

General

Organisation name (if you are responding as an individual, please leave blank)			British Infection Association
Name of commentator			Andrew Ustianowski (author) and Anna Goodman (Guidelines secretary and submitting)
Role of commentator			As above
1	G	G	We are grateful to BHIVA on compiling a detailed and comprehensive 'Standards of Care'. We fully support the ethos and aims of the document
2	G	G	There are several examples of auditable outcomes where targets are not expressed (eg. multiple examples in section 3b but also elsewhere in document), or the outcomes themselves are not specific or measurable as they are presently stated. Examples of the latter include: specific training on HIV-related stigma (what would be deemed as sufficient?); page 22- departments are required to provide information to staff (is this HIV departments? all medical departments? etc); page 25 - 'skilled peer workers should have a structured recruitment and training process' (what would be sufficient? How is this to be assessed and by whom?); page 34 - what would classify as a 'timely manner' for access to mental health support? Etc.

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
1	G		NB all my comments relate to measurable and auditable outcomes. My particular concerns are that: These should actually be measurable, eg that denominators should be clear and well-defined.

			Targets should be realistic.
2	Intr o/G	10?	Suggest include a section on “Structure of the standards” – perhaps before “Development of the standards”. This should explain that each comprises a standards statement, a rationale, quality statement(s) and measurable and auditable outcome(s). It should go on to say that inclusion of outcomes does <i>not</i> imply that all of these should or will be audited. Some are suitable for national audit, either routinely via surveillance data or occasionally via eg BHIVA audits, but others are offered as optional suggestions for local or regional audit.
3	1a AN D G	16	Some outcomes suggest 98% targets. I’d suggest using 97% instead as the target for any outcome where we’re aiming for 100% compliance (which isn’t measurable). The reason for choosing 97% is because this allows for audit of 40 cases with one failure (eg due to poor recording). To measure 98% requires audit of more than 50 cases, which can be problematic.
7	1b 5a 5b G	19	<p>“Evidence of a patient experience survey to assess satisfaction regarding discussion around HIV transmission and HIV prevention options.” etc</p> <p>I’m concerned about outcomes which appear to call for multiple patient experience surveys. Such surveys are potentially wasteful and time-consuming for people to design, collect and analyse data, especially as there are no validated measures for most things. If these outcomes are to be retained at all, I would suggest re-wording them along the lines of “Evidence of inclusion of satisfaction regarding discussion around HIV and HIV prevention options within patient experience surveys” [with cross-ref to section 3b]. That avoids implying there should be separate surveys.</p>

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.

1	G	all	The guidelines have no less than 177 auditable measurable outcomes. Who is going to collect this data and who will analyse it ? Most hospital departments do not have staff sitting around with time on their hands. If you want data on this scale you will need more staff. You would do better if you picked a much smaller number of easy to measure outcomes. Have you lost sight of the financial pressures in the NHS ?
---	---	-----	--

Organisation name (if you are responding as an individual, please leave blank)			Gilead Sciences UK
Name of commentator			Chris Robinson
Role of commentator			HIV Medical Affairs
1	G	G	We welcome these standards and are fully supportive of their aims

Organisation name (if you are responding as an individual, please leave blank)			
Name of commentator			Cipriano Martinez
Role of commentator			Advocate
1	1	NA	There is additional opportunities to reduce fear stigma and discrimination if HIV Peer Professionals are used to conduct and follow up with HIV testing results.

Organisation name (if you are responding as an individual, please leave blank)			HIV Pharmacy Association
Name of commentator			Sonali Sonecha

Role of commentator			Expert panel member –on behalf of HIVPA
1	G	G	Overall: We welcome the update to the standards and are in agreement with both the overall ethos of the standards and the particulars. We believe they will continue to contribute to excellent patient care and hope that the NHS governing bodies will take these on board and implement into their guidance.
4	G	G	An increasing number of pharmacy services are being provided by either an outsourced hospital pharmacy or via homecare and increasing numbers of pharmacy services are no longer co-located with the HIV clinic (e.g. due to separation of GUM and HIV services) or provided by the same provider. This is more of an issue than in the previous iteration of the standards. It would be helpful to recognise this in the guidelines and consider a quality statement to ensure quality of care maintained through changing providers, supported by commissioners.

