

Standard 3a

Organisation name (if you are responding as an individual, please leave blank)			
Name of commentator			Ben Cromarty
Role of commentator			
1	3a	36	<p>So the rationale says:</p> <p>"Best outcomes for people with HIV-related pathology depend on rapid recognition and appropriate intervention, and everyone who is newly diagnosed with HIV should be seen for this specialist assessment within two weeks of receiving an HIV positive diagnosis."</p> <p>...which is fine, but doesn't actually say anything about starting ART. BHIVA folk say that this is covered in the Treatment Guidelines, but I think it needs to be spelled out more here, for patients to see.</p>
2	3a	38	<p>In the Quality Statements, it says:</p> <p>- People who have a new diagnosis of HIV should expect to have their HIV fully assessed by appropriately trained staff within 2 weeks of receiving an HIV positive test result.</p> <p>... an assessment...but again, why not add, "where the benefits of starting ART as soon as possible should be reviewed with the patient" or something similar?</p>

10	3	36	Somewhere in this section, it needs to spell out that ART should be started as soon as the individual is able...this has clear clinical benefits not only for the individual, but also, more widely as a result of TasP. Here, in this section, there's mention of having an assessment within 2 weeks... but no mention of when to start ART. I know this is covered in the BHIVA treatment guidelines, but people shouldn't have to plough through those to get this essential bit of information... start ART as soon as you can! This shouldn't be left unsaid in this document...
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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
21	3a	39-40	<p>“The proportion of people with known HIV infection who are not known to have transferred their care or died, who have accessed HIV clinical services within the past 12 months (target: >95%).”</p> <p>And</p> <p>“Patients attending HIV services 1 year ago who have not been lost to follow up – all patients (numerator: number of patients receiving some aspect of care in the past 12 months who have not died and who received some aspect of care between 24 and 12 months ago; denominator: number of patients who received some aspect of care between 24 and 12 months ago).”</p> <p>These two are similar. Do we need them both? I think the first is problematic at a service level since it implies trying to trace everyone who has attended, <i>ever</i>, unless they're known to have transferred or died. Of course it's good to do this to the extent that's feasible, but I think achievement against this target will largely be a measure of out-migration. Suggest retain only the second one, which is on p 40.</p>

22	3a	40	<p>“Where peer support needs have been identified, excluding those newly diagnosed, the proportion of patients who report awareness of peer support services, and the proportion who report subsequent use of peer support (target: >95%).”</p> <p>I don’t think the “where peer support needs have been identified” denominator can be operationalised in practice. I doubt one can identify such needs without the person being aware of what’s available and having a sense of how it might help him/her. In this case I think the best approach is to widen the denominator, and alter the target to allow for some people not feeling a need for peer support. I’d suggest:</p> <p>“Excluding those newly diagnosed, the proportion of patients who report awareness of peer support services (target 70%), and the proportion who report use of peer support.”</p> <p>It’s possible that my suggestion of 70% may be too low here.</p>
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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	

	8c	106 - 107	<p>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.</p> <p>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.</p>
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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
2	3a	37 / 39	Transfer of care – we would request that the quality statement includes clarification that baseline results (e.g. VRT) are sent as a minimum alongside current test results in line with BHIVA monitoring guidelines and also to tie in with the quality statement on page 44 of this document.

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
21	3a	36	People newly diagnosed with HIV should indeed <i>‘be offered a full assessment, carried out by an appropriately trained practitioner with specialist expertise in HIV’</i> . However, for people actively engaged in injecting drug use, this practitioner will have to be located in an accessible and acceptable location and setting or be willing to travel to one to meet the

