Testing public health intervention guidance on increasing the uptake of HIV testing among men who have sex with men.

Final fieldwork report

National Centre for Social Research, Sigma Research and the National AIDS Manual (NAM)

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Contact details:

Dr Peter Keogh
National Centre for Social Research
35 Northampton Square, London EC1V 0AX
020 7549 7130
Peter.keogh@natcen.ac.uk

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Executive Summary

Background

The National Institute for Health and Clinical Excellence (NICE) was asked by the Department of Health to produce public health guidance on increasing the uptake of HIV testing to reduce undiagnosed infection and prevent transmission among men who have sex with men. A consortium consisting of NatCen, Sigma Research and NAM was commissioned to test the draft guidance. This report presents the results of fieldwork to test this guidance.

Research Design

The research took a mixed-mode approach incorporating face-to-face, telephone and web-based fieldwork. These included:

Participative workshops
89 people likely to be involved with implementing the guidance attended one of six half-day regional participative workshops undertaken in Birmingham, York, Sheffield, Brighton, London and Liverpool.

Online Questionnaire
183 people completed an online questionnaire seeking their perspectives on the guidance.

Telephone Interviews
Telephone interviews were conducted with four GPs and one GUM consultant to gather their opinions of the guidance.

General views on the guidance

The majority of those participating in the fieldwork welcomed the aim and content of the recommendations.

The majority of those participating in the fieldwork felt that most recommendations in the draft guidance (with the exceptions of recommendations 5 and 6) provided a clear articulation of measures that were or should already be in place.

Participants welcomed the clear inscription of partnership-working approaches across the guidance.

Participants were eager for the guidance to be 'future-proof' especially in the light of forthcoming NHS and commissioning reform.

The question of funding and resources was raised repeatedly. There was general consensus that the benefits of the guidance outweighed the costs, but many felt that the economic evidence and arguments supporting the guidance could be stressed more.

There were some concerns regarding implementability of recommendations around primary care. Many stressed lack of capacity, expertise and funding in these settings alongside a need for 'culture change' within primary care settings.

The role of leadership and co-ordination was repeatedly stressed in relation to fostering political will and support around implementing the guidance. Most participants felt that the guidance could emphasise more the roles of leader, champion or coordinator.

The 5 professional groups considered may have the greatest difficulty in implementing the recommendations were general practitioners, clinical staff in A&E, clinical staff in walk in centres, health centres and community clinics, primary care practice managers and commercial venues owners.

The Recommendations

Recommendation 1: planning services

The majority of those participating in the fieldwork felt that recommendation 1 was clear and easy to understand, was broadly implementable and would have a beneficial impact on HIV testing services for MSM.

Most thought that although recommendation 1 did not describe new ways of working, it formalised a model of best practice in integrated service planning.

The greatest barrier to implementation of recommendation 1 was the current environment of cutbacks and strategic restructuring. Participants were eager to ensure that recommendation 1 should be able to map onto future planning structures.

As in other recommendations, the need for clearer delineation of leaders or champions in implementing recommendation 1 was noted. This was seen to be especially important in the light of a constrained funding environment where HIV will need to compete with other public health priorities.

The question of whether a local HIV testing strategy should be 'stand-alone' or integrated into pre-existing local sexual health strategies was frequently raised.

Many felt that recommendation 1 should specify detained or cared-for populations and institutions (such as prisons and young offenders institutions, care homes and mental health facilities). Some felt that education institutions should also be specified.

A range of interventions were mentioned that would further support local implementation of recommendation 1. These included a national HIV testing campaign targeting MSM to reinforce local strategies; development of templates for HIV testing strategies in high and low incidence areas to support commissioning; and planning at regional rather than commissioning-level, in order to include less metropolitan areas.

Recommendation 2 results: Integrated Care Pathways

The majority of those participating in the fieldwork felt that recommendation 2 was clear and easy to understand, was broadly implementable and would have a beneficial impact on HIV testing services for MSM.

Although most thought that recommendation 2 did not describe new ways of working, it formalised a model of best practice in developing comprehensive integrated care pathways.

Care pathways from GUM to the voluntary sector were seen to be less evolved as were those to and from the voluntary sector and primary care settings.

Concerns were raised about the feasibility of GP services being integrated into care pathways at present. Some suggested that obstacles to GP involvement may be reduced by including those commissioning primary care in the commissioning related to this recommendation.

Care pathways for men who test negative (for example into community health interventions or psychological services) were seen to be largely absent from current practice. The need to develop these pathways was stressed.

Gay supportive psychology and counselling services were seen as vital to work with groups of men at risk. However, many said these services were insufficient.

Concerns were raised that recommendation 2 specifies only clinical service providers and commissioners in planning integrated care pathways. Many felt that this should also involve the voluntary sector and should be led by commissioners in order to ensure balanced input across stakeholder organisations.

The resource implications of recommendation 2 were seen to be relatively minor. However, concerns were raised that implementing this recommendation would lead to increased demands for resource intensive services (such as psychological or counselling services).

The main barrier to implementing recommendation 2 was seen to be the role of stigma and cultural taboos in discouraging MSM to disclose sexual identity, behaviour or risk to clinicians or GPs. Moreover, this was seen to deter many non-sexual health clinicians from discussing testing and sexual risk with patients.

Recommendation 3: Promoting HIV testing and reducing barriers

The majority of those participating in the fieldwork felt that recommendation 3 was clear and easy to understand, was broadly implementable and would have a beneficial impact on HIV testing services for MSM.

Overall this recommendation was strongly welcomed as supporting a better resourced and more focused approach to the promotion of HIV testing.

However, in general the recommendation was seen to risk being too restrictive in describing a limited range of venues for and approaches to the promotion of HIV testing as well as target

groups. Thus many felt that the recommendation should either not specify venues, approaches or target groups or should specify a larger range of these.

The inclusion of scene proprietors and primary care practitioners as active promoters of HIV testing in recommendation 3 was welcomed. However, it was also seen as challenging.

The potential role of government and national organisations in both promoting HIV testing to MSM and in reducing the barriers to accessing tests in a range of settings was also stressed. Many felt that the guidance should refer to and support such national interventions.

Resource issues were identified as the main barriers to implementing recommendation 3. Some mentioned the additional resources needed to develop campaigns around HIV testing. Others stressed the resources necessary for GP services to provide testing to patients.

Participants from a GUM background raised the concern that promoting HIV testing without the context of sexual health screening could lead to other STIs going undiagnosed. They were therefore keen to see the guidance recommending the promotion of HIV testing within the context of sexual health screens.

Recommendation 4: Universal testing in sexual health services.

The majority of those participating in the fieldwork felt that recommendation 4 was clear and easy to understand, was broadly implementable and would have a beneficial impact on HIV testing services for MSM.

Overall, there was consensus that universal opt-out testing to all men accessing sexual health services would normalise and de-stigmatise the test and would therefore lead to an increase in the uptake of HIV testing.

However, a sizeable minority of participants raised concerns that universal testing would draw attention and resources away from targeting those at highest risk and pre-and post-test risk reduction interventions.

Although the recommendation was clear and easy to understand, this fieldwork identified the need for the guidance to define what constitutes a sexual health service (such as primary care settings, community settings, educational and custodial settings etc) as well as specifying protocols for offering opt-out testing in the range of settings where sexual health services occur.

Some participants felt that it might be useful for this recommendation to use the language of level 1, 2 and 3 services, as outlined in other guidance in this area.

The main barriers identified to implementing recommendation 4 were a lack of consistency across services in terms of whether or not opt-out testing was offered and the ways in which it was offered. A second barrier identified was lack of resources. Participants stressed the need to present the cost-benefit argument regarding opt-out testing. Finally, others identified stigma as a continuing barrier to the offer and uptake of opt-out testing in some settings.

Recommendation 5: routine HIV testing in primary care

The majority of those participating in the fieldwork felt that recommendation 5 was clear and easy to understand and would have a beneficial impact on HIV testing services for MSM. However the implementability of recommendation 5 was questioned.

Overall, the provision of routine testing in primary care settings was supported in terms of increasing access to testing, case finding as well as normalising and hence de-stigmatising the test.

Although the recommendation was perceived to be clear and easy to understand, many participants noted the need to define primary care services more fully in the guidance (for example whether or not it included A&E, dentistry etc.). Others raised concerns about how it might be possible to define an area with a 'large community of men who have sex with men' and how useful such a definition might be.

Compared to all other recommendations, recommendation 5 was seen to involve the greatest innovation to current practice and therefore held the greatest challenges around implementation.