Organisation name (if you are responding as an individual, please leave blank)			
Name of commentator			Shaun watson
Role of commentator			Clinical Nurse Specialist (HIV Community)
		33	General comment – I'd like some clarification about who is the care coordinator as this role is traditionally the remit of a specialist nurse (community or clinic) and rarely a clinician, I'd like this to be made explicit.

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

1	G		DHIVA welcomes the update and is encouraged by the tone of the document, with emphasis on people living with HIV having active engagement in decision-making in their care and self-management.
---	---	--	---

Organisation name (if you are responding as an individual, please leave blank)			
Name of commentator			Roy Trevelion
Role of commentator			UK-CAB BHIVA Rep, i-Base staff
1	G		Dear BHIVA, This is a really great and timely update on the 2013 standards. Many thanks.
9	7	78	Sections a b c: This is a great addition to the Standards. It is proof – if needed – that ART works, and works well. Also great is the way the subsections connect with other main sections of the Standards.

Organisation name (if you are responding as an individual, please leave blank)			LASS
Name of commentator			Service Delivery
Role of commentator			Staff Team
6	G	G	Consider adding guidelines and pathway for HIV positive people in prison

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
1	G	<p>General Comment: One – This draft document seems dated and is largely irrelevant to some people in the field.</p> <p>There have been several recent outbreaks of HIV infection among drug injectors in the UK including one in south Wales. An uncontained outbreak of 118 new cases identified in people who inject drugs in less than 24 months or so with low levels of treatment engagement is a significant public health issue for Glasgow and could potentially happen almost anywhere across the UK. In this context, the Standards of Care document reads already like a dated document with a focus on sexual transmission. It is largely irrelevant to those tasked with addressing the challenges of this outbreak.</p>
2	G	<p>General Comment: Two – This draft document does not acknowledge the scale nor even describe the nature of the challenge HIV represents</p> <p>A current outbreak of HIV in Glasgow among people who inject drugs has provided evidence of significant inadequacies in the response and the configuration of services designed for sexual transmissions amongst men who have sex with men and, to a lesser extent, people originally from sub-Saharan Africa.</p> <p>Issues identified are</p> <ul style="list-style-type: none"> • the location of services; • the demands of appointment systems and other elements of service configuration inappropriate for some people who inject drugs; • patient communications in terms of levels of literacy and the ability to receive and keep written communication while homeless; • The reluctance amongst some frontline specialist sexual health staff to talk to people about their drug use and the reluctance amongst some frontline drug treatment staff to talk to people about sex. There is a significant cultural issue and training need. • the prescription and dispensing of medicines to people unable to keep daily routines that include this or to travel to services or store medicines; • people with lifestyles about which staff have no experience or insight; • working with people with cognitive impairment; • working with people under the influence of street drugs / medication.

			As drafted the Quality Standards do not capture the scale of these challenges nor does it offer quality standards that would address them.
Organisation name (if you are responding as an individual, please leave blank)			Sophia Forum
Name of commentator			Sophie Strachan
Role of commentator			Co Chair
3	G	22	Whilst acknowledging this is a document to aspire to, we believe it is failing to acknowledge how it doesn't speak to transgender people as a lot of services /professionals do not have the skills/knowledge to care for this patient cohort.
4		10	We welcome the breadth of acknowledgement in setting where people will require equitable access and delivery of care
19	7	78	We welcome HIV across the life course in its entirety

Organisation name (if you are responding as an individual, please leave blank)			Centre for Primary Care and Mental Health, Queen Mary University of London
Name of commentator			Dr Werner Leber
Role of commentator			NIHR CLAHRC Clinical Lecturer in Primary Care
5	G		Generally, your focus on collaborative working between specialists and primary care throughout the document is great. However, I miss the patient voice in this and wonder if patient engagement in co-producing their own care in partnership with the primary, secondary, and social care providers including HIV charities should be made more explicit throughout the whole document?