			person. A lesson from the Glasgow outbreak is that this is difficult to achieve and so initial engagement and treatment is a challenge if not impossible. Services are currently not configured for this group of people at risk.
22	3a	36	‘Access to HIV-appropriate emotional, psychological and peer support services is particularly important for people as they adjust to their diagnosis’ These are wholly or largely undeveloped for people who inject drugs. They simply do not exist for many people at risk.
23	3a	37	In the Glasgow HIV outbreak amongst people who inject drugs, tracing people with whom injecting equipment has been shared has been undertaken. This is a new challenge for some staff used to sexual partner tracing and involves training in issues around injecting so that patients can be understood. This should be mentioned in the care standards. Interestingly local paperwork and work terminology does not exist for this practice and it is referred to as ‘partner tracing’.
24	3a	37	‘...indicators for the proportion of patients who re-attend during the 12-24 months after HIV diagnosis and after being seen for care’ These indicators should be reported on separately for people who inject drugs so that issues in engaging this particular group are not missed in overall statistics.
25	3a	39	Measurable and auditable outcomes should include separate reporting for people who have been infected through injecting drug use and/or are injecting drug users so that issues in engaging and retaining people in this particular group are not missed in overall statistics.

Organisation name (if you are responding as an individual, please leave blank)			Sophia Forum
Name of commentator			Sophie Strachan
Role of commentator			Co Chair
10	3a	38	We welcome these quality statements

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
6	3a	40	You may wish to add our protocol evaluating HIV testing and diagnosis in general practice: Leber W, Beresford L, Nightingale C, Barbosa EC, Morris S, El-Shogri F, McMullen H, Boomla K, Delpech V, Brown A, Hutchinson J, Apea V, Symonds M, Gilliam S, Creighton S, Shahmanesh M, Fulop N, Estcourt C, Anderson J, Figueroa J, Griffiths C. Effectiveness and cost-effectiveness of implementing HIV testing in primary care in East London: protocol for an interrupted time series analysis. <i>BMJ Open</i> . 2017 Dec 14;7(12):e018163. doi: 10.1136/bmjopen-2017-018163
7	3a	40	Initial data from our service evaluation in Tower Hamlets (unpublished data) suggest that between 3-6/80 odd patients were lost to follow up following diagnosis at the GP over a six year observation period, stressing the importance of GP support/training around the time of diagnosis and the need for improved collaboration with secondary care. Barts Sexual Health has recently introduced a failsafe allowing a health advisor to track any patient with a positive test in GP. Hackney has had such a procedure in place for many years, and I would recommend that this be recommended in other high prevalence areas where HIV screening in GP will hopefully be introduced shortly.
7	1a		Also section 3a. An audit of delayed diagnosis could also be a great training opportunity for GP staff to learn about the importance of providing patient support at the time of diagnosis and prompt linkage with the clinic. Interviews with some of the patients diagnosed during RHIVA2 also highlighted lack of support/lack of professionalism when receiving a reactive POC test result (unpublished data still, unfortunately). GPs really seem to struggle with this and more training is needed. I also wonder whether the 2 week entry target is too wide and should be reduced even further? Should patients be given a referral form to attend the clinic at their most early convenience? Also, what is your policy on clinical lead for newly diagnosed patients with comorbidity? Should their initial care be at the clinic rather than the GP and if yes, when should they transition over?

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
7	3a	37	<p>Para 4: people may become disengaged....</p> <p>An example addressing disengagement is given of “increasing the offer of evening appointments” – however, factors affecting healthcare are often more complex than this. We believe that it would be helpful to note that there is a strong relationship between disengagement and underlying complex psychosocial issues (Michlig et al, 2018). These issues need to be understood and articulated as factors underpinning and/or causative of disengagement. It should be noted that an MDT approach may be required to understand and address disengagement, and perhaps a reference to section 4c of the BHIVA standards as this section addresses the area of complex needs.</p>
8	3a	37	<p>Para 5: The sentence that begins with: “Close working links.....” should also include reference to mental health services, to make explicit the importance of the inclusion of mental health professionals in the provision of holistic HIV care.</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

16	3a	38	24 hr standard for specialist assessment of new HIV diagnoses with symptoms/signs potentially due to HIV – or for review of a person diagnosed within a hospital setting: This is considered to be quite challenging – and probably unrealistic at weekends. 48 hrs probably more realistic and appropriate – unless there is an urgent medical concern.
17	3a	38	Patients receiving formal psychological support and peer support with 2-weeks: does it mean 2-weeks from the test or 2-weeks from their first HIV diagnosis consultation? Either way seems quite ambitious.

