support this work building that currently delivered by the African Health Policy Network (AHPN). Recommend LA’s and other public health sector funders acknowledge the importance of this work in future funding decisions.</td>
<td>The national HIV prevention programme for African communities has contributed to toolkits for the Christian and Muslim faith leaders (produced by AHPN) and are developing further.</td>
<td></td>
</tr>
<tr>
<td>Needle Exchange</td>
<td>Continued provision supported</td>
<td>Local provision in place. Investigation to understand link with other related prevention information required.</td>
</tr>
<tr>
<td>HIV and Schools</td>
<td>Teaching on the biological and social aspects of HIV and AIDS should be integrated into SRE. SRE should be mandatory within national curriculum from Key Stage 1 (with teaching age appropriate) External providers have a role to play but training should be provided by teachers in the first instance which must focus on all aspects of HIV Teacher will require related training.</td>
<td>HIV and Schools As a result of the office for standards in education report on PSHE (2010) a PSHE review is planned and will take into account these recommendations. HIV and Schools Current provider of SRE to schools includes HIV and AIDS education. Work to further understand SRE provision in schools within sexual health strategy but development post to develop curriculum and work with schools and been cut.</td>
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<td>Mother to child transmission</td>
<td>Procedures developed to limited mother to child transmission have been a success and should continue. Free infant formula milk should provided to HIV positive mothers who have no recourse to public funds</td>
<td>Local NHS trust are responsible for determining which services to provide in line with the needs of the local population, therefore free infant formula milk needs to be decided locally. BHVA and CHVA provide advice on access to financial assistance where this may be a barrier to avoiding breastfeeding. Repeated requests from voluntary sector and HIV treatment services for the implementation of a local scheme to provide free infant formula to HIV positive mothers (approx £6k cost per annum).</td>
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<td>Testing</td>
<td>Earlier diagnosis ensures that those infected receive timely treatment - this is cost effective in the long run. The government should endorse the 2008 professional testing guidelines, 2011 NICE testing guidelines and recommendations made by HPA in Time to Test HIV testing must become more widespread. Professionals more particularly GPs must become more confident and competent in offering and administering</td>
<td>The Government agrees wit the importance of early testing and will ask the UK National Screening Committee to consider all of the evidence. Training and education for health professionals is very important Offering HIV testing should be within the competence of any nurse or doctor. This is especially relevant where a person is presenting with symptoms which could be an indicator of HIV infection or live in a high prevalence area. Existing guidelines state that areas with HIV prevalence above 2 per 1,000 should implement enhanced testing - this has not yet been implemented locally with testing outside of GUM and antenatal limited to HIV quick testing clinics in GP practices during working hours and targeting the SSA community.</td>
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Training and education are important tools to use to achieve this and should form an important part of local testing strategies. And must include HIV related stigma. Medical practitioners need the knowledge and skills to manage HIV.

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<td>Local prevention programmes and the voluntary sector bodies that deliver them have played an important role in tackling HIV. Local Authorities and health service funders should avoid undermining local HIV prevention work when taking budget decisions</td>
<td>Government agreed that voluntary sector and community based organisation have made a major contribution to tackling HIV - their links knowledge and understanding of communities most affected by HIV means that prevention messages are relevant and acceptable to communities targeted</td>
<td>There are opportunities to further engage with local voluntary sector organisations working with highest prevalence groups to increase HIV prevention and testing initiatives.</td>
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Encouraging people to test through the provision of education, training and support can have significant benefits for the public. We support the development of local testing strategies, recommended with NICE testing guidelines equipping people with the knowledge and desire to get tested should form an integral part of these strategies.

Agree

Local strategies should be developed.