Organisation name (if you are responding as an individual, please leave blank)			African Health Policy Network
---	--	--	-------------------------------

Name of commentator			Deryck Browne
Role of commentator			Chief Exec
5	assorted	<p>There should be equality of access to, and equity in provision of, health and social care for all people regardless of age, gender, sexuality, ethnicity, physical ability, health literacy, immigration or residency status.</p> <p>This stigma may be in addition to pre-existing stigma based on actual or perceived membership of different social groups (e.g. gender identity, religion, age, class, ethnicity, sexuality etc.).</p> <p>There can also be stigma associated with accessing mental health services (e.g. Henderson & Thornicroft, 2009), especially in some cultural groups such as black and minority ethnic (BME) communities and men, and so for these reasons people living with HIV may under-report their difficulties in consultations.</p> <p>When working with people living with HIV careful attention should be paid to their lifespan stage (e.g. adolescence, young to middle adulthood, older age, end of life) and personal demographics (e.g. gender, race and ethnicity, migration status, religion and sexual orientation) as these (and the interaction of these) may serve as either resilience or stress factors for their psychological well-being and mental health, and affect both how they understand and access services.</p>	
	G	<p>Generally the new standards represent an excellent and detailed piece of work. The above references to the African descent population are all valid. One point that has been constantly made to AHPN throughout the consultation process however is that, although the document is looking at overall standards of care, caution needs to be exercised that the reader is not left with the message that ‘one size fits all’ in respect of care. Differing key populations will have differing needs and priorities at differing times, as you above indicate.</p> <p>In the current political climate it’s almost becoming harder to talk about equality and diversity. Equality is about allowing all access to the same services and ensuring the best possible treatment and outcome for each individual. Diversity is about the recognition and valuing of difference in its broadest sense – creating a culture, practices and approaches that recognise, respect, value and harness difference for the benefit of the service and the individual.</p> <p>Our clients assert that many services claim to be ‘colour blind’ or assert that everyone is treated the same. This approach is even considered to be liberal and progressive by some as the client appears to be considered as an individual irrespective of culture or ethnicity – but the opposite is often true as any assessment, treatment or care cannot be properly carried out unless a person is seen in context. And importantly with regard to HIV services this context includes culture, race and faith.</p>	

		<p>So, I'm not sure myself what this might mean for the BHIVA Standards document. I think somewhere relatively up-front there has to be a declaration about key populations and differing circumstances and needs. Following, there should be some consideration under each key heading how services might meet the standards of care for African descent clients.</p>
	G	<p>AHPN also afforded service users/volunteers the opportunity to comment on the document.</p> <p>Volunteer Response: On the BHIVA STANDARDS OF CARE I think much of the information is very correct and as AHPN we are fully aware of the issues involved in this document. We make direct consultations with real people who are willing to share their experiences. That is the strength and uniqueness of AHPN. Some of them have been discussed in some of our focus group meetings. I also never thought about directly involved in some of these issues until recently when I slipped and fell. I experienced all in this stanza in the last 2 months.</p> <p>1-They find it difficult to manage their treatments or day-to-day activities - 2-They receive care and support from multiple services and need additional services - 3-They have both long-term physical and mental health conditions - 4-They have frailty or falls - They frequently seek unplanned or emergency care - 5-They are prescribed multiple regular medications</p> <p>So our needs change as we grow older with HIV as well. (personal experience) Just this morning I had another terrible fall right in front of my house on my way to catch the bus to work. I feel so scared right now.</p>