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
16	3	36	We wondered what type of assessment was being envisaged was it an holistic health and wellbeing as this would impact on the nature of the practitioner
17	3	36	As with the assessment is the ‘HIV care continuum’ just clinical or health and wellbeing
18	3	39	Add to the quality statement ‘access to financial and housing support’

Organisation name (if you are responding as an individual, please leave blank)			
Name of commentator			Laura Waters
Role of commentator			Consultant Physician
23	3a	38	If there is to be an outcome measure based on assessment by appropriately trained staff then I think ‘appropriately trained’ needs to be defined.

24	3a	39	Measureable and auditable outcomes 2-4 all ultimately say the same thing – suggest condense to one standard for specialist review within 2 weeks, regardless of the setting in which the diagnosis as made (including online servies)
25	3a		Sorry but I think there are simply too many quality standards here – however ideal it is unrealistic ro expect any service to document and measure all of these so my fear is they will be ignored completely – I’d argue strongly for far fewer, shorter standards in the main document with a full list as an appendix.

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>Patients attending HIV services 1 year ago who have not been lost to follow up – new diagnoses (numerator: number of patients in care at the beginning of the year who have not died who were NEWLY diagnosed between 24 and 12 months ago and have received some aspect of care in the past 12 months; denominator: number of patients who were NEWLY diagnosed between 24 and 12 months ago).</p> <p>Patients attending HIV services 1 year ago who have not been lost to follow up – all patients (numerator: number of patients receiving some aspect of care in the past 12 months who have not died and who received some aspect of care between 24 and 12 months ago; denominator: number of patients who received some aspect of care between 24 and 12 months ago).</p> <p><i>Could you clarify what you mean by some aspect of care (virtual, community HIV team ? GP). As we are working with new models to keep the harder to reach engaged, does this need to care by an HIV specialist or with support of and HIV specialist?</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 relation to references to transfer of care, in addition to discussion of for example transfer of information, reference should be made to provision of adequate medication to cover the transfer period. This mentioned at a later point (p.46 re prisons and places of detention) but it would be useful also to have this explicitly discussed in this Rationale section here.

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>The proportion of people newly diagnosed with HIV who have a CD4 count result in their clinical record within 1 month of their HIV diagnosis (target: >95%). (pg 39)</i> <p>PHE measures this outcome and could be measured every three months from HARS.</p>
			<ul style="list-style-type: none"> <i>The proportion of people newly diagnosed in primary care who are seen in an HIV specialist department within 2 weeks of diagnosis (target: >95%). (pg 39)</i> <i>The proportion of people newly diagnosed in secondary care who are seen in an HIV specialist department within 2 weeks of diagnosis/discharge from hospital (target: >95%). (pg 39)</i> <i>The proportion of people newly diagnosed in community settings who are seen in an HIV specialist department within 2 weeks of diagnosis (target: >95%).(pg 39)</i>