Implementation was thought to require extensive interventions at a State or regional level. These might include the development of training for a range of primary care staff; a general population campaign regarding HIV testing in primary care settings and publication of results of any pilots of HIV testing in primary care settings alongside a cost-benefit analysis.

Others stressed the need for protocols for offering and administering the HIV test in primary care settings.

Those working within general practice felt that increasing the availability of HIV testing in primary care settings would depend on incentivising general practice and including HIV testing in the Quality and Outcome Framework (QOF) for GPs.

The barriers to the implementation of recommendation 5 identified by participants included lack of capacity in the primary care settings and a possible unwillingness on the part of primary care services to undertake this work.

Recommendation 6: Outreach rapid point-of-care tests

The majority of those participating in the fieldwork felt that recommendation 6 was clear and easy to understand, was broadly implementable and would have a beneficial impact on HIV testing services for MSM.

Recommendation 6 was supported as increasing the provision of HIV testing in non-standard and non-clinical settings. This was seen as a vital way of increasing the uptake of testing and identifying undiagnosed infection.

However, like recommendation 3, this recommendation was seen to risk being too specific in the settings and approaches it describes. Participants were clear that testing in community

settings encompasses a broad range of approaches to and settings for community testing as well as target groups.

There was a wide variety of opinion amongst those involved in community health promotion regarding how recommendation 6 might be implemented locally.

The need for protocols for 'community testing approaches' was also identified to cover training standards, targeting, test administration and clinical governance as well as referral /care pathways.

As with other recommendations, participants emphasised the need to specify leadership or coordinating roles (perhaps at commissioner level) to ensure such protocols are implemented, quality and clinical governance maintained and care pathways are established.

The main barriers identified to implementing recommendation 6 were resources required (for both community and clinical staff).

As in other areas, some participants expressed concern that offering an HIV test without the context of sexual health screens may lead to other STIs going undiagnosed and a downplaying of the importance of a sexual health screen generally.

Recommendation 7: Repeat testing

The majority of those participating in the fieldwork felt that recommendation 7 was clear and easy to understand, was broadly implementable and would have a beneficial impact on HIV testing services for MSM.

Recommendation 7 received majority support as a means of increasing early diagnosis and identifying men at risk for other interventions.

However, it was emphasised that the guidance should make clear the aim and purpose of the recommendation. That is, the role of repeat testing as an HIV prevention intervention should be distinguished from its case-finding role. Moreover that repeat testing should not be seen as an appropriate or only intervention for men who take repeated risks or men who test repeatedly despite little or no risk (the 'worried well').

As in other recommendations the need for protocols regarding the offer and follow-up of repeat testing in a range of settings was stressed. These protocols should specify how to identify men for repeat tests, how to present repeat tests to the patient and why the patient is being advised to test again. They should also specify a range of approaches and methods for follow-up.

The need for clearer guidance on the window period was stressed: how it varies for different testing technologies and how to present this information to the user.

Recommendation 7 was perceived by some to be at odds with previous BHIVA guidance. The main difference is that the BHIVA guidance is perceived to recommend annual testing for all

MSM regardless of risk, but that this recommendation specifies an element of risk assessment.

Although recommendation 7 was judged to be clear and easy to understand, the perceived need to assess risk caused some confusion. Some wondered whether the guidance was specifying annual testing for all men with more frequent testing recommended for men judged to be at higher risk of exposure.

The use of the word 'barebacking' was noted as out of place or inappropriate with some objecting to its use.

The main barriers to implementation of recommendation 7 identified were resources. Specifically, the extra resources required from GUM in locating and following up men for repeat tests.

Recommendation 8: Training

The majority of those participating in the fieldwork felt that recommendation 8 was clear and easy to understand, was broadly implementable and would have a beneficial impact on HIV testing services for MSM.

Overall, recommendation eight was supported universally as training was seen to be vital in underpinning all other recommendations and improving testing services.

Although the recommendation was not perceived to describe new ways of working for VCS and GU staff, it was considered entirely new in the case of primary care staff. Such training was seen as vital but difficult and resource intensive to implement.

Although recommendation 8 was considered clear and easy and to understand, some felt that it needed more detail, especially in relation to the types of training appropriate, how such training might be delivered and at what level.

The integration of training into pre-existing service training or continuing professional development was seen as being preferable to developing stand alone training.

As in other recommendations, the need for the development of protocols for training (to include quality control procedures, curriculum development, monitoring and learning outcomes) was stressed.

The need to involve service users and MSM living with HIV in the development and delivery of training was stressed.

Some perceived that the wording and ordering of the recommendation might be unacceptable to some groups (specifically primary care providers).

As in other recommendations, the need for a clearer specification of a leadership or coordinating role was stressed.

The main barriers to the implementation of recommendation 8 identified were those associated with resources and increased burden for staff undergoing such training.

Conclusions

The overwhelming majority of those participating in the fieldwork found the recommendations to be clear and easy to understand.

The majority of those participating in the fieldwork felt that each of the recommendations or its implementation would help to improve local HIV testing services. Recommendations relating to training and integrated care pathways were most favoured by online respondents.

For online respondents, the perceived potential for implementation varied by recommendation. Recommendation 5 and 6 were perceived to be implementable by only a minority of respondents whereas recommendations 1, 4 and 7 were most commonly rated as implementable.

With regard to what was perceived to be new in the recommendations for online respondents, recommendations 5: Routine HIV testing in primary care and recommendation 6: Outreach rapid point-of-care tests were considered as a new way of working by the majority.

Both event participants and interviewees perceived some gaps or omissions in the recommendations. These pertained to target groups (in particular men in custodial or cared-for settings and educational settings); responsible actors (specifically the role of leader, responsible party or coordinator) and approaches (in particular a broader range of community-based and face-to-face approaches could be specified).

Participants in events felt that local implementation of the recommendations would benefit substantially from the support of a range of national centrally coordinated interventions including general population campaigns, campaigns for MSM and capacity building campaigns with key professional groups (such as general practitioners). Central government or national organisations were identified as those who should be responsible for implementing these interventions.

In general, participants and interviewees saw the recommendations as 'future proof' with regard to pending changes to public spending, scrutiny and oversight – particularly in the area of public health commissioning. However, the need to revisit the guidance once changes had been announced and new structures have 'bedded in' was stressed at events.

The greatest perceived barriers to implementing the guidance overall were lack of current resources, future reduction in resources and funding, societal stigma and existing negative professional attitudes.

Overall, participants in interviews would like to see greater clarity and consensus regarding the aim of increasing HIV testing among MSM. That is whether this was case finding and treatment and/or opportunities to carry out HIV promotion interventions with those at highest risk. Some felt that the guidance would benefit by reference to the role of 'testing and

treatment for prevention'. That is, testing to identify infection and risk as well as treatment to reduce population viral load and hence transmission.

Many participants and interviewees felt that the guidance differed from that issued by other bodies (such as BHIVA/BASHH) in some key respects. They felt that the guidance would benefit from being consonant with such other guidance.

Finally, potential risks associated with promoting HIV testing in isolation or without the context of a more general sexual health screen were highlighted by those from clinical backgrounds. That is, the aim of testing for HIV only may lead to undiagnosed/untreated STIs. These are detrimental to health and will impact on susceptibility to HIV infection and infectiousness of those with HIV.

Organisation of the report

This fieldwork report describes the findings of a range of research activities undertaken by NatCen and Sigma Research. It does not include any of the consultation responses collected directly by NICE through its online consultation with registered stakeholders. Chapter 2 describes in detail the various research methods used and the sample of participants. Chapter 3 presents how those who participated in the fieldwork felt about the draft guidance as a whole. Following on from this, Chapter 4 through to Chapter 11 each offer a detailed description of participants' views of each recommendation made in the draft guidance. Chapter 12 then offers a summary of the findings, as well as the research team's identification of key themes emerging from the fieldwork and how these might warrant consideration of particular areas of the draft guidance. The appendices at the end of the document provide methodological information, sample data collection instruments and organisational tools for this research.

1   Introduction

1.1   Background

The National Institute for Health and Clinical Excellence (NICE) was asked by the Department of Health to produce public health guidance on increasing the uptake of HIV testing to reduce undiagnosed infection and prevent transmission among men who have sex with men.

The draft public health guidance was released on 27 September 2010, and is intended for NHS and other commissioners, managers and practitioners who have a direct or indirect role in, and responsibility for increasing the uptake of HIV testing among men who have sex with men. This includes those working in: local authorities, education and the wider public, private voluntary and community sectors. It may also be of interest to men who have sex with men and are at risk of HIV infection, or are living with HIV, and other members of the public.

