

Standard 8a

Organisation name (if you are responding as an individual, please leave blank)			
Name of commentator			
Hilary Curtis			
Role of commentator			
BHIVA Clinical Audit Co-ordinator			
45	8a	102	I think clearer wording would be “Proportion of provider organisations which include key HIV information within mandatory training”.

Organisation name (if you are responding as an individual, please leave blank)			
DHIVA Dietitians in HIV Association			
Name of commentator			
Clare Stradling			
Role of commentator			
Chair			
8	7	102	reference 6 is missing http://dhiva.org.uk/wp-content/uploads/2013/01/DHIVA_Competerencies_Jan_14.pdf

Organisation name (if you are responding as an individual, please leave blank)			
Name of commentator			
Roy Trelvelion			
Role of commentator			
UK-CAB BHIVA Rep, i-Base staff			
11	8	97	The Section a, Knowledge and training, highlights the importance of knowledge, training and specialist skills in HIV. The section on the peer support team is great. It says the peer support team should have core competencies : “Core competencies should include knowledge and understanding of HIV and treatments, ability to recognise and work with

			<p>diversity, effective listening and communication skills, understanding of confidentiality and of safeguarding for vulnerable adults.”</p> <p>Comment: Keeping up this training and knowledge, and these skills and competencies, with a backdrop of funding cuts to the NHS and support charities is an uphill struggle.</p> <p>Sections b and c are thorough and detailed – great!</p>
--	--	--	--

Organisation name (if you are responding as an individual, please leave blank)			
Name of commentator			Mel Rattue
Role of commentator			Woman living with HIV
8	8	97	<p>“This will help reduce HIV stigma that still exists within the health service (1).”</p> <p>Violence against positive women is any act, structure or process in which power is exerted in such a way as to cause physical, sexual, psychological, financial or legal harm to women living with HIV, The implications for clinicians and policymakers are: that stigma and discrimination against women living with HIV are forms of GBV and need to be recognized as such;</p> <p>Orza L et al. Journal of the International AIDS Society 2015,18(Suppl5):20285 http://www.jiasociety.org/index.php/jias/article/view/20285 http://dx.doi.org/10.7448/IAS.18.6.20285</p>

Organisation name (if you are responding as an individual, please leave blank)			Scottish Drugs Forum
Name of commentator			Austin Smith
Role of commentator			Policy and Practice Officer

48	8	97	<p>Service Quality – Knowledge and Understanding of HIV Specialist Staff Working with Vulnerable Groups and HIV policy planners and service planners, commissioners and managers</p> <p>There is a generalised lack of insight and understanding about substance use generally and of the needs of people who inject drugs as well as the barriers they face in engaging with treatment amongst this group. This seems to have developed into a cultural if not institutional disregard or failure to prioritise the needs of people affected by drugs. Where the prevalence of HIV in people who have injected drugs is low then the consequences of this are unnoticed but in a case like Glasgow where there is suddenly an uncontained outbreak the dangers of this culture become obvious. The draft document perpetuates a complacent and dangerous culture that is a risk to the health and well-being of people who inject drugs.</p>
49	8	97	<p>Service Quality – Knowledge and Understanding of Non-HIV Specialist Staff Working with Vulnerable Groups</p> <p>The ongoing outbreak of HIV in people who inject drugs in Glasgow has exposed significant training and information needs for people working with the group most at risk in drug treatment, mental health and housing/homelessness settings. Knowledge levels about HIV-related matters amongst this group are generally very poor. This affects their ability to support people through testing, diagnosis and treatment.</p> <p>There are issues with inaccurate or dated understandings around –</p> <ul style="list-style-type: none"> • Routes of transmission • Testing • Treatment • Treatment outcomes. <p>For many such staff their understanding was based on 1980s public health advertising and there were low levels of knowledge about new treatments, the possibility that someone may have an undetectable viral load through effective treatment or that life need not be significantly shortened by HIV.</p> <p>Training and awareness raising is required on all these matters. There is a double benefit – not only are people better supported through testing, diagnosis and treatment by the workers closest to them but also these services themselves are better delivered. It is impossible to offer personal care, for example to someone who you (however unreasonably) fear may infect you with HIV.</p>

Organisation name (if you are responding as an individual, please leave blank)			Terrence Higgins Trust
Name of commentator			Alex Sparrowhawk
Role of commentator			Membership and Involvement Officer
10	8a.	G	This section should be develop to broaden the range of professionals and organisations it includes. This standard currently focuses on medical and healthcare professionals and there is an obvious omission of social care providers and workers who will play a much greater role in the care of people living with HIV in the coming years than they have previously.

