NICE National Institute for Health and Care Excellence

Consultation on draft quality standard – deadline for comments 5pm on 21 April 2017 **email:** QSconsultations@nice.org.uk

	Please read the checklist for submitting comments at the end of this form. We cannot accept forms that are not filled in correctly. We would like to hear your views on these questions: 1. Does this draft quality standard accurately reflect the key areas for quality improvement? If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures? Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted. 2. [Insert any specific questions about the quality standard from the Developer, or delete if not needed]
Organisation name – stakeholder or respondent (if you are responding as an individual rather than a registered stakeholder please leave blank):	[**British HIV Association]**
Disclosure Please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry.	[**No conflict of interest**]
Name of commentator person completing form:	[**David Chadwick**]

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Supporting the quality standard - Would your organisation like to express an interest in formally supporting this quality standard? More information.		[**Yes**]	
Type		[office use only]	
Comment number	**Section**	**Statement number**	**Comments** Insert each comment in a new row. Do not paste other tables into this table because your comments could get lost – type directly into this table.
1	Questions for Consultation (Q1)	-	Yes – these standards broadly address the key areas, although one could argue that as well as hospitals and General Practices, GUM/Sexual Health Services should also specifically be mentioned as important sites of testing, especially in relation to Standards 3, 4 and 5.
2	Questions for Consultation (Q2)	-	In general systems may be in place in some areas, however probably not all. In General Practice (Statements 2,5), we understand that electronic patient records (EPR) would require there to be 'templates' created to measure how many patients are offered tests when registering. Moreover with current EPRs or Order-Comm systems it would be difficult to measure how many patients undergoing blood tests who had not been tested in the past year were tested, without substantial modifications to these systems or manual extraction of data. It is likely that most hospitals would be able to collect data on testing for the Statement 1, but may find it difficult to measure whether tests had been offered (without the 'templates in EPRs mentioned earlier). The only other method for measuring this outcome in hospitals would be case notes review, which would be time and resource-consuming.
3	Questions for Consultation (Q3)	-	This question is slightly ambiguous. If it is asking whether the statements would be achievable given current resources, and without additional resources (e.g. QOF or locally-enhanced service for GPs), assessing most of the measures which are harder to measure would not easily be achieved. Periodic audits of small samples of patients could be undertaken by many hospitals, GP surgeries or Sexual Health clinics for some of the measures which are easier to assess. However, we believe that measuring all these measures will require substantial additional resources. It should be mentioned that there is potential for some of these measures to be incorporated into HARS or other PHE datasets, with appropriate additional resources.

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			In addition, mention issues such as GUMCAD reporting accuracy and whether some of the V3 items are included in the measures outlined here.
4	Questions for Consultation (Q4)	3	Yes – this is a reasonable list of indicator conditions to flag up and should also include shingles.
5	Questions for Consultation (Q5)	6	Yes this timescale is appropriate
6	Statements 1-3 & 6	1-3 & 6	We believe that the term 'offer' in each of these statements is not sufficiently prescriptive. Arguments for adopting a more prescriptive term than 'offering' HIV testing are: 1. HIV is a serious infectious disease with high mortality if diagnosed late. 2. Diagnosing HIV earlier is beneficial to society since it reduces transmission of infections. 3. The term 'offer' is more consistent with the 'AIDS exceptionalism' era when testing for HIV was perceived to be different to other routine tests and required pre-test counselling. Current attempts to normalise HIV testing through 'opt-out' and other testing strategies are hampered by the use of terms such as 'offering' tests. 4. The term 'offer' suggests uncertainty or ambivalence on the part of the clinician as to the medical benefit of having an HIV test, which should clearly not be the case given the extensive evidence available. In fact one could argue that HIV testing has a greater clinical and cost-effectiveness benefit, and less risk attached, than many tests we currently recommend (rather than 'offer') to patients. Whilst it might be reasonable to *recommend* a test to patients without indictor conditions or other risk factors (e.g. screening in areas of high/very high prevalence) there should be no doubt that testing is an absolute necessity for patients with indictor conditions or risk factors. 5. Most other NICE quality standards do not use the term 'offer', or suggest clinicians do anything but strongly recommend or complete an important course of action, when referring to key diagnostic tests e.g. *'People presenting in primary care with symptoms that suggest oesophageal or stomach cancer **have** an urgent direct access upper gastrointestinal endoscopy.'* [QS124]*;* '*People with suspected deep vein thrombosis **have** all diagnostic investigations completed within 24 hours of first clinical suspicion*.' [QS29]; '*Adults with spinal pain suggestive of spinal metastases, …, **have** an MRI of the whole spine and any necessary treatment plan agreed within 1 week of the suspected diagnosis.'[QS56]; 'People who are referred to a tuberculosis (TB) service, who meet specific criteria, **have** rapid diagnostic nucleic acid amplification tests (NAATs).* [QS141]*'; Adults presenting in primary care with symptoms that suggest colorectal cancer, …, **have** a test for blood in their faeces.'* [QS124] Suggested replacement terms (alternatives to 'offer'):

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			1. **Have** an HIV test… 2. **Are tested** for HIV 3. **Are recommended to have** an HIV test…. (less ideal than above term, but could be used where test is suggested for patients more as a screening test, e.g. new registrants at GP surgeries or attenders at A&E departments in areas of high HIV prevalence) We believe that using either of the three above terms (rather than 'offer') will make these quality standards more consistent with other NICE quality standards, provide greater impetus to clinicians to test patients in each of these situations and consequently improve compliance with these quality measures.
7	All statements	1-6	We believe that it should be made explicit in these standards that for the vast majority of HIV tests, opt-out tests are provided and that pre-test counselling is no longer needed for most patients. Unfortunately, particularly in some lower-prevalence areas, many clinicians are still not aware of this.

Insert extra rows as needed

Checklist for submitting comments

- Use this comment form and submit it as a Word document (not a PDF).
- Complete the disclosure about links with, or funding from, the tobacco industry.
- Include section number of the text each comment is about e.g. introduction; quality statement 1; quality statement 2 (measure).
- If commenting on a specific quality statement, please indicate the particular sub-section (for example, statement, measure or audience descriptor).
- Combine all comments from your organisation into 1 response. We cannot accept more than 1 response from each organisation.
- Do not paste other tables into this table – type directly into the table.
- Underline and highlight any confidential information or other material that you do not wish to be made public.
- Do not include medical information about yourself or another person from which you or the person could be identified.
- Spell out any abbreviations you use
- For copyright reasons, comment forms do not include attachments such as research articles, letters or leaflets (for copyright reasons).We return comments forms that have attachments without reading them. The stakeholder may resubmit the form without attachments, but it must be received by the deadline.

You can see any guidance and quality standards that we have produced on topics related to this quality standard by checking NICE Pathways.

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

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