The draft guidance was open to stakeholder consultation through two processes:
1) Registered stakeholders were able to comment on the draft directly to NICE through its website until 22 November 2010.
2) Practitioners, funders and those who influence policy in the field were approached by independent researchers (see section 1.2 below) to participate in one of a range of consultative feedback activities (see Chapter 2) closing on 11 November 2010. This fieldwork report is based on these independent research activities only.

The draft guidance on increasing the uptake of HIV testing among MSM complements NICE guidance on increasing the uptake of HIV testing among black African communities living in England. The two pieces of guidance were developed and consulted upon separately.

This public health guidance was drafted within the context of recently released National Guidelines for HIV Testing (BHIVA, BASHH, BIS 2008) which recommend testing being available in more settings, including non-specialist ones, and that the informed consent obligations for an HIV test are no different than they are for other medical procedures. These testing guidelines also recommend that MSM should test annually, or more frequently if they are routinely exposed to the risk of transmission.

1.2   The fieldwork team

The consultation activities were led by the National Centre for Social Research (Peter Keogh, Sally Bridges and Gary Boodhna), in collaboration with Sigma Research (Peter Weatherburn, Catherine Dodds and David Reid) and the National AIDS Manual (Selina Corkery). Sigma Research is highly experienced in applied research in the areas of HIV, MSM and HIV prevention whilst the Health and Wellbeing Group at NatCen has conducted extensive research in the broader field of health and sexual health. Furthermore, NAM possesses the detailed knowledge of and access to the HIV prevention and treatment communities in the UK. Access to both Sigma Research and NAM's databases of clinicians, policy makers, commissioners, voluntary sector and statutory practitioners across England were essential in deriving a broad sample of consultation participants.

2 Research method and sample

The purpose of this fieldwork was to determine how acceptable the guidance is to a range of practitioners and other stakeholders as well as how feasible they perceive implementation of the recommendations to be. We investigated the challenges practitioners expect to face with regard to the guidance and recommendations, what opportunities the guidance may afford to develop practice and what kinds of support might be needed with respect to implementing the guidance and recommendations.

The guidance is intended for commissioners, managers, policy makers and other practitioners within the NHS as well as local authorities and the wider private, voluntary and community sectors (VCS). As such this constitutes a diverse group with a range of perspectives and possible concerns regarding the impact and appropriateness of the guidance on their practice. We selected a research design that would adequately address that diversity, drawing out similarities and differences, while also ensuring that a broad range of practitioners in different geographical locations would have some means of accessing one of the consultation activities.

Each of the research methods described in section 2.1 asked those working in the field to consider the following:

- The relevance and usefulness of the guidance/recommendations to current work and practice? Which of the recommendations are both feasible and likely to make a difference to practice?
- What are the potential consequences of the guidance/recommendations for improving health and tackling health inequalities?
- What is the potential impact of the guidance/recommendations on current policy, service provision or practice?
- What factors (e.g. time available, training) could impact - positively or negatively on the implementation and delivery of the guidance/recommendations?
- What would be the relative priority of each of the recommendations?

The research took a mixed-mode approach incorporating face-to-face, telephone and web-based fieldwork. These included:

- **Participative workshops**
A series of six half-day regional participative workshops undertaken in Birmingham, York, Sheffield, Brighton, London and Liverpool investigated the perspectives of those likely to be involved with implementing the guidance.

- **Online Questionnaire**
Those unable to attend workshops were targeted with a self-complete online questionnaire seeking their perspectives on the guidance.

- **Telephone Interviews**
  A small number of telephone interviews with GPs and GUM staff gathered their opinions of the guidance. These interviews were undertaken for small number of respondents who were deemed to be significant for this consultation but who were not amenable to either participative or web-based approaches.

These approaches were selected in order to maximize our ability to collect meaningful and considered feedback from a broad range of stakeholders within the time and budget allocated for this work.

A total of 270 people participated in qualitative and quantitative research undertaken by NatCen and Sigma Research which aimed to seek opinion of a range of selected participants (frontline practitioners, health professionals, voluntary sector service providers, commissioners and policy makers) on the public health guidance over a five week period. A pragmatic recruitment strategy (described in greater detail in **Appendix A**) was implemented across the three methodological approaches described in detail below to ensure a broad representation of members of the targeted populations.

Throughout the report, distinctions are made between the findings from each of the three methods, given the differences between those being sampled, small differences in question formation and different approaches to analysis as a result. We regard these various methods as providing the capacity for triangulation of results, which is why we have made the decision to maintain a distinction between the methods when reporting the findings.

2.1   Consultation workshop events

Event design

The structure of the participative workshops encouraged a coherent dialogue and gave us the opportunity to present complex information, monitor reaction and reflect iteratively on this information. They provided the opportunity for participants not only to articulate their own perspectives, but also to discuss how these perspectives differ between different groups and stakeholders. Thus they produced data on individual and group experiences and opinions whilst also drawing out the extent and nature of consensus or dissent around a complex topic.

A sample event plan and further detail about the structure of the events is provided in **Appendix B**. The workshops lasted three hours, affording the opportunity both to monitor how participants' thoughts and opinions changed as different questions and information were presented, and to provide more time for quieter participants to speak. An opening presentation on the draft recommendations and the consultation process was followed at each event by guided large and small group discussions on each of the eight recommendations.

Participants were asked to work within pre-selected groups (selections were based on job roles as they related to the specific recommendation to be discussed). Each small group was assigned a single recommendation to discuss, and each participant took part in two different

small groups across the course of the workshop event. **Appendix C** contains a sample question form intended to guide the discussion for each small group. Each small group then fed back to the whole group. Ample opportunity was given for discussion of each recommendation in turn by the whole group, so that everyone in the room had the opportunity to contribute their views on each recommendation, even where they were not assigned to the small group tasked with discussing it in detail. Undertaking two rounds of small groupwork and large group feedback ensured that all eight recommendations were covered at every event (at two events where group composition was small, it was necessary to confine discussion regarding recommendation 7 to the large group only).

This method was limited only to those who have the capacity to attend, and who were captured within the geographically bounded search undertaken by the research team prior to purposive sampling and invitation. Participation in a group setting was also likely to encourage participants to be more guarded in what they might have said in a less public forum.

Event sample

A total of 89 professionals participated in consultation events held across England. Many of those who attended events in these cities travelled from outlying areas, meaning there was a reasonable mix at these events of those who worked inside and outside of larger metropolitan areas.

The following table illustrates the number of participants attending each of the six consultation events, and their role with relation to our purposive sampling frame.

Respondent role	London	Birmingham	York	Sheffield	Brighton	Liverpool	Total
NHS Sexual Health Commissioners	1	3	1	2	2	2	11
Local Authority Personnel	0	1	2	3	0	3	9
Primary Care Practitioners	1	3	1	1	2	2	10
GU Practitioners (Clinicians and Nurses)	2	4	4	2	3	6	21
A&E Practitioners	0	0	0	0	0	0	0
VCS Organisations (HIV health promotion and care)	4	3	7	3	5	8	30
Policy Makers	5	0	0	0	0	3	8
TOTAL attending each event	13	14	15	11	12	24	**89**

2.2   Online survey

Survey design

Some individuals wanting to participate in this consultation were unable to physically attend the events held regionally. In addition to this, we wanted respondents from across the country to be able to participate, rather than restricting inclusion only to those 6 areas selected for events. Relevant professionals in the sector were invited to complete an online anonymous survey hosted on the secure servers of www.demographix.com which was made available via the URL www.NICEconsultationMSM.org.uk.

The survey was entirely self-contained in that the entire text of the 8 recommendations were included, and participants were able to read this text prior to answering 5 closed ended questions on each recommendation. Depending on responses to these questions, respondents then received an open ended question asking them to expand. Although it was necessarily more condensed in content and format, web-based participants were asked many similar questions - about relevance, implementability and acceptability - to those attending the group events. Due to the structure of the online survey and its presentation of each recommendation in turn, it was not feasible to ask about overarching impressions at the outset of the survey (as we did at the consultation events). In order to simplify the questionnaire to keep its duration to 20 minutes, we asked overarching questions about barriers to implementation, and the professional groups that might find the guidance most difficult to implement, rather than asking these questions in relation to each recommendation.

In addition, all participants were also asked: their job role(s), the English region in which they worked; which groups might find the guidance most difficult to implement, the feasibility in terms of cost, and what barriers to implementation they felt there may be. The entire text of the online survey is provided in **Appendix D**.

