BHIVA, BASHH, BIA and RCEM rapid guidance on opt-out blood-borne virus testing in high-prevalence and extremely high-prevalence acute medical settings and emergency departments 2024

Public consultation comments

Compilation of all comments received via the BHIVA website. The writing group thanks everyone who responded to the consultation. The guidelines have been revised based on the comments unless otherwise stated.
17 April 2023

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	Name	Affiliation	Comments	Writing group response
1.	David Hawkins	Chair UKAP, Honorary Consultant Physician Chelsea and Westminster	In the introduction second paragraph it is stated that the guidance is for EDs and 'other facilities managing people who present for urgent care' To be clear this should specifically mention Urgent Care Centres (UCCs) as they may be run by contracted in services and the training needs to be specifically addressed to any staff who work permanently or temporarily for these latter services.	This has been clarified
2.	Richard Hall	University Hospital of North Staffordshire	The advantage to testing for BBIV in the Urgent Care setting in areas of low prevalence will be associated with significant logistical and cost implications and like all screening services the cost benefit will have to be evaluated. We need to understand at what prevalence point does the the cost-benefit have impact. This would ideally need either a national pilot study of study in areas of varying prevalence. The testing of patients having other blood test investigations undertake in ED	This is an interesting point and we agree that pilot studies in lower-prevalence settings are needed. We disagree about 'national guidance' saying follow-up of results is ED's responsibility, and associated implications. We specifically say this should not be the case and our ED colleagues' consensus is consistent with this

			is the easy part however the cost implication will be substantial for laboratories including equipment and personnel. The logistics' of result management will also complex. Either patients having to wait for results in the ED so that the results can be discussed by a trained member of staff (cost implication of training staff) or the results will have to be followed up after admission (simple) or after discharge. Under national guidance the follow up of results would be the responsibility of ED (cannot be handed back to GPs for follow up results). The logistics of contacting and arranging follow up with GUM would also need to be arranged and any additional staffing (from secretarial support, management support and senior clinician support - both ED and GUM). With the stigmata that still exists in the general public around such infections, face-2-face consultation on obtaining the results would be the best option. This may lead to delays in ED waiting for results and have effects of productivity, crowding and national ED KPI performance (non-admitted performance)	
3.	Viv Wholey	Co.Durham and Darlington NHS Foundation Trust	1) I know Syphilis assumed consent opt-out is available to women undergoing ante-natal checks alongside HIV and sometimes Hepatitides. However, knowing that pregnancy can be associated with increased risk of domestic violence; management can be compromised. There is also evidence of a decreasing birth rate and as such potentially less opportunity to catch women. We know that Syphilis spreads in mysterious ways in a population. Rates are increasing; despite the provision crisis in sexual health services. From a public health perspective and for the individual who could present anywhere with/ without expected pathology, is there any mileage in adding syphilis screening too, even when a developing baby does not need protection? 2) Totally agree that lab request databases need to enable clinicians to this easily.	We agree but this should be at a later stage and probably needs local seroprevalence pilots in EDs
4.	Michael Johnston	NHS Tayside	The health board region in which I work was one of the very first regions to declare that Hep C been eradicated. I am also fairly sure that the overall incidence of HIV is low locally. I am therefore of the opinion that routine testing of ED patients would not be useful. I also feel that even if our local incidence of HIV and other BBV infections	It has never been a policy to introduce ED testing in low-prevalence settings

			were high then the additional workload burden for the ED would be very significant given the need for training of our junior medical and nursing staff which would need to be incorporated into an already onerous induction programme. ED's across the UK are at breaking point and we need to be very wary about taking on additional work. It would be interesting to hear if Guys, Bart's, and Leeds would be as happy to take this on now rather than several years ago before the 'explosion' of workload that has eventuated.	
5.	Alastair Baird	NHS Tayside	Given the extensive pressure on EM across the UK I cannot support this process if it results in any increased work for Emergency Department clinicians at any stage. Either the process is entirely automated on biochemistry results (E.g. samples are sent from the biochemistry lab (after initial blood tests are completed) for microbiological analysis) or it is done in a downstream department e.g. AMU. I am concerned that this proposal reflects an attitude in the NHS where specialties outside of Emergency Medicine impose their mission objectives on EM when emergency care is under incredible strain and so am thankful for this consultation process.	It has never been a policy to introduce ED testing in low-prevalence settings
6.	Russell Duncan	NHS Tayside	While I understand that there is an opportunity when people attend the ED for bloods to be screened for BBVs this is definitely not core EM business and the EM specialty cannot be responsible for counselling, monitoring or taking action on results. It should be for the lab based specialties to decide if they want to add screening tests to bloods tests and ID to follow up on positive test results. Nothing to do with Emergency Medicine.	It has never been a policy to introduce ED testing in low-prevalence settings
7.	Eleanor Matthew	NHS Tayside	Dear Colleague, While I see that you intent is clearly positive, I have several concerns about blanket testing in all UK EDs: 1. Our department in NHS Tayside in not in a high prevalence area for HIV and I am not sure how this testing would serve our patients. 2. It is not the role of an Emergency Department to carry out 'opportunistic' testing - we respond and resuscitate the seriously injured and unwell. How does blanket public health testing fit into that? 3. Given that my area is low prevalence, how can the cost of this be justified? I see this note: A pilot study of this approach in an ED in Leeds (2018–2019) identified 247 people with HCV, 128 people with HBV and 124 people with HIV, out of 33,816 tests [1]. The majority of these people were already	It has never been a policy to introduce ED testing in low-prevalence settings