Organisation name (if you are responding as an individual, please leave blank)	Sophia Forum
Name of commentator	Juno Roche
Role of commentator	Writer and campaigner

1)	G	<p>The document is written using 'key population' language to describe good intentions and minimum standards for the whole community of PLHIV but the whole language lacks any sense of intersectionality and diversity. We know, for example, that frontline care for the transgender community(s) is at best patchy in quality and at it's worse is entirely absent - it has taken me well over a year to be referred to a specialist endocrinologist who is able to look at a trans woman living with HIV and make hormonal recommendations. I wanted to change the appointment and because they had none within 3 months I was sent back to the beginning again. We know that trans people especially at the start of transitioning are treated terribly by front line staff often due to lack of guidance and/or training but in no sections is there any guidance or even signposting to specialist intersectional support.</p> <p>In the second document regarding 'supporting people with higher levels of need' no mention of the intersectional, interactiveness of trans and HIV care pathways. It must matter because enough of the structures have asked for advice and support, yet it is not in evidence. This guidance is almost completely absent of any acknowledgement that the trans community has additional needs which are being completely unmet by current services. Therefore as it stands this document does not improve services for the trans community at all. We know the issues but yet again we remain almost unnamed.</p>
----	---	---

Organisation name (if you are responding as an individual, please leave blank)				CHIVA			
Name of commentator				Dr Bala Subramaniam			
Role of commentator				Executive member, CHIVA			
3	2	21	Person centred care- doesn't equality act apply in UK? Not just England				
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
1	G	G	An accessible, plain English accompaniment must be produced for people living with HIV.
2	G	G	<p>There is a lack of consistency with regards to the U=U message throughout the standards. In the introduction and in 2c. p27 'Undetectability also means that people with HIV do not pass on the virus to others' the statement is strong and clear. Elsewhere different language is used: 5a. p60 'negligible risk of sexual transmission'; 5a. p61 mentions 'reduce risk' and 'reduced rates'.</p> <p>The language is robust again in 5b. p65 'the risk of transmission to the HIV-negative partner is effectively zero'.</p> <p>We would recommend that the document is carefully reviewed and a strong standardised version of the U=U message is used throughout in order that there is no excuse for people living with HIV not to be provided with this knowledge by their HIV care team.</p>

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
16	G		<p>The Society welcomes this document and believes that it is thorough and comprehensive, with excellent attention to the wide range of healthcare and psychosocial issues pertinent to people living with HIV. However, this level of detail, understandably, results in an extremely lengthy document, which may be difficult to digest in its entirety. It is possible that some areas would benefit from synthesis to enhance readability.</p>

Organisation name (if you are responding as an individual, please leave blank)		Scottish HIV Clinical Leads group
Name of commentator		Dr Nick Kennedy
Role of commentator		Consultant Physician. Former Clinical Advisor on HIV to Healthcare Improvement Scotland (HIS); former Co-chair of HIV Clinical Leads group
1	G	The Scottish HIV Clinical Leads group welcomes these revised (2018) BHIVA Standards. In Scotland we currently expect HIV services to meet our Healthcare Improvement Scotland (HIS) Standards for HIV Services (2011) – which should probably be referenced in these BHIVA Standards. The HIS standards are now somewhat dated and rather than revising these we would envisage in future adopting the 2018 BHIVA Standards and formally retiring the HIS Standards, assuming that HIS and the Scottish Health Protection Network (SHPN) are in agreement with this approach. However, to do so we would wish to see slightly more care being taken to ensure that the BHIVA Standards are written as a truly ‘British’ document throughout, rather than a document written predominantly for an English/ London audience. Thus it should be noted that comments on the new NHS commissioning landscape (page 4), Outcomes Framework and QIPP programme (page 10) apply to NHS England and not NHS Scotland.
2	G	Overall, we feel that the authors should be congratulated on the development of a well-written and very comprehensive HIV Standards document. However, it is a very lengthy document – perhaps too long? In developing the HIS Standards for HIV (2011) we deliberately set out to produce a fairly concise document with a limited number of Quality Statements, with the aim of maximising their impact. Parts of the current BHIVA document would probably have more impact if significantly condensed – e.g Sections 2b-d . Limiting length of some of the ‘Rationale’ and ‘Measurable and Auditable outcomes’ sections – with more uniformity on the length/ depth between Standards – would be helpful.
3	G	The Quality Statements themselves should be clear, concise and unambiguous - and made to stand out more from the other text. Numbering these (rather using bullet points) and showing them in bold text would help.
4	G	We strongly support the principle of high quality HIV care being provided no matter where you live, whilst recognising the significant challenges that this poses in many rural and semi-rural areas. The emphasis on collaborative working and networks, without being over-prescriptive about exact structures (‘no single model’), is absolutely correct. The central ethos of service user engagement in all aspects of HIV care, including service design, is also strongly supported.