Standards 8b and 8c

Organisation name			
Name of commentator			Dr Anthony France
Role of commentator			Retired consultant physician – HIV & Respiratory Medicine I set up the HIV/AIDS service in Dundee in 1989 and ran it until I retired from HIV work in 2012. I do not see HIV patients now. I have no conflict of interest.
4	3a	37	The document fails to grasp the vital role of Primary Care. Some loosely worded ambitions and a weak standard on annual communication with GPs for patients with stable HIV is all you have to offer. Why are HIV services so reluctant to communicate with GPs ? As a bare minimum, each appointment with a doctor in an HIV clinic should be followed by a letter to the GP within two working days. When I ran the HIV service in Dundee every patient had a letter after each appointment. Most letters were sent electronically to the GP's inbox before the patient got home after the clinic. It can be done.
	3b	41	
	3b	44	
	4b	54	You are slowly coming round to sharing information but still allow patients to conceal information from their GP. This is an area where failure to allow sharing should be seen as an adverse event and lead to a critical analysis of "Why not ?" I see no standard about %age of patients who refuse to share info with GPs. This is where you need a look back exercise.
	8c	106	Eventually it comes down to the epidemiologists and public health departments to crack this issue. Using CHI or NHS numbers is the obvious way forward. Why no standard ? It would help to avoid duplicate dispensing and other misdemeanours.

Organisation name (if you are responding as an individual, please leave blank)	
Name of commentator	Roy Trelivon
Role of commentator	UK-CAB BHIVA Rep, i-Base staff

11	8	97	<p>The Section a, Knowledge and training, highlights the importance of knowledge, training and specialist skills in HIV. The section on the peer support team is great. It says the peer support team should have core competencies : “Core competencies should include knowledge and understanding of HIV and treatments, ability to recognise and work with diversity, effective listening and communication skills, understanding of confidentiality and of safeguarding for vulnerable adults.”</p> <p>Comment: Keeping up this training and knowledge, and these skills and competencies, with a backdrop of funding cuts to the NHS and support charities is an uphill struggle.</p> <p>Sections b and c are thorough and detailed – great!</p>
----	---	----	---

Organisation name (if you are responding as an individual, please leave blank)	Scottish Drugs Forum
Name of commentator	Austin Smith
Role of commentator	Policy and Practice Officer

50	8	97	<p>Evaluation of the effectiveness of services</p> <p>To develop effective services service planners, commissioners and managers will have to listen not only to HIV patient groups and those who seek to represent them but to other vulnerable group and those who represent or have experience in working effectively with people in these vulnerable groups. This includes people with experience of injecting drug use and services working effectively with people who inject drugs. It is inadequate simply to work with currently engaged HIV patients from other groups.</p> <p>People at risk of HIV through injecting drug use, people living with HIV who inject drugs and people in HIV treatment who inject drugs will all have to be involved in the evaluation of the effectiveness of services which should be measured not only in terms of early diagnosis and engagement in effective treatment but their accessibility and acceptability to these groups.</p>
----	---	----	---

Organisation name (if you are responding as an individual, please leave blank)				Sophia Forum
Name of commentator				Sophie Strachan
Role of commentator				Co Chair
20	8c	105	We welcome this section/QS	