			known to be living with BBVs but were not currently engaged in care. I note it does not say how many of these people were known to have a BBV but it does say 'the majority' - how useful is it then? 4. I am also concerned about who takes responsibility for these tests? I see that the plan is for a 'designated department' to handle 'non-negative' results. We generally work on the principle that if we conduct the test, we are responsible for it. It makes no sense that this should differ. I ultimately see the benefit of widespread opt-out testing for BBV testing but strongly feel that the Emergency Department is not the place to do it.	
8.	Jamie Morrison	NHS Tayside	Thanks for the opportunity to provide some thoughts regarding this. I would strongly advocate that this is very far removed from the core work of Emergency Medicine as a speciality. Whilst I appreciate it is important to capture the prevalence of BBV in the community I fail to understand how the screening should be undertaken by the Emergency department. This in addition to the multiple other activities we as a speciality have been asked to take on. For example, in Scotland as part of the redesign of urgent care the government mandate given to emergency departments has been to provide in scheduling and direction of patients for their healthcare needs. Locally the number of phone interactions this has generated has hugely increased the number of total interactions we have. This is in addition to increasing demand on the shop floor which for 2022 has been significantly greater than pre-pandemic activity. The evidence provided in the written consultation puts forward that the positive results identified are rarely new cases. In addition it is put forward this is best applied in high prevalence areas. We are fortunate that we operate in very low prevalence area for HIV with significant advances in curative Hep C management based on the excellent work done by our GI colleagues. Ultimately, I do not believe this task is one that should be undertaken or delivered by our speciality anywhere in addition to my thoughts on a locally. We are busier than ever and I see little evidence or rationale as to why the responsibility for delivery of this should the responsibility of Emergency Medicine.	It has never been a policy to introduce ED testing in low-prevalence settings

9.	Carlos Smith		1) Within the assummed consent E.D consultation document. A lot has been spoken about "HIV exceptionalism". So, if the BHIVA is against "HIV exceptionalism". Why does the BHIVA recommend the following; High visible posters, banners, accessible leaflets on how to opt out of testing, how and where to obtain test results. This does not occur in any other diagnostic test, within, an Emergency Department setting. So if the BHIVA is saying it is routine. Why have all of the above information available to patients. Makes it not routine. BHIVA is totally contradicting it's self. 2) All patients should be verbally consented, as a minimum requirement to HIV opt-out testing. Because, how will Emergency Department clinicians or nurses, know who is illiterate or not. It is common place for people to hide their illiteracy, because of stigma. 4) There are those of us, HIV positive patients. That do not want to disclose our HIV positive status to an Emergency Department. What safeguards, are the BHIVA going to recommend, to protect us. For example if we was unconscious, and the clinician decides in the best interest of the patient, to test for HIV. 5) Concent, The General Medical Council States the following, with NO EXCPTIONS The seven principles of decision making and consent Decision making and consent The seven principles of decision making and consent Published 9 November 2020 One All patients have the right to be involved in decisions about their treatment and care and be supported to make informed decisions if they are able. Two Decision making is an ongoing process focused on meaningful dialogue: the exchange of relevant information specific to the individual patient. Three All patients have the right to be listened to, and to be given the information they need to make a decision and the time and support they need to	This is a fair point about publicity, but we cannot get around this aside from suggesting posters also include information on other tests done e.g. FBC/U&Es, pregnancy test. Eurotest definition of opt-out is consistent with advice given in this guidance around opt-out consent

			understand it. Four Doctors must try to find out what matters to patients so they can share relevant information about the benefits and harms of proposed options and reasonable alternatives, including the option to take no action. Five Doctors must start from the presumption that all adult patients have capacity to make decisions about their treatment and care. A patient can only be judged to lack capacity to make a specific decision at a specific time, and only after assessment in line with legal requirements. Six The choice of treatment or care for patients who lack capacity must be of overall benefit to them, and decisions should be made in consultation with those who are close to them or advocating for them. Seven Patients whose right to consent is affected by law should be supported to be involved in the decision-making process, and to exercise choice if possible. The Care Quality Commission (CQC) Regulation 11. CQC can prosecute for a breach of this regulation or a breach of part of the regulation and can move directly to prosecution without first serving a Warning Notice. Additionally, CQC may also take other regulatory action. See the offences section for more detail. CQC must refuse registration if providers cannot satisfy us that they can and will continue to comply with this regulation. On a personal note. When it comes to "HIV exceptionalism". To those arrogant people out there, that want to preach that rubbish about "exceptionalism". Until you get HIV. I kindly suggest you, shut your mouths, about issues, you are not qualified to talk about. Also each patient should be RESPECTED at all times and NOT side lined regarding being given full information verbally to MAKE AN INFORMED choice about HIV testing.	