			PHE can measure the above 3 outcomes from HARS based on the available facility of diagnosis data and subsequent entries. However we use 1 months rather than a 2 week timeline to allow for variation in date entries.
			<p><i>The proportion of people with known HIV infection who are not known to have transferred their care or died, who have accessed HIV clinical services within the past 12 months (target: >95%). (pg 39)</i></p> <p>PHE can measure this outcome from HARS; however we would recommend including those that have transferred care as HARS can de-duplicate individuals who move between sites.</p>
			<ul style="list-style-type: none"> • <i>Patients attending HIV services 1 year ago who have not been lost to follow up – new diagnoses (numerator: number of patients in care at the beginning of the year who 40 have not died who were NEWLY diagnosed between 24 and 12 months ago and have received some aspect of care in the past 12 months; denominator: number of patients who were NEWLY diagnosed between 24 and 12 months ago). (pg 40)</i> • <i>Patients attending HIV services 1 year ago who have not been lost to follow up – all patients (numerator: number of patients receiving some aspect of care in the past 12 months who have not died and who received some aspect of care between 24 and 12 months ago; denominator: number of patients who received some aspect of care between 24 and 12 months ago). (pg 40)</i> <p>We recommend using the retention in care indicators in the Clinical Reference Group HIV dashboard to measure retention among newly diagnosed and all patients:</p> <ul style="list-style-type: none"> ○ proportion of newly diagnosed adults retained in care in the following year of diagnosis (HIV09aii) <p>proportion of adults retained in care in the following year (HIV09bii)</p>

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

26	G	G	<p>Standard 3a retention etc.</p> <p>Very please to see the standard about passing on adequate information for a patient who has transferred, but it should be clear that the onus is on clinics to provide within a specific time frame when they are asked, not on the new clinic to have to keep asking, which I find is common.</p> <p>The standard says this "Evidence that when patients transfer into the service an attempt is made to obtain the following information from the previous care provider: baseline resistance status, previous treatment regimens and the reasons for any treatment switch. This information should be recorded in the care record." This would be a good opportunity for BHIVA to produce a prescriptive transfer of care template. I often find the transfer info is very sketchy.</p>
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Standard 3b

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
4	3	40	Penultimate auditable outcome - presumably requires exclusion of those that have transferred their care elsewhere also

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
23	3b	43	<p>“Evidence that all patients have been given information, whether oral or written, about the effect of anti-retroviral therapy on the risk of transmission (95%).”</p> <p>Check this against treatment and SRH guidelines and use same wording. I think they refer to “discussion” rather than information being given.</p>
24	3b	43	<p>I would suggest omitting:</p> <p>“Important modifiable risk factors for longer term health such as smoking history, BMI and blood pressure should be recorded and documented according to BHIVA guidelines with formal cardiovascular risk calculation as specified by those guidelines.</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 documented assessment of renal function, to include an assessment of proteinuria in the last 15 months (>90%).”</p> <p>And amending to:</p> <p>“Evidence that patients are assessed and monitored in accordance with BHIVA guidelines, whether on or off treatment.”</p> <p>This is simpler and allows for changes to BHIVA guidelines within the lifetime of the standards.</p>
25	3b	44	<p>“Survey of patient experience in the preceding 3 years (target: 95%).“</p> <p>I don’t know what this target means. 95% seems too high for a response rate, but too low as a target for conducting the survey. Suggest “Survey of patient experience in the preceding 3 years (target: 80% for response rate)“ although even that strikes me as a bit high.</p>
26	3b	44	<p>“Evidence of recording of clinical incidents and complaints and their investigation (target: 95% completed investigations).“</p> <p>It’s not possible to set a target for recording, because if they’re not recorded they can’t be included in a denominator. So suggest clarifying that target is for investigations.</p>
27	3b	44	<p>“Evidence of a care pathway whereby patients with viraemia and limited options to construct a fully suppressive regimen have their case reviewed directly or remotely (by virtual clinic) by a multidisciplinary team consisting of at least one consultant virologist, two HIV consultants, and a specialist HIV nurse or pharmacist. Evidence should be available to demonstrate that patients are reviewed via this clinic.”</p> <p>Shouldn’t it say “nurse and pharmacist”? They have different roles and I would imagine both are needed.</p>