Use of this method helped to overcome some of the limitations described with regard to the consultative workshop events. The inclusion of snowballing, and the broad national dissemination of the survey beyond those who had been purposively sampled meant that a much wider array of views could be captured. Given that the anonymous responses were given in a private, rather than a public forum, these might be subject to slightly less self-censorship than the other two methods used.

Statistical analysis software (SPSS 16.0) was used to organise and analyse the data for reporting. Valid survey data is used to provide the wider context to responses in chapters 3-11.

Survey sample

A total of 183 people completed the online survey and submitted their responses. A small proportion of these were excluded either because there was no indication that they worked in England, or that they were professionals doing work related to this consultation. This left us with 176 valid survey responses which form the basis of the quantitative analysis provided throughout chapters 4-11.

In the online survey all participants were asked *"Which of the following roles do you carry out"* *(tick as many as apply).* Given that respondents were allowed to complete more than one field, the total number of responses to this question was greater than the total number of respondents.

Professional roles of online participants

(N=175 missing 1)	*Correlation with roles outlined in 2.4.1*	%	N
NHS or Local authority commissioner	*Commissioners/LA personnel*	14	24
General practitioner	*Primary Care practitioners*	5	9
HIV specialist consultant	*GU clinicans*	15	26
Nurse		21	37
A&E clinician	*A&E*	0	0
Staff at an HIV or MSM charity	*VCS Organisations*	14	25
Health promoter		35	61
Volunteer at an HIV or MSM charity		3	5
Policy maker (local or national)	*Policy Makers*	7	12
Policy officer		3	5
Researcher	*Non-correlated*	6	11
Administration managerial duties		15	27
Non-HIV specialist consultant		5	9
Counsellor/psychiatrist		3	6
Other		23	40

37 individuals specified what other roles they had including:
- Public health x2
- Voluntary sector management and delivery x6
- Commissioning of services x3
- Sexual health clinicians and advisors x16
- Providers of social care x4
- Other related roles x5 (such as phlebotomist, psychologist and other service provision)

Respondents completing the online survey were asked in which Strategic Health Authority they worked. The table below illustrates their answers. Those working in London comprised just over one quarter of the online sample (26%), while those from the North West, South East Coast, and Yorkshire and the Humber also each comprised at least one tenth of the sample. Each of the remaining SHAs was represented to a varying degree.

Strategic Health Authority of work

(N= 176)	%	N
London	26	45
North West	12	21
South East Coast	11	19
Yorkshire and the Humber	10	18
West Midlands	9	16
East of England	8	14
North East	7	13
East Midlands	7	12
South West	6	11
South Central	4	7
National (across England as a whole)	1	2

In the online survey all participants were asked *In what type of setting would you say your work is mainly carried out?*

Almost three quarters of all respondents carried out work mainly in urban areas, while 1-in-twenty worked mainly in rural locations and 1-in-five worked in an even mix of the two.

2.3   Telephone interviews

Telephone interview design

As general practitioners were under-represented at the participative events and as these are a key stakeholder group for the guidance, we decided to conduct a small number of telephone interviews in order to gain the perspective of this group. We recruited through recommendations from event attendees as well as through lists of GPs on the databases we used for initial recruitment. A small number were approached by email and those consenting were called at a pre-arranged time. The interview was designed to elicit similar information to that collected at the workshop and through the survey. In particular, respondents' views on the relevance, usability and acceptability of the NICE draft guidance was elicited. The topic guide used in these interviews is made available in **Appendix E**. Interviewees were asked their views on which elements of the recommendations they felt could be feasibly implemented, which ones could not, and why. Five interviews lasting between 20 and 30 minutes were conducted. With the interviewees consent, all interviews were audio-recorded and these recordings were annotated by two researchers.

The telephone interview method made it possible to focus in on those practitioner groups that had been under-represented in the other fieldwork, and was therefore undertaken at the end of the data collection period. Although limited in its scope, and prescribed by selective invitations, this data does afford insights into some of the key issues raised by GPs that would not have otherwise been voiced.

Telephone interview sample

Interviews were booked with six individuals initially and after cancellations, five were completed. These consisted of a lead GUM Clinician in Yorkshire and The Humber SHA, 1 GP from North West SHA and 3 GPs from Yorkshire and Humber SHA.

3   Overarching Views

As described in the description of the research design, different methods allowed for differing complexities of question design. Given that the event attendees were expected to have a high degree of familiarity with the document in advance of the event (as a part of their commitment to the process), we were able to ask them about their immediate impressions of the draft guidance at the outset of the event. The incremental format of the online survey meant that no such opening question was feasible. Instead, online respondents were asked a number of questions about the recommendations as a whole toward the end of the survey, once individuals had considered each recommendation briefly in turn.

These broad findings emanating from two different fieldwork approaches are presented here, by means of introduction to and reinforcement of the detailed findings on each recommendation offered in the subsequent chapters.

3.1   Event participants' immediate impressions

At the outset of the 6 consultation events, participants were asked to express their immediate impressions of the draft guidance and its recommendations. The various topic areas raised during these parts of the workshop were often elaborated upon more fully as the event wore on, and for this reason they are written up in detail in each of the relevant chapters to follow (Chapters 4-11). Here we will simply summarise these themes, as it is useful to have an understanding of the issues that were at the forefront of participants' minds at the outset of the process:

Agreement with the aims

With some notable exceptions, the majority of participants at the events were clearly in support of the goal of increasing the proportion of MSM who access HIV testing through routinised and normalised points of access.

Formalising current best practice

To a large extent, participants felt that most recommendations in the draft guidance (perhaps with the exceptions of recommendations 5 and 6) provided a clear articulation of measures that should already be in place. This was an approach that was welcomed as affirming, and one that would help to ensure good quality provision across the country. At many events, those from non-metropolitan and rural areas felt that much of this document represented a state of affairs that may already exist to some extent in their nearest large city, and was a goal to which they aspired.

Participants from all backgrounds welcomed the clear inscription of partnership-working approaches across the entire document. While some felt that it may have gone further to ensure multi-directionality of referral and collaboration, participants broadly praised the benefits of voluntary and statutory sector collaboration, and were pleased to see it form such a key part of this guidance.

Strategic and practical changes ahead

Many were concerned that while most of the recommendations were straight-forward, and represented a formalising or an extension of the good work that was already underway, that it would be difficult to know how such an agenda for action would be maintained in light of forthcoming NHS and commissioning reform. It was often repeated that while the document and what it represented was quite straight-forward, there was currently little clarity about what any of the structures for provision and leadership might look like in the coming years. Therefore, there was an overarching concern that there was little clear means of visualising implementation and leadership with regard to the guidance as a whole in the current economic and political climate.

Economics

The matter of funding was raised in considerable detail when each of the recommendations was discussed. At the outset, a number of participants set out their concerns about economic implications. Firstly, there was a desire for a more clear articulation of the benefits of ensuring greater uptake of HIV testing among this population, both in the recommendation document itself, as well as concise documentation that would assist with the implementation of the recommendation (i.e. for distribution to commissioners). In addition to this, some wanted to know exactly what provision would be made for the increased immediate costs that such a course of action would require (including the costs of test kits themselves, increased laboratory costs, and the potential need to incentivise GPs to undertake opt-out testing).

The realities of primary care

Those attending the workshops felt that immediate implementation of HIV testing in primary care practices would be unlikely. In addition to the structural needs such as capacity, expertise and funding, there was a broader concern among participants that the current culture among GP surgery staff would make it very difficult to enforce the kind of change that the recommendations would require. In most workshop events, participants cast primary care settings as being largely oriented towards a reactive rather than a preventive mode, and that the implementation of the recommendations would require an extensive cultural shift within existing practices. It was also repeatedly pointed out that with the workload that is currently expected of primary care practitioners, addition of an entirely new and time consuming range of screens would have a prohibitive impact on their time and resources.

3.2 Online feedback on overarching barriers

Towards the end of the online survey all participants were asked *"What do you consider the main barriers to implementing these recommendations?"*

Almost all of the 156 online respondents who answered gave an immediate response that fell into one of two categories: a lack of funding, or lack of will. There was no other question asked in any of the fieldwork that offers such uniform findings.

Roughly half (N=70) of those responding to this question felt that the most significant impediment to the implementation of the recommendations would be financial. Most of those making this point were quite brief in their statements:

> "Cost - where is the money coming from?" (online respondent)

Others considered the overarching costs that the implementation of such a widespread programme would cost, in addition to the incentivisation that might be required in order to encourage GP participation.