10.	Mark Gompels	North Bristol NHS Trust	It looks thorough and comprehensive to me. Thanks	
11.	Tristan Barber	Royal Free London NHS Foundation Trust	I think this is great! Congratulations to all authors.	
12.	Sarah Cochrane	University Hospitals Bristol and Weston	This is a clear and thoughtful document, and covers lots of the queries which commonly arise. Is it possible to add a link to reference 10 (NHS. Blood-borne viruses opt-out testing in emergency departments in London: good practice guidance v1. 2022.) which is referenced a couple of times in the text.	This has been done
13.	Chloe Orkin	QMUL and Barts Health NHS Trust	Thanks for the excellent guidelines which I fully support. However the systematic review excludes the Going Viral project out which happened in 2014. Going Viral was the first ever BBV testing week which occurred in 9 EDs from Glasgow to London in 2014. It preceded the first EU BBV testing week by one year. 'Incorporating HIV/hepatitis B virus/hepatitis C virus combined testing into routine blood tests in nine UK Emergency Departments: the "Going Viral" campaign' Orkin et al https://onlinelibrary.wiley.com/doi/full/10.1111/hiv.12364 As you see , it was published in BHIVA's journal- HIV Medicine in 2016 and is referenced (number 173)in the Public health guidance on HIV, hepatitis B and C testing in the EU/EEA guidelines (https://www.ecdc.europa.eu/sites/default/files/documents/hiv-hep-testing-guidance.pdf) Here are the findings of GV : Results A total of 7807 patients had blood taken during their ED visit; of these, 2118 (27%) were tested for BBVs (range 9–65%). Seventy-one BBV tests were positive (3.4%) with 32 (45.1%) new diagnoses. There were 39 HCV infections (15 newly diagnosed), 17 HIV infections (six newly diagnosed), and 15 HBV infections (11 newly diagnosed). Those aged 25–54 years had the highest prevalence: 2.46% for HCV, 1.36% for HIV and 1.09% for HBV. Assuming the cost per diagnosis is £7, the cost per new case detected would be £988 for HCV, £1351 for HBV and £2478 for HIV.	We are happy to include this reference. To our knowledge, Leeds was the first to do it with assumed consent. We have mentioned the Going Viral project in the background section, but also noted that Leeds was first to do it with opt-out/assumed consent. Apparently in the Going Viral project it was not clear that many sites were using opt-out/assumed consent in the way described in this document, however we have referred to it

			Conclusions In the first study in the UK to report prospectively on BBV prevalence in the ED, we identified a high number of new viral hepatitis diagnoses, especially hepatitis C, in addition to the HIV diagnoses. Testing for HIV alone would have missed 54 viral hepatitis diagnoses (26 new), supporting further evaluation of routine BBV testing in UK EDs. Your guidelines wrongly suggest that the Leeds project was first to study this in 2018/19 which is factually incorrect Subsequent to this we published on linkage to care during GV: Linkage to care after routine HIV, hepatitis B & C testing in the emergency department: the 'Going Viral' campaign. Dhairyawan R, O'Connell R, Flanagan S, Wallis E, Orkin C. Sex Transm Infect. 2016 Nov;92(7):557. doi: 10.1136/sextrans-2016-052742. PMID: 30208368 No abstract available. I wrote an editorial in Lancet HIV on 2015 on BBV testing in the ED Should HIV testing week be blood-borne-virus testing week? Orkin C, Wallis E. Lancet HIV. 2015 Dec;2(12):e510-1. doi: 10.1016/S2352-3018(15)00227-1. Epub 2015 Nov 16. Subsequent to this the approach was rolled out for on year at the Royal London ED We found cases of advanced Hep B Implementing routine blood-borne virus testing for HCV, HBV and HIV at a London Emergency Department - uncovering the iceberg? Parry S, Bundle N, Ullah S, Foster GR, Ahmad K, Tong CYW, Balasegaram S, Orkin C. Epidemiol Infect. 2018 Jun;146(8):1026-1035. doi: 10.1017/S0950268818000870. Epub 2018 Apr 17. PMID: 29661260 As well as wanting correct an omission which makes your guideline historically incorrect I am also raising this as a member of several other guideline writing groups for BHIVA and as a past Chair of BHIVA who cares greatly about its international reputation.	

			I am concerned that the systematic review is flawed and strongly suggest it is repeated to ensure its integrity and those of the guidelines.	
14.	John Day	Southend University Hospital, M&SE NHS Trust	I am very grateful to the working group for this much needed guidance. Page 6 Point 5 Reference is made to patients who "acutely lack capacity", which seems to imply that best-interests decisions do not apply to those who are not expected to ever regain capacity. Patients with chronic cognitive impairment are a significant proportion of our ED cohort. I would be grateful if this could be clarified that best-interests decisions should be taken for these also. Thank you	We agree; this has been clarified in the document