Organisation name (if you are responding as an individual, please leave blank)				British Psychological Society (BPS)
Name of commentator				Sarah Rutter & Tomás Campbell
Role of commentator				Chair & Treasurer of the BPS Faculty of HIV & Sexual Health
15	8b	97	<p>In the descriptions of different disciplines working within or into HIV services, there is no mention of mental health teams. Given the high relevance of psychosocial issues within HIV care (WHO, 2008; Michlig, 2018), we believe that it is important to draw specific attention to the need for psychological support for this population (BPS, BHIVA & MedFASH, 2011).</p> <p>Mental Health Support The stepped care model in the standards for psychological support for adults living with HIV (BPS, BHIVA & MedFASH, 2011) provide a comprehensive framework for the assessment and provision of care to meet the needs of this population. All healthcare professionals offering frontline care in HIV services are engaged in providing general psychological support, with specialist nurses often delivering enhanced care relating to emotional needs. Practitioners equipped with skills in counseling can offer support with mild or transient psychological problems, however as complexity of issues increases more specialised mental health input is required. Specialist services for more longstanding and complex psychological problems include Counselling Psychology, Clinical Psychology, Psychiatry</p>	

			and Psychotherapy. These professions may be integrated into the HIV service, or may be available locally as clinical health psychology services, generic mental health services, primary care or the Improving Access to Psychological Therapies (IAPT) programme. Regarding cognitive impairment, care may be accessed via acute hospital rehabilitation facilities and/or community rehabilitation teams. Although these services may be embedded into specialist HIV teams, in most parts of the country they are accessed through general or neurorehabilitation services.
--	--	--	--

Organisation name (if you are responding as an individual, please leave blank)			
Name of commentator			Eileen Nixon
Role of commentator			Consultant Nurse / Research Fellow
		p104	<p>Quality Statement - All HIV services should have procedures to alert people to appropriate opportunities for them to join in ethically approved research programmes and clinical trials if they so wish.</p> <p>Auditable outcome - They are aware of HIV-relevant research within the NIHR research portfolio and elsewhere, are actively involved in research that is appropriate to their patient population, and that mechanisms are in place to alert patients to relevant research programmes.</p> <p><i>Should the quality statement also include active involvement in research?</i></p>

Organisation name (if you are responding as an individual, please leave blank)			NAT
Name of commentator			Yusef Azad
Role of commentator			Director of Strategy

			In the sub-section on 'Public health surveillance' etc, there is a sentence on p.106 which is somewhat unclear, 'Within the HIV clinic, implied consent is assumed for data sharing within the multi-disciplinary team and for sharing data across teams for referral to GP or specialists'. There is then a further sentence a few lines further down stating, 'HIV patient should be informed about how their personal medical information is stored and shared outside of the HIV service and explicit consent may be required to share this information with other health professionals'. The first sentence is obscurely phrased and could be redrafted to be a bit clearer. The principle it contains – that implied consent is assumed both for care internal to the clinic but also for referrals for direct care – is slightly at odds with the second sentence that explicit consent needs sometimes to be sought. Both statements are in fact true but there needs to be a bit more explanation in the text that the usual assumptions around implied consent do not apply routinely in the context of HIV care, and that there needs to be an explicit discussion with the patient about how implied consent works and where it will be assumed, so that the patient can then raise any concerns or objections, and ask if need be for explicit consent to be sought.
			The Quality statements in this section should therefore include a more patient-focussed expectation that 'all HIV clinics must ensure that the patient is aware of how their information is stored, handled and shared. There should be constant attention to make sure there are 'no surprises' for the patient living with HIV as to how their personal confidential information is used, and that there is genuine consent to that use'.
			NAT agree on the need for separate, detailed consideration and consultation on the use of the NHS number and look forward to this taking place in the near future.
			NAT has both a policy document and a resource on HIV patient information and NHS confidentiality which can usefully be referenced in this section ('HIV Patient Information and NHS Confidentiality in England' NAT Jan 2014; 'Confidentiality in the NHS: Your Information, Your Rights' NAT July 2014; 'Your Choice: A Guide to Confidentiality and HIV in Scotland' HIV Scotland/NAT Sept 2016).

Organisation name (if you are responding as an individual, please leave blank)	PHE
Name of commentator	Valerie Delpech

Role of commentator			Lead for national surveillance of HIV for the UK
			<ul style="list-style-type: none"> • <i>Evidence from Public Health England or Health Protection Scotland that services have provided:</i> <ul style="list-style-type: none"> ○ <i>Data for all patients seen for care in the relevant reporting period</i> ○ Data within agreed time frames ○ Data should be complete (mandatory fields should be 90% complete) and consistent <p>Data for all patients seen for care is submitted by clinics to PHE within two weeks of the end of a quarter. Mandatory fields should be complete.</p>