> "Funding. Some of the recommendations will necessitate an increase in funding to providers that PCTs (whilst they still exist) simply don't have. It is also a HUGE challenge to get GPs to do anything about HIV - and they are unlikely to do." (online respondent)

The remaining half of online respondents (N=65) answering this question felt that commissioning and service delivery priorities lay elsewhere, and that this was too specialist an area to demand the kind of mainstream attention inferred within the guidance. These responses drew on a range of different indications and experiences of the sector. Some felt that

> "Lack of interest and commitment among some commissioners and providers. HIV / MSM are low priorities with most of the public." (online respondent)

Others felt that GPs and other primary care providers may find that the changes required were too demanding – in terms of resources as well as individual skill-sets and outlooks. Most of these responses revealed a very negative view of primary care provision for gay men.

> "In primary care - main barriers are likely to be time in the consultation - bringing the subject up - identifying those at risk - confidence in giving results especially if positive - identifying seroconversion - enquiring about sexual behaviour especially in groups with strong moral injunctions against same sex behaviour." (online respondent)

There were also those included within this category who regarded what they saw as a historic lack of collegiality and exchange between those delivering voluntary and statutory service provision as a major barrier to the type of widespread partnership work recommended in the guidance. These types of responses were in the minority, however, as the key factor that respondents ascribed to the difficulty of implementation was the low priority they felt that gay men's issues and HIV have received within the scope of current NHS commissioning and service delivery.

3.3 Online feedback on challenges across professions

In the online survey all participants were asked *to rank "Which five professional groups do you think will find these recommendations hardest to implement?"*
The list of groups given were generated from all those named in the draft guidance as actors.

General practitioners were ranked as most likely to find the recommendations hardest to implement with scores suggesting that a majority of people ranked them in the top five and ranked them very highly when they did so. This group was by far the most likely to be included in respondents' top ranking. Ranking below GPs, but still being mentioned by many respondents were: clinical staff in A&E; clinical staff in walk-in centres, health centres and community clinics; primary care practice managers, and commercial venue managers and staff.

The groups identified least frequently in this ranking exercise included: clinical staff in specialist sexual health services, public health specialists, and health promoters – indicating that respondents felt that these groups would have the least difficulty in implementing the guidance.

3.4   Online feedback on overarching costs and benefits

Towards the end of the online survey all participants were asked the overarching question: *Do you think the costs associated with these recommendations are worthwhile in relation to the potential service improvement?*

A majority (72%, n=118) of all respondents agreed they were; and just a small proportion (3%, n=4) said they did not. The remaining quarter (25%, n=41) were not sure whether the costs associated with these recommendations are worthwhile in relation to potential service improvement.

Do you think the costs associated with these recommendations are worthwhile in relation to the potential service improvement?

72%

■ Yes

■ No

■ Not Sure

25%
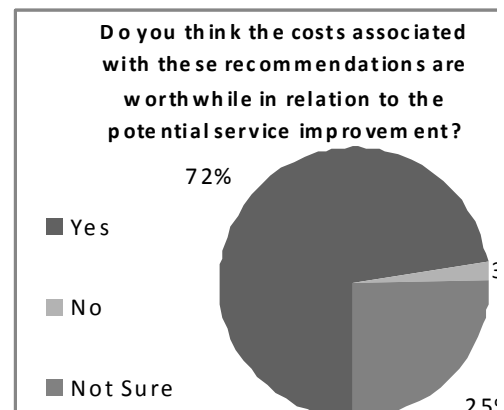
4   Recommendation 1: planning services

Most of those participating in the consultation welcomed the way in which this recommendation formalises a model of best practice in integrated service planning. The need for clearer leadership in this respect was noted as was the inclusion of input from front-line workers and people with HIV.

4.1   Considering the recommendation in light of current practice

In the online survey all participants were asked *Does recommendation 1: planning services, describe new ways of working or new activities in relation to the organisation you work for?*

Two-fifths of all online respondents agreed that recommendation 1 described new ways of working or new activities in relation to the organisation they worked for; and a 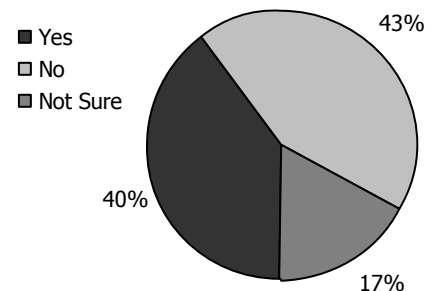similar proportion said it did not. One-in-six of all online respondents were not sure whether recommendation 1 described new ways of working or not.

Does Recommendation 1 describe new ways of working?

■ Yes
□ No
■ Not Sure

43%

17%

40%

In the consultation events, most participants felt that the approach of recommendation 1 was grounded in good public health planning, so that ideologically it was not new. However, even where participants did not feel that the recommendation was innovative, most appreciated its comprehensiveness. Some commented that it was a welcome change to have local planning and coordination processes formalised, given that in many locations existing processes are contingent upon particular personalities, or historical relationships.

> "It will pin down stuff that has always been done on good will amongst professionals in the past." (event participant)

Several event participants pointed out that recommendation 1 establishes best practice, given that clearly articulated planning processes in this area are patchy at best. Sometimes such processes are virtual or informal, and in areas with less gay community infrastructure there is little awareness of the need for evidence-based, joined up working premised upon a partnership approach. There was some discussion about the extent to which a local HIV testing strategy would be expected to be 'stand-alone' (which represents a fairly novel approach), or whether this recommendation made it possible for such a strategy to be integrated into pre-existing local sexual health strategies (an approach considered to be more of the norm at present). However, it was also pointed out that sexual health strategies are not at the top of the agenda in many areas, and that it would be naive to make this assumption.

Participants attending several events mentioned that identifying venue-owners, landlords and land-owners of locations where sex between men takes place as stakeholders in the establishment of local HIV testing policy planning was novel (their views on this are noted in

greater detail below). Some participants felt that the stipulation to undertake local needs assessment (beyond the *Gay Men's Sex Survey*) was new, and that this helped to address an ongoing concern about gaps in local data.

4.2   Content and language

In the online survey all participants were asked *Is recommendation 1: planning services, clear and easy to understand?*

The vast majority of all online respondents agreed that recommendation 1 was clear and easy to understand. Less than one-in-ten, felt it was not clear or were not sure whether recommendation 1 was clear and easy to understand.

Is Recommendation 1 clear and easy to understand?

93%

- ■ Yes
- ☐ No
- ■ Not Sure

2%   5%
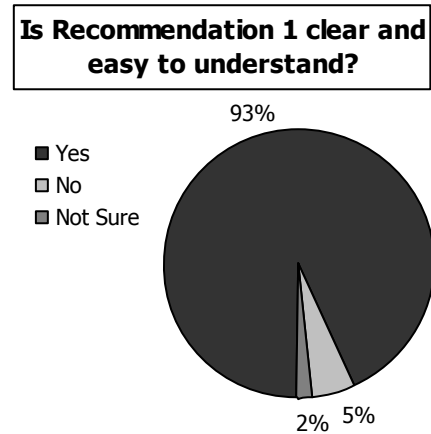
During the consultation events, there were very few concerns regarding the clarity of recommendation 1. Most participants appreciated its comprehensiveness, although there was some concern about how this idealised view of planning joins up with a real world that is in a state of heightened flux given pending changes in NHS planning and commissioning structures. Thus it was pointed out that while this was an easy recommendation to understand, the lack of clarity would come in its implementation.

Where any comments were made about lack of clarity – these tended to relate to a desire to see a more clearly delineated leadership over the planning process. Without this, members of one discussion group felt that this recommendation ran the risk of being too "woolly and non-directive" (event participant).

One minor correction to the language was suggested. Given that Sigma Research's *Gay Men's Sex Survey* has recently become biennial, it was suggested that the word 'annual' be changed to 'periodic' when describing that dataset.

4.3   Roles and responsibilities

There were four overarching themes in relation to actors that arose across a number of events, each of which will be described here in some detail.

More inclusive range of actors required

Participants at a number of different events felt that those directly involved in the strategy, such as frontline service providers, practice based commissioners, service users and people with diagnosed HIV should also be named as key agents in the planning process, rather than only being those who are 'acted upon'.

Inclusion of incarcerated and cared-for populations

A range of participants at three of the six events were surprised and concerned that there was no mention of the key role to be played by detention and care institutions (such as prisons

and young offenders institutions as well as care homes and mental health facilities) in contributing towards testing strategies for incarcerated and cared-for populations. These participants felt that incarcerated MSM should be explicitly mentioned in the opening section on 'whose health will benefit', alongside other groups with elevated need (such as young MSM, and migrant MSM). Inclusion of the incarcerated population of MSM would naturally mean that prison governors and officers should be included in the list of stakeholder consultees identified under 'What action should they take?'