5	G		In terms of our Scottish Boards' ability to meet these Standards, some HIV Leads felt that the draft Standards are 'hugely aspirational' (perhaps particularly for small and medium-sized Boards) and will require considerable investment in dedicated time for HIV care, not only for HIV clinicians but also other services (e.g. psychological services and pharmacy) if the Standards are to be met. There will also need to be restructuring of pathways with Specialist oncology (including haematology) and Tertiary HIV care for 24/7 MDT advice (not seen as too problematic, however).
6	G		Throughout standards, there is very little mention of people living with addiction problems. Assessing for drug/alcohol problems is mentioned, as well as onwards referral, but no advice/standard on actually providing HIV care to this important yet vulnerable group and recognising the challenges that this poses. This has always been a significant aspect of HIV care in Scotland – and one which has been re-emerging in recent years.

Organisation name (if you are responding as an individual, please leave blank)			Scottish HIV Clinical Leads group
Name of commentator			Dr Nick Kennedy
Role of commentator			Consultant Physician. Former Clinical Advisor on HIV to Healthcare Improvement Scotland (HIS); former Co-chair of HIV Clinical Leads group
25	7	78-96	Section 7 is important, but unfortunately rather disappointing. It lacks balance, with a relatively large amount of space given to issues such as Transition of care from paediatric to adult services (fortunately an increasingly uncommon scenario now) and Sexual Health (which is obviously very important but could/should be cross-referenced to Standard 5a) , whilst only providing a short and, frankly, weak section on Older age (7c). The latter is the area that is going to dominate our lives as HIV care providers over the coming years and we need more substance here on issues such as frailty, mobility, cognitive decline, loneliness, interface with generic services relevant to older people (primary care teams, geriatrics, falls teams, other hospital specialities, AHPs, social services, housing, third sector, family support, etc). Whilst there is some brief mention of some of these issues under 'Complex HIV care', this is not really the right heading as the HIV care is in fact often very straight-forward – it is everything else that is challenging!

Organisation name (if you are responding as an individual, please leave blank)			Positive East
Name of commentator			Mark Santos & Steve Worrall
Role of commentator			Director & Deputy Director
1	G		We were concerned that reference to the role of the Clinical Nurse Specialist is omitted from the document. These roles are important in terms of preventing the escalation of need and supporting the avoidance of unplanned episodes of care. They are particularly important in the management of the complex care where people living with HIV may have multiple co-morbidities. The CNS also plays significant role in the management of people who are at risk of being lost to follow up and bridging the gap between health and social care.
25	G		We were wondering that there should be a reference within the document that reflects that fact that some people are struggling, and that space should be given for them to be able to raise this without people feeling stigmatised or shamed that they have difficulty in e.g. achieving viral suppression or are having poor health
26	G		We thought that there should be a reference to the importance of spirituality or faith perhaps in the wellbeing section as this may be an important feature of an individual's strategy in maintaining their health and wellbeing.