Organisation name (if you are responding as an individual, please leave blank)			
Name of commentator			Sum Yee Chan
Role of commentator			I am a consultant in GUM and HIV in CNWL Surrey. Outside of this work I am also doing a PGCE in special education and music and am currently placed in a special needs school for blind and visually impaired children
			<p>Also I was part of the writing group for HIV outpatient care and treatment. Thank you for putting in the part about people who may be incarcerated or detained. Could you also consider adding a section about how much medication people should have once they leave prison or a detention centre? People are often given no medication or a few tablets and there is guidance that say they should be given enough medication to ensure a safe transfer to another care organisation (or another prison).</p> <p>https://www.nat.org.uk/sites/default/files/publications/May-2011-Tackling-Blood-Borne-Viruses-in-Prisons.pdf</p> <p>People who leave hospital are given TTOs with enough ARVs, so I feel that people leaving places of detention/ prisons should also be given the same quantity.</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.
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	
		107	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			Kaveh Manavi
Role of commentator			Consultant physician in HIV
8	3b	44	'HIV services should be able to demonstrate that they are able to provide results for HIV viral load, CD4 count, HIV resistance assay, HLA-B5701, and tropism tests within 2 weeks.' The two week laboratory turnaround time is over five years old. The current laboratory assays can produce results in shorter period. Why have we not set a more ambitious target?
9	3b	45	references are missing.

10	3b	48	'Proportion of patients who are new to treatment who are prescribed a treatment regimen in line with BHIVA guidelines'. The treatment options that we can offer to patients is now limited by what NHSE recommends. Some of NHSE recommended regimes are not first line BHIVA recommended regimes. I proposed the statement should be modified to reflect this fact.
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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
3	3	44	Statement under 'Patient experience' regarding 'Evidence of easy access to multidisciplinary support services' needs to include dietetics.

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
26	3b	43	Measurable and auditable outcomes on <ul style="list-style-type: none"> • Preventing premature mortality, reducing morbidity and preventing transmission • Clinical practice in line with national guidelines should include separate reporting for people who have been infected through injecting drug use and/or are injecting drug users so that issues in this particular group are not missed in overall statistics.

27	3b	44	<p>Measurable and auditable outcomes on</p> <ul style="list-style-type: none"> • Patient experience • Patient Safety <p>should include separate reporting for people who have been infected through injecting drug use and/or are injecting drug users so that issues in this particular group are not missed in overall statistics.</p>
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Organisation name (if you are responding as an individual, please leave blank)			Sophia Forum
Name of commentator			Sophie Strachan
Role of commentator			Co Chair
11	3b	42	We welcome these quality statements

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
9	3b	41	<p>Para 2 of the rationale section: The sentence that begins with “As increasing numbers of people....” would benefit from a reference to the paper which proposes the idea of a ‘fourth 90’, which relates to people living well with HIV, beyond just viral suppression (Lazarus et al, 2016).</p> <p>Also, in the same sentence, it may also be useful to make specific reference to mental health services, alongside general health, social services etc.</p>

10	3b	41	Para 3; The Society believes that it would be helpful to reference section 4c and section 6 here, to direct the reader toward parts of the standard that deal directly with complex health and psychosocial needs.
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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
18	3b	42	<i>'People with HIV should receive care in appropriate designated facilities which guarantee privacy and confidentiality. There should be ...'</i> This is an important Quality Statement in cash-strapped times; it should be retained in the final Standards

Organisation name (if you are responding as an individual, please leave blank)			
Name of commentator			Laura Waters
Role of commentator			Consultant Physician
26	3b	41	I think virtual appointments have a role beyond situations where a face to face appointment is not feasible, including patient preference so suggest this should be acknowledged
27	3b	42-45	Many of the quality statements/outcomes overlap with other sections or duplicate outcomes on the relevant BHIVA guidelines – again suggest removing duplication and reducing the number for reasons outlined already. There are 36 quality statements/outcomes in this one section alone.

Organisation name (if you are responding as an individual, please leave blank)			NAT
Name of commentator			Yusef Azad
Role of commentator			Director of Strategy
			There could usefully be further reference in this section to prisons and other places of detention, with citation of NAT's Framework 'Tackling Blood-Borne Viruses in Prison' - https://www.nat.org.uk/publication/tackling-blood-borne-viruses-prison - and the forthcoming NAT/BHIVA Guidance on HIV in Immigration Removal Centres.