Scope of stakeholder institutions

The inclusion of the National Trust and the Forestry Commission in the list of those to be consulted as stakeholders in the development of HIV testing strategies also elicited some attention from participants. Some who work in community-based services welcomed the recognition of Public Sex Environments (PSEs) within a formal NICE document, and felt that this was a radical step forward. Others wondered exactly what role a representative from the Forestry Commission might play in an HIV testing strategy, though it might be more appropriate for them to be included in community safety and well-being strategies. As such, their inclusion here did evoke a certain amount of bemusement. Some raised a similar point about what might motivate involvement from commercial or website owners – whose principal interests are commercial rather than public health. What was more generally welcomed, however, was the inclusion of the police in this list, given that they are frequently involved as liaisons with regard to the use of PSEs, and that police forces on the whole may have a role to play in making HIV testing referrals in community settings. Participants at one event felt that educational institutions should also be added to this list, given their potential influence over health and well being of young MSM.

Leadership

Finally, there is the implied matter of leadership in the identification of actors. This is a theme that arose in discussions about most of the recommendations. When asked if the list of identified actors was complete, and if the roles ascribed to them were appropriate, most participants were in broad agreement. However, there was an overriding concern that with the pending changes to public spending, scrutiny and oversight – particularly in the area of public health commissioning – it was difficult for many participants to know exactly how these recommendations might map onto future planning structures, given that these have not yet been articulated by the coalition Government. Given the range of anticipated changes, and the certainty of budget reductions, there was considerable concern expressed about the practicability of knowing who might actually drive forward HIV testing planning processes in each locality. Some participants pointed out their appreciation of the fact that the flexible definition of actors was open enough to include whomever it might be that has a 'remit for sexual health', as this is not explicitly tied to the current structures that are about to change. However, for some others, this left the recommendation frustratingly open to interpretation, therefore leaving open the possibility that in some areas, no one would take leadership on the issue. There was some concern expressed by one discussion group that the actors listed in this recommendation were too 'high level' and that it was difficult to see how they interacted with the array of stakeholders listed in the 'What action should they take?' section.
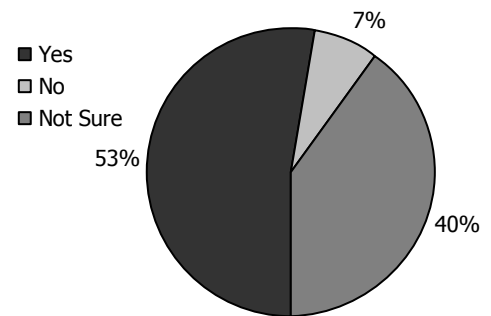
4.4   Feasibility

In the online survey all participants were asked *Is recommendation 1: planning services, locally implementable?*

More than half of all online respondents agreed that recommendation 1 was locally implementable. Less than one-in-ten, felt it was not with the remainder being not sure.

Is Recommendation 1 locally implementable?

■ Yes
□ No
■ Not Sure

7%
40%
53%

During the consultation events, a number of participants felt that recommendation 1 might be considered to be rather aspirational, and that this was likely to be a strength, rather than a weakness. However, there were many others who felt that it was the implementation of this recommendation that would be the greatest challenge. Those who took this view felt that while there was little on paper that was contentious in this recommendation, they did not feel it would be easy to know who would do it, and under what remit. Such participants felt that in order to get real traction, this recommendation needed to be more explicit about the likely structures to which it can be attached. Many also concluded that within a constrained budget environment, it would be difficult to establish this issue as enough of a priority to fund the various stages of consultation and data collection that this recommendation requires.

There was recognition among a number of consultation event participants that the implementation of recommendation 1 is very closely tied to recommendation 8, and that each of them would benefit from explicitly drawing this to readers' attention.

4.5   Impact

In the online survey all participants were asked *If recommendation 1: planning services, would help to improve local HIV testing services?*

Would Recommendation 1 help to improve local HIV testing services?

■ Yes
□ No
■ Not Sure

75%
5%
20%

Three quarters of online respondents agreed that recommendation 1 would help improve local HIV testing services and only one-in-twenty felt it would not. A fifth were not sure.

Similarly, the majority of event participants were broadly supportive of recommendation 1. Many felt that it had the potential to build capacity and improve local practice by formalising and strengthening the collection of local evidence and mapping activity. Making strategy formation explicit would challenge the frequent assumption that such plans are already in place, in all localities.

Participants at two different events felt that needs assessment would have to go further, in order to assess why people at risk do not test for HIV and that this recommendation should push the needs assessment mandate even further to include measures of these more difficult

questions. It was also suggested that HIV testing intervention outcome evaluations should be clearly included as one component of local data collection.

A range of participants at various events carefully considered how to gain the best value-for-money. Suggestions included: a well-resourced national HIV testing campaign targeting MSM to reinforce local strategies; development of templates for HIV testing strategies in high and low incidence areas to support commissioning; ensure that planning links up with community safety and other strategies already in place; and consider planning at regional rather than commissioning-level boundaries, in order to include less metropolitan areas.

4.6   Barriers and challenges

The greatest challenge for this recommendation and its implementation articulated across a wide range of events was the current environment of cutbacks and strategic restructuring. Many participants found it hard to envisage how this strategy for a small part of the local population would survive the extensive changes in public health planning and spending that have been proposed, but not yet clarified.

Given this challenge, participants felt that establishing ownership of local strategy development through a powerful local champion might be the only way to ensure its success. However, the paradox remains that it is impossible to identify in the NICE guidance who the champions might be, when there is no clarity about what public health structures will look like.

Finally, participants at one event focussed extensively on the challenge of under-representation within this recommendation. They felt that needs assessments of any kind will always run the risk of under-sampling those who live in rural areas, or who do not identify as MSM, and also that the establishment of MSM user forums for strategic consultation are unlikely to be representative of the local population. It was also pointed out that political, philosophical and practical differences between various voluntary and statutory organisations would mean that they might have competing and opposing viewpoints on the best way forward, presenting a challenge for partnership-working.

5 Recommendation 2 results: Integrated Care Pathways

Overall, the recommendation on integrated care pathways was broadly supported as formalising and documenting processes that would lead to improvements in service delivery.

Care pathways from GUM to the voluntary sector were seen to be less evolved as were those to and from the voluntary sector and primary care settings. In addition, concerns were raised about the feasibility of GP services being integrated into care pathways at present. Care pathways for men who test negative (for example into community health interventions or psychological services) were seen to be largely absent. The need to develop these pathways was stressed by many event participants.

Gay supportive psychology and counselling services were seen as vital to work with groups of men at risk. However, many reported these services to be insufficient in all areas and largely absent in rural areas.

5.1 Considering the recommendation in light of current practice

In the online survey all participants were asked *Does recommendation 2*: *integrated care pathways, describe new ways of working or new activities in relation to the organisation you work for?*

Almost one third of all online survey respondents agreed that recommendation 2 described new ways of working or new activities in relation to the organisation they worked for; however a majority said it did not. One-in-eight of all respondents were not sure whether recommendation 2 described new ways of working or not.

Does Recommendation 2 describe new ways of working?

- ■ Yes
- □ No
- ■ Not Sure

57%
30%
13%
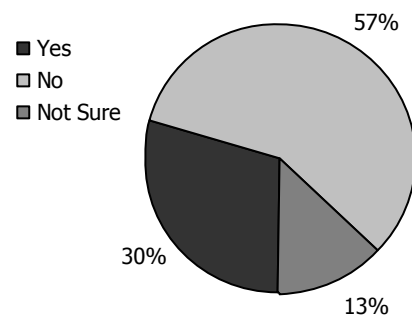
Similar to recommendation 1, discussion of recommendation 2 at the consultation events concluded that its novelty lay in the fact that it would formalise informal arrangements that were often already in place. This was broadly welcomed as a positive move forward, as all participants felt that increasing the integration of a range of care pathways would improve outcomes for service users.

> "For people that I see, all these things [listed in recommendation 2] happen, but I don't necessarily know about other people who are testing elsewhere." (event participant)

There were a number of participants across different events who commented that at present, referrals most commonly go in one direction, from the voluntary sector to clinics, and that it is not often the case that clinics refer patients to seek voluntary sector services (although various examples of this do exist, for example where voluntary agencies have staff available on-site during certain clinic days, this is not regarded as the norm). Participants at one event hoped that implementation of this

recommendation would mean that information given to clinic patients about voluntary sector agencies would be universally distributed, rather than only being given to those in most apparent need.