Organisation name (if you are responding as an individual, please leave blank)			
Name of commentator			Laura Waters
Role of commentator			Consultant Physician
1	G	G	Well done all a hugely comprehensive piece of work – very impressive indeed.
2	G	G	As part of the SRH GL feedback we were, quite rightly, criticised for not including some specific information & recommendations for trans individuals and I suggest you should consider a section acknowledging the additional

			challenges faced by trans people living with HIV – the BHIVA ART GL and SRH GL will both address trans-specific issues so could be signposted
3	G	G	As with many draft GL there is a lack of consistency in terms of style, slow and detail as is common when sections are written by different individuals/groups so I suggest a overally review and some editing accordingly. As someone who volunteered to assist and did absolutely bugger all I'd be very happy to assist if that would be useful
4	G	G	I think they are too long and some heavy editing could actually improve their impact. There is a similar no of pages to the 2013 standards but with a different layout so I imagine word count much more – will there be a concise version?
16	2		References quoted up to 12 in this section but only 5 references listed? There are some pretty strong statements and associations credited to references 6-12 but it's impossible to comment.

Organisation name (if you are responding as an individual, please leave blank)			
Name of commentator			Kaveh Manavi
Role of commentator			Consultant physician in HIV
12			<p>The document has some inconsistencies in its recommendations; for many outcomes, it appropriately refers the reader to the national guidelines for that topic. This is not the case for TB or PREP guidelines.</p> <ul style="list-style-type: none"> • The recommendation that 'People with HIV from high and medium TB incidence countries should undergo testing for latent TB infection.' is not consistent with BHIVA guidelines. There are further criteria that the guideline stipulates before recommending screening for LTBI. Would it not be better to refer the audience to the guideline? • PREP: the indications in page 19 are very specific. Again I think the reader should be referred to the BASHH/ BHIVA guidelines.

14	7		I found the section too detailed and at some points repetitive. For example, the auditable outcomes on page 87 are already mentioned in other sections. Personally, I think the section can be shortened significantly to reduce the repetition
----	---	--	---

Organisation name (if you are responding as an individual, please leave blank)			UK-CAB
Name of commentator			Ben Cromarty
Role of commentator			
			For the general section, there has been a bit of discussion. Everyone welcomes the idea of a non-technical summary for PLWH, but several worry that it might be too short if it is just 2 sides of A4.
			There was also a view that the key changes in HIV since the last SoC need to be really highlighted...U=U; TasP; PrEP; starting ART asap; ageing cohort...and one wondered if this might be done in the HIV across the life course sections.
			I still feel the best place might be up front in the intro, and maybe even as a "text box" or figure, that we can refer back to in the other sections, since these things crop up in several places...
			People wonder why U=U isn't mentioned...especially since BHIVA formally endorsed it. It's really important to a lot of folk!
			And more support for a more layman friendly version...focus sing on what someone as a user of services should expect ...

Organisation name (if you are responding as an individual, please leave blank)			Catholics for AIDS Prevention and Support Positive Catholics
Name of commentator			Jim McManus

Role of commentator			
			Jim McManus': "my only comment was the absence of spirituality otherwise looks good"
			<p>"Jim, I agree with your initial observation re spirituality (only mentioned explicitly in palliative care). Faith is mentioned once in 2c (participation) and 6a (emotional wellbeing). I started going through document and making notes – but this became too burdensome. Nevertheless I attach the few notes I made FYI. My conclusion is that something more specific should be included somewhere – but I am not sure where it would best go. And that it should mention aspects of faith, spirituality and religious belonging. I think it important to note that spirituality and faith are not just individually constructed challenges and/or benefits – the dimension of belonging within a faith community is also important and can be to good affect or negative affect. Perhaps in the statement of general principles? The fact is these aspects are applicable almost everywhere – and seem to me to be often referred to or implied in the category 'psychological'. Sorry not to be of more help. Overall I think it is a good document and at least faith or spirituality is mentioned three times.</p> <p>Best for now"</p>