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
			<p><i>Evidence that newly diagnosed patients are clinically assessed and offered the opportunity to start anti-retroviral treatment according to BHIVA guidelines (95%).(pg 43)</i></p> <p>Evidence of clinical assessment could be collected through the proportion with a CD4 count within one month. We can also measure time from diagnosis to starting treatment as an auditable outcome in light of NHS England's announcement of the availability of funding for immediate ART for newly diagnosed patients.</p>
			<ul style="list-style-type: none"> <i>Evidence of easy access to multidisciplinary support services – in particular: phlebotomy, specialist nursing, adherence, specialist HIV pharmacy advice, and peer and advocacy support. (pg 44)</i> <p>This outcome can be partially met from PV, which asks patients to document their experience of HIV related services in the last year. Specifically, "professional help to take your HIV tablets on time and correctly" and "Peer support/social contact with other people" (HIV related services, E1)</p>

		<ul style="list-style-type: none"> • <i>Evidence of ready access to defined care and support services, e.g. dispensing, mental health care, social care advice, sexual health advisor. (pg 44)</i> <p>There is a section in the PV survey on “what you need” covering HIV related services (E1), health services (E2) and social and welfare services (E3). Responses to these three sections could be used to assess access to care and support services.</p>
		<ul style="list-style-type: none"> • <i>Survey of patient experience in the preceding 3 years (target: 95%).(pg 44)</i> <p>Participation of clinics in the PV survey could be used as evidence of conducting patient experience surveys.</p>

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
10	3b	44	'HIV services should be able to demonstrate that they are able to provide results for HIV viral load, CD4 count, HIV resistance assay, HLA-B5701, and tropism tests within 2 weeks.' The two week laboratory turnaround time is over five years old. The current laboratory assays can produce results in shorter period. Why have we not set a more ambitious target?
11	3b	45	References are missing.
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Organisation name (if you are responding as an individual, please leave blank)		UK-CAB
Name of commentator		Angelina Namiba
Role of commentator		
		<p>Comment received via forum:</p> <p>I can find no mention of lipodystrophy in any of the documents, I wonder if this is because people who are on new HIV medication no longer acquire this condition. However like myself, I know of several people who are affected by lipodystrophy.</p> <p>Just last week I was told during my Chelsea & Westminster Newfil appointment that I was required to obtain a new referral from the hospital consultant; this was the first time I've ever been asked this question during the many years I've received treatment which as you are aware requires injections into the face with the Newfil substance.</p> <p>Would you please add whatever comments you wish in order to ensure lipodystrophy is mentioned as a condition requiring ongoing treatment.</p> <p>I welcome your comments and feedback.</p>

Standard 3c

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
5	3c	47	We are not sure Standards can easily specify what is included in clinical PAs - though there could be encouragement that there need to be SPAs related to HIV care
6	3c	47	Is it correct that there is an outcome that medicines optimisation should be undertaken by a <i>specialist HIV pharmacist</i> at least annually? Medicines optimisation is of obvious importance, but some centres may not have such pharmacists (except in an advisory role as part of a network). Or is the meaning that such an advisor should be communicated with annually?

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
28	3c	48	<p>Suggest re-word as:</p> <p>“Among responding patients, proportion who report that they were as involved as they wanted to be in treatment decisions (>90%).”</p> <p>Also, treatment decisions and reporting side effects are two issues, probably best to separate:</p> <p>“Evidence that patients are offered written information and access to peer support when making treatment decisions.</p>

			Evidence that patients are offered written information about how to report side effects, including how to access peer support.”
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Organisation name (if you are responding as an individual, please leave blank)			
Name of commentator			Kaveh Manavi
Role of commentator			Consultant physician in HIV
11	3c	48	some of the references have incomplete information.