According to some participants, the greatest change they noted within this recommendation is the intensive involvement of primary care GPs within the testing process. Although there is extensive discussion about the challenges of this vision below, many welcomed that inclusion of primary care practitioners in care pathways.

Participants at most events welcomed the new focus in this recommendation on the experiences of those who test HIV negative:

> "In terms of innovation, I don't quite remember seeing so much about behavioural intervention for people who test negative. That's often the bit that gets missed." (event participant)

There is more discussion of this particular topic in further sections below.

5.2   Content and language

In the online survey all participants were asked *Is recommendation 2: integrated care pathways, clear and easy to understand?*

The vast majority of all online respondents agreed that recommendation 2 was clear and easy to understand. The very small remainder felt it was not clear or were not sure whether recommendation 2 was clear and easy to understand.

Is Recommendation 2 clear and easy to understand?

98%

- Yes
- No
- Not Sure

1%   1%

Participants at two of the consultation events sought more clarity on the definition and governance of 'gay-affirmative psychological and counselling services'. It was suggested that there could be some description the various types of therapeutic interventions that are available (with a focus on their different ranges of intensity, commitment and approach). Others wanted to know whose responsibility it might be within this recommendation to ensure that these types of services will remain available across changes to delivery.

It was mentioned that this recommendation could to more to list examples of points of access, in order to broaden readers' understanding of the breadth of points into the integrated care pathway.

There was some uncertainty expressed among event participants about the language used for the promotion of repeat testing among those who test negative. It was raised at more than one event that there can be no single intervention that will increase repeat testing, and that relevant interventions will have to be tailored for an individual. In some cases, service users should repeat after the window period in relation to a particular event, however there was concern that the only support for excessive repeat testers who go on to take risks is to suggest more testing. Interventions for those who test negative require attention to individual requirements in terms of recommended repeat testing intervals, as well as other risk-reduction interventions. Essentially it was emphasised that regardless of the result of a test, the care pathway for those who test negative and those who test positive needs to be of a high quality, and requires absolute consistency.
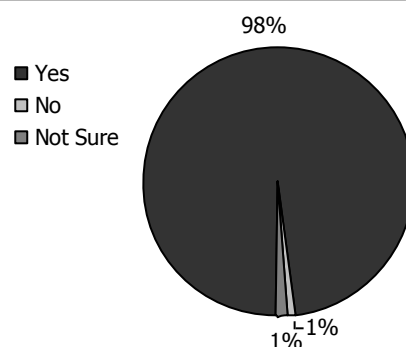
5.3   Roles and responsibilities

Participants at various events voiced concern that in the 'Who should take action' section, only clinical service providers and commissioners were leading the planning of integrated care pathways, to the exclusion of voluntary sector managers. These participants felt it was necessary to ensure multi-agency involvement when writing the pathways (and that this process should be led by commissioners) in order to ensure that there is a balance of power and input across stakeholder organisations.

There was some concern expressed about the fact that to some extent, the tone of this recommendation continues to silo voluntary sector agencies as providers of support, while clinics 'undertake tests' when this delineation is increasingly challenged by service delivery models.

A short discussion in one consultation event captured a degree of confusion about whether this recommendation actually involves primary care practitioners to any significant extent. Although they are listed in the range of actors, it was felt that the ensuing actions implied improved pathways between clinics / community test points / and voluntary sector service providers. One participant surmised that the system was most likely to work if GPs simply refer into clinic, and then the full integration works from that point onward (however, this is likely only to work for those with an HIV positive test result).

5.4   Feasibility

In the online survey all participants were asked *Is recommendation 2: integrated care pathways, locally implementable?*

Almost three quarters of all online respondents agreed that recommendation 2 was locally implementable. Less than one-in-ten, felt it was not with one-in-five being not sure.

Is Recommendation 2 locally implementable?

■ Yes
□ No
■ Not Sure

73%
6%
21%

Participants from a GU clinical background at one event felt that such a referral protocol would only be possible with support from commissioners, as they believed that it can be very difficult for those working in clinical settings to influence how services are configured.

At several events, there were concerns raised about the feasibility of including unwitting primary care services into these types of referral pathways, when up until now, the vast majority of GPs tend to exclude themselves from sexual health work. Such participants felt that it was unlikely that they would immediately be embedded into a working network model as envisaged here. Participants at a separate event suggested that some of these issues may be remedied by entrusting the bulk of commissioning related to this recommendation with those who commission primary care.
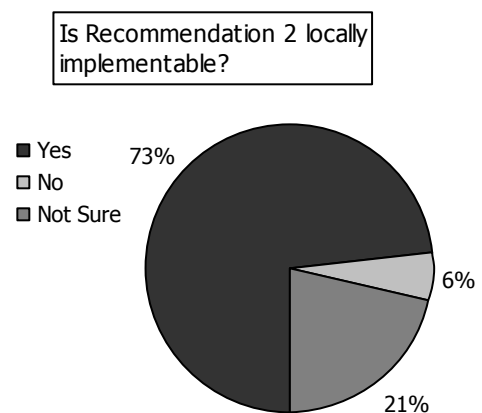
It was pointed out that the resource implications of devising clear care pathways are relatively low, which is a benefit of this recommendation, making it quite feasible and desirable. As one participant from the voluntary sector commented:

> "What I like about this guidance is that it brings us more into the fold more clearly. We could probably get more out of each other with a bit of a more robust link." (event participant)

It is essential however, that resources are provided to sustain services under increased demand. Participants across a range of events felt that in many settings, psychological support services were not currently available – so creating the pathway would require provision of what, in some instances, would be a totally new service with intensive resource implications.

5.5   Impact

In the online survey all participants were asked *Do you think recommendation 2: integrated care pathways, would help to improve local HIV testing services?*

A majority of all online respondents agreed that recommendation 2 would help improve local HIV testing services and only one-in-twelve felt it would not. One-in-ten were not sure.

Would Recommendation 2 help to improve local HIV testing services?

- ■ Yes
- □ No
- ■ Not Sure

81%

8%

11%

Participants across a range of consultation events focussed on the extent to which such pathways needed to appropriately meet the needs of those who test HIV negative. They felt that increasing the number of people driven toward testing will require a more nuanced range of responses available for those who repeatedly test negative, for instance, as well as a need to balance the resources spent on attending to keeping diagnosed individuals in contact with services. As one clinician noted, there is a distinct tension between driving up the numbers of people using a testing site, and the quality of service provision for each individual. They said that by delivering negative test results by SMS text:

> "We're not wasting a lot of time getting people back to sit in a waiting room...[and]... the number of tests have increased markedly." (event participant)

They went on to point out that while this avoids a further opportunity for health promotion intervention, it wasn't possible to achieve optimal individual and population outcomes at the same time.

Participants at two further consultation events questioned how this recommendation might better provide for service users who repeatedly engage in sexual risk, and test HIV negative repeatedly – thus creating a sense of invulnerability to harm. They felt that this recommendation needed to go further to identify where responsibility for addressing this type of need (which involves intensive follow up and referral pathways – possibly from clinic to voluntary sector agencies) resides. Some mentioned that there are other existing harm reduction protocols from other fields (i.e. suicide attempts) which may be adapted for use in these contexts. There was a general sense across most events that while participants felt that integrated care pathways for people diagnosed positive were
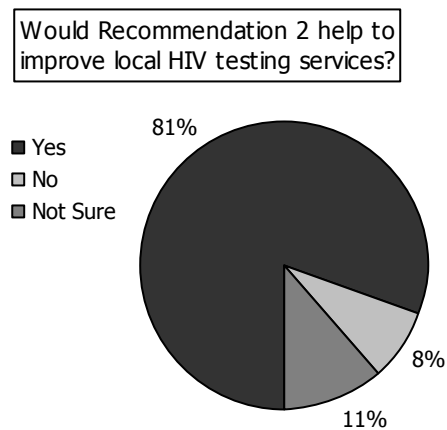
relatively strong (particularly outside of London), this recommendation challenged them to create similarly strong pathways for those who receive a negative test result.

One participant pointed out that referral pathways will differ depending on the specific point of entry. They gave the example that referral routes for someone who attends a simple screening intervention will be very different to an intervention that involves a sexual health discussion where a full history is taken. Participants at a range of events who are familiar with community POCT testing pointed out that referral protocols have necessarily (and beneficially) been improved with these interventions, because of their often very detached nature. They emphasised that ensuring that the experience is as supportive as possible for the individual will require true clarity regarding governance, and referrals.