Organisation name (if you are responding as an individual, please leave blank)			ADPH
Name of commentator			Policy Manager - ADPH
Role of commentator			Rachel Cullum
			It may be a good idea for practical use if the document was condensed as it currently stands at over 120 pages

Organisation name (if you are responding as an individual, please leave blank)			
Name of commentator			Mary Dicks

Role of commentator			Clinical Psychologist
	G		<p>Exhaustive coverage of HIV issues but just wondered if possible to expand sections on:</p> <ol style="list-style-type: none"> 1. initial diagnosis – a degree of sensitivity and understanding of impact is required from staff in non-HIV settings. Would it be possible to specify minimum training and/or identify specialist communicator in such settings? 2. confidentiality in non-HIV medical settings – where this is breached, patients are left feeling powerless and angry. Is it possible to identify pathways for patients to seek redress without further disclosing their status? And/or to identify pathways for further training requirements in such settings?

Organisation name (if you are responding as an individual, please leave blank)			
Name of commentator			Eileen Nixon
Role of commentator			Consultant Nurse / Research Fellow
			<p>I think the new standards are excellent and really well written. Although they are quite long, I really like the detail. The standards provide robust evidence for the role of HIV specialist services, something very much needed in today's climate. I particularly like 4c. Well done to all involved.</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

			NAT congratulates BHIVA on developing an excellent draft of the new Standards of Care. We have only a few comments. One general point which we would hope can be explored further within the working group, is whether the role and responsibilities of primary care are as yet adequately covered.
			A second issue is whether the role of the voluntary and community sector, especially around advice and advocacy, gets the attention it needs.

Organisation name (if you are responding as an individual, please leave blank)			BASHH HIV Specialist Interest Group (SIG)
Name of commentator			Tristan Barber
Role of commentator			Chair, BASHH HIV SIG
14	G	G	<p>The document has some inconsistencies in its recommendations; for many outcomes, it appropriately refers the reader to the national guidelines for that topic. This is not the case for TB or PREP guidelines.</p> <ul style="list-style-type: none"> The recommendation that 'People with HIV from high and medium TB incidence countries should undergo testing for latent TB infection.' is not consistent with BHIVA guidelines. There are further criteria that the guideline stipulates before recommending screening for LTBI. Would it not be better to refer the audience to the guideline? <p>PREP: the indications in page 19 are very specific. Again I think the reader should be referred to the BASHH/ BHIVA guidelines.</p>
18	G	G	Throughout the standards, there is very little mention of people living with addiction problems (in fact the word addiction is not in the document). Discussed assessing for drug/alcohol problems and referring onwards but no advice/standard on providing HIV care to this vulnerable group and recognising the challenges but the importance of that. Suggest a recommendation that those with addiction problems should be offered additional support to engage in traditional HIV care models and HIV services may be required to adapt to facilitate engagement in HIV care.
19	G	G	I have concerns about the basic purpose of the standards. Are they aspirational or are they the minimum standard required? Are they for the whole UK or are they really only directed at settings where commissioning is happening. I think