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
3	3c	47	Statement 8 – unclear if ‘HIV specialist’ refers to an HIV specialist pharmacist or and HIV specialist of any discipline. We assume it means an HIV specialist pharmacist or an adequately trained pharmacist (may wish to consider competent, trained pharmacist phrasing) but it is ambiguous.

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

4	3	47	Quality statements to include, weight to be monitored after ARV initiation, aiming to limit excess weight gain during the first 12 months post ARV initiation to reduce risk of future development of CVD and diabetes.
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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
5	3c	46	A sentence or two about generics could be included here. Well-informed and supported patients need to know that cheaper generics work as well, and are as safe, as more expensive branded drugs.

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
28	3c	47	<p>‘Persons in prisons or other detention facilities should have a regular and continuous supply of anti-retroviral medications alongside adequate access to HIV specialist, and continuity of both treatment and access should be maintained when being moved between facilities.’</p> <p>Indeed. It should also be possible to be tested, diagnosed and commence treatment in a prison setting. In fact this should be the focus of effort both to find cases and to initiate treatment on people who have found it difficult to engage in treatment in community settings.</p>

29	3c	48	Auditable outcomes for ARV prescribing should include separate reporting for people who have been infected through injecting drug use and/or are injecting drug users so that issues in this particular group are not missed in overall statistics.
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Organisation name (if you are responding as an individual, please leave blank)			Sophia Forum
Name of commentator			Sophie Strachan
Role of commentator			Co Chair
12	3c	48	https://www.nice.org.uk/guidance/qs156/chapter/Quality-statement-1-Medicines-reconciliation for those incarcerated

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
4	3c	48	You may wish to add our audit on co-prescribing in primary care to this section: Wellesley R, Whittle A, Figueroa J, Anderson J, Castles R, Boomla K, Griffiths C, Leber W. Does general practice deliver safe primary care to people living with HIV? A case-notes review. Br J Gen Pract. 2015 Oct;65(639):e655-61. doi:10.3399/bjgp15X686905.

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

7	3c.	G	<p>Generic ARVs are omitted from this section. At a time where more generics are being prescribed it is important that the standards reflect the necessary information and engagement required when switching a person to generic meds.</p> <p>We would suggest the standards at least reflect what is covered in our information on generics for people living with HIV (see link below), namely discussions around what generics are, what to expect during the switching process and what to do should the generic meds have any adverse effects.</p> <p>http://www.tht.org.uk/myhiv/HIV-and-you/Your-treatment/Generic-HIV-treatment</p> <p>Our Medical Director also wrote a blog on the subject with BHIVA chair Chloe Orkin which may be of use: http://www.tht.org.uk/Our-charity/Media-centre/Blog/2017/August/Terrence-Higgins-Trust-and-BHIVA-advise-on-the-use-of-generic-HIV-antiretroviral-therapy/</p>
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Organisation name (if you are responding as an individual, please leave blank)			
Name of commentator			Laura Waters
Role of commentator			Consultant Physician
28	3c	47	“ARVs should only be prescribed by an appropriately qualified practitioner” – you reference standard 3C which simply states the same – what constitutes ‘ appropriate’ in this context please? I thin this is essential.
29	3c		Some references are in the text, the numbering doesn't start at 1 and the formatting is inconsistent – all stating the obvious I am sure

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>Adherence documented within the first 3 months of starting antiretroviral treatment (ART) and at least annually thereafter (target: 95%, both) (pg 48)</i> <p>Three-monthly and annual adherence could be monitored through HARS using the suppressed viral load as a measure of effective treatment.</p>
			<ul style="list-style-type: none"> • <i>Patients starting or established on ART with HIV viral load and safety monitoring performed in accordance with national guidelines (target: 95%). (pg 48)</i> <p>This can be measured by HARS as the proportion with a viral load measure among those on ART treatment.</p>

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
13	3c	48	Some of the references have incomplete information.