One group discussed their discomfort with the recommendation's suggestion that clinical access for those who test positive could require as much as 2 weeks, and they were all much more comfortable with a 48 hour target, and believed this to be feasible. One participant felt that this target should be monitored while another went further to say that it should be matched by a goal to also ensure access to psychological support within 48 hours for anyone with a positive test result.

Participants at several events commented that having a standardised referral protocol is likely to cut down on duplication, which would be welcome. It was also pointed out that the only way to understand the impact of this recommendation will be to ensure that uptake and effectiveness are appropriately monitored.

5.6   Barriers and challenges

Participants at a few events discussed how stigma and a range of cultural or other sub-group taboos are likely to continue to keep many MSM from talking to clinicians or GPs about their sexuality, or attending for HIV testing in a GU setting. Other event participants were concerned that many primary care or non-specialist health care providers simply are not open to the possibility that some service users may be MSM. It isn't possible for care pathway protocols to challenge these kinds of embedded issues and fears. One example given of the real difficulties these issues can pose, is the situation where a person tests HIV positive in a primary care setting, but it may be difficult for a GP to know how best to make onward referrals if full disclosure of sexuality has not been made.

Some participants felt that despite protocols, clinics and agencies alike will continue to struggle with those who do not attend appointments, and those who may have the will to attend, but are too afraid. There was some discussion of the value of befrienders or chaperones who might help those in greatest need to ensure that they are able to attend.

Similarly, it was pointed out by participants at one event that recommendation 2 tends to expect significant behavioural results from health promotion interventions in clinical settings. They warned that there are limitations to what we can expect to achieve with regard to behavioural interventions. It was agreed, however that increased collaborative working would only help to support that behaviour change in a positive direction.

Attendees at one event raised concern about how this recommendation is situated within the broader context of foregoing guidelines. It was noted that the move away from sexual history taking as exemplified within the BHIVA HIV testing guidelines was actually a backward step – and not harmonious with a fully supportive and integrated service as proposed within this recommendation

(but see discussion on recommendation 7). It was also pointed out that BASSH guidance on HIV testing proposed that homosexually active men should primarily be accessing level 3 services for HIV testing (i.e. HIV clinic / GU settings).

6 Recommendation 3: Promoting HIV testing and reducing barriers

Overall this recommendation was strongly welcomed as supporting a better resourced and more focused approach to the promotion of HIV testing. However, in general the recommendation was seem to risk being too restrictive in describing the range of venues for and approaches to the promotion of HIV testing as well as target groups. Thus many felt that the recommendation should either not specify venues, approaches or target groups or should specify a larger range of these.

The potential role of government and national organisations in both promoting HIV testing to MSM and in reducing the barriers to accessing tests in a range of settings was also stressed. Many felt that the guidance should refer to and support such national interventions.

6.1 Considering the recommendation in light of current practice

In the online survey all participants were asked *Does recommendation 3: promoting HIV testing and reducing barriers, describe new ways of working or new activities in relation to the organisation you work for?*

One third of all survey respondents agreed that recommendation 3 described new ways of working or new activities in relation to the organisation they worked for; Just over half said it did not. One-in-eight of all respondents were not sure whether recommendation 3 described new ways of working or not.

Does Recommendation 3 describe new ways of working?

■ Yes
□ No
■ Not Sure

54%

33%

13%
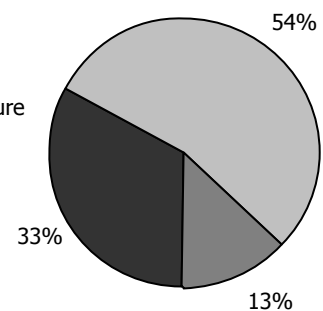
Amongst health promotion workers at consultation events, the idea and practice of promoting the beneficial qualities of testing to MSM was not considered novel. Many said that they had been doing this in one way or another for some time. However, the clarity of the guidance in clearly stating this recommendation was considered new, with some comparing it to other national guidance

> "In terms of promoting testing it is new as Making it Count 3 wasn't particularly pro-testing". (event participant)

Other novel aspects of the guidance among event participants concerned the involvement of scene proprietors and primary care practitioners as active stakeholders in promoting HIV testing. Whereas all supported and saw the logic of this aspect, most commented on how difficult this would be (see implementation below). Participants in three groups saw it is a recommendation to do specific work on HIV testing (rather than integrating HIV testing into their work generally). Although participants at these events have already been promoting HIV testing, this recommendation alerted them to the possibility and desirability to carry out more focussed work on issues such managing disclosure to

partners, friends and family, the financial and insurance implications of testing HIV positive and the ways in which a test may be used as an opportunity to reflect on risk and modify behaviour.

6.2   Content and language

In the online survey all participants were asked *Is recommendation 3: promoting HIV testing and reducing barriers, clear and easy to understand?*

The vast majority of all online respondents agreed that recommendation 3 was clear and easy to understand. A tiny minority either felt it was not clear or were not sure whether recommendation 3 was clear and easy to understand.

Is Recommendation 3 clear and easy to understand?

97%

■ Yes
□ No
■ Not Sure

2% 1%

 Overall, the recommendation was judged to be clear and easy to understand by participants at consultation events. However, later discussion around the recommendation showed some confusion regarding the details of the recommendation. The main way in which this emerged was that reference in the recommendation to leaflets, booklets, posters and other health promotion materials led to the impression that printed materials or advertisements were the only methods endorsed by the guidance for promoting HIV testing. Many were therefore critical of what they perceived to be an absence of reference to the wider range of health promotion approaches used (such as face to face, psychological or structural approaches).

> "As a whole we felt the recommendation was quite confusing as health promotion within MSM encompasses a wide range of different things." (event participant)

The language of the recommendation was therefore perceived to jump between the particular and the general in terms of specifying goals (general) but also specifying, or naming methods (particular)

6.3   Roles and responsibilities

Although all groups agreed that the list of actors specified should all be involved, participants in two groups mentioned the role of national organisations or government in promoting testing. Moreover as the guidance itself was seen as an intervention to promote testing by a national agency, many felt that their local promotion should be underpinned by a number of national campaigns and infrastructural interventions. Examples of these included national testing advertising campaigns for all men and MSM in particular, campaigns to promote HIV testing in primary care and community settings and training/capacity building interventions with primary care practitioners.

From their own past experience, participants identified venue owners and primary care practitioners as the hardest to engage with in relation to the promotion of HIV testing. This was mainly because venue owners were businesses interested in making profit and had little sense of ownership over the health of their clients. Moreover, primary care practitioners were seen as being reluctant to engage with patients around sexual health or the promotion of sexual health interventions (see recommendation 5). However, those participants from the voluntary and community sector expressed an ongoing willingness and interest to engage with these two groups.
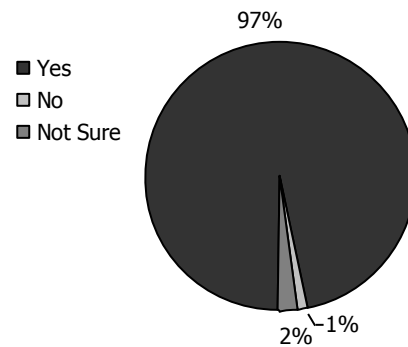
6.4   Feasibility

In the online survey all participants were asked *Is recommendation 3: promoting HIV testing and reducing barriers, locally implementable?*

More than half of all online respondents agreed that recommendation 3 was locally implementable. Less than one-in-ten, felt it was not, with almost a third not sure.

Is Recommendation 3 locally implementable?

- Yes
- No
- Not Sure

62%

6%

32%

When participants at consultation events were asked to discuss local implementation, two concerns arose. The first was universal and concerned the resources needed if they were to develop specific campaigns around HIV testing. However, a broader concern was shared by those in rural areas: the availability of convenient and appropriate HIV testing. In one area fast tests were not available so a worker described how he referred clients to clinics outside of his area. Related to this was a reluctance to promote HIV testing in primary care settings unless all local GPs had the capacity to deliver the test in an appropriate way (see recommendation 5).

> "Instead of doing an HIV testing campaign to the public we need to do one to the health care professionals first." (event participant)

In summary therefore, some participants felt that there were substantial capacity and competency interventions required with local GUM and GP services before they could wholeheartedly promote HIV testing.

The second concern centred on the participation of stakeholders mentioned in the guidance; specifically general practitioners, community venue owners and the police. We discuss difficulties associated with increasing participation of primary care practitioners elsewhere. However, involvement of venue