			they should be prescriptive minimum standards and it does say that is what they are in the introduction and therefore need to be much clearer and robust and realistic about absolute minimum requirements. In many respects they do not read like a prescriptive standard document, because of the much of the language used, specifically terms like preferred, recommended, may, etc.. For those working in small cohort settings may be unrealistic e.g. HIV specialist pharmacist. Does the advice that this is mandatory mean that in theory small centres without this should stop providing care because they cannot comply?
20	G	G	Throughout the document there is repeated mention of commissioning issues. This does not apply to the whole of the UK. The document is lengthy and repetitive. The rationale sections are quite variable in how readable they are and the level of detail.
21	G	G	I think some sections would lend themselves to presenting information in infographics. For example the data on page 7, some of which is unnecessarily repeated later in the document too.
22	G	G	There are quality statements that reiterate unnecessarily elements of the rationale section. For instance from page 97. "HIV remains a stigmatising condition that disproportionately affects people who often are already vulnerable. For example, because of single or combined factors relating to gender, sexuality, age, race, income, education or medical and social history. All staff in HIV services should have appropriate training regarding the diversity of affected communities and important social influences." Only the last sentence is a quality statement.
23	G	G	There are a lot of instances of wordy and confused descriptions that I feel are superfluous. There are paragraphs and bullet points that appear to be about not clearly connected issues. For example, from page 14: "Where an HIV test has been recommended and declined this should be carefully recorded in the patient's medical record. Reasons for declining a test should be explored. Written information about HIV testing can be given to the patient and testing should be re-offered at the next earliest opportunity. In addition, the availability and use of community testing should be encouraged and advertised, with appropriate funding from local authorities." Does it not go without saying that this interaction with a patient/client should be recorded? That is required of us as part of good medical practice. We would record all consultations and particularly something as important as this. What does "carefully recorded" mean? Just recorded is adequate. Reasons for declining ...should be explored. - well doesn't this go without saying? The availability of community testing should be encouraged - well that statement is not really anything to do with the individual who has declined testing, and should not appear in that bullet point. The next paragraph talks about POCT, saying it may be appropriate in some circumstances, but is it an absolute standard requirement? That is not clear to me. It says that patients should be

			<p>advised of the sensitivity and specificity of their POCT. I don't really think that is what is meant as I guess it would be a small proportion of the population who would be able to interpret those figures. I guess what they mean is that people should give informed consent and, again, this should go without saying as it is standard medical practice that should apply to all tests.</p>
25	G	G	<p>There are quite a few auditable outcomes that are problematic in their wording and are not SMART measures. For example: "Evidence of a patient experience survey to assess satisfaction regarding discussion around HIV transmission and HIV prevention options." In what time frame?</p> <p>"Proportion of patients with viral hepatitis screening and offer of appropriate vaccination as well as appropriate screening and advice about other vaccine preventable diseases (targets as specified in BHIVA monitoring and immunisation guidelines)."</p> <p>"Patients with a smoking history documented in the last 2 years (90%) and blood pressure (BP) recorded in the last 15 months (90%)."</p> <p>Both of these are actually several measures in effect. There are a few like that.</p> <p>I am wondering why there are suggested auditable outcomes that are lifted from the guidelines. Would it not be more reasonable to say that all services should work according to widely accepted guidelines (BHIVA generally) and have a programme of quality improvement against those guidelines. They should be required to participate in the BHIVA national audits but also have a minimum number of other quality improvement projects going on and an annual report of this activity should be mandatory. The document has very numerous auditable outcomes and it is not clear whether services should be able to provide data for all of those measures and how often or whether this is a list of suggestions and how many they should do. Also it would be better to move towards quality improvement principles rather than audit.</p>
27	G	G	<p>There are standards that don't need further, wordy explanation. For instance is it not enough to say that "People living with HIV should receive care overseen by a consultant physician specialist in HIV" or I think more specifically by someone with an appropriate CCST. Is it necessary to then give a run down of the contents of the syllabus of that training? There is also reference to appraisal for doctors requiring HIV content. This is surely as required by the GMC anyway; your appraisal should cover the whole scope of your practice. They only need say that doctors must practice in accordance with GMC requirements. In fact even that is superfluous really. We are required to comply with GMC requirements. I think reconsidering a lot of this included information might allow a shorter, clearer document with more impact.</p>

16	7		I found the section too detailed and at some points repetitive. For example, the auditable outcomes on page 87 are already mentioned in other sections. Personally, I think the section can be shortened significantly to reduce the repetition
----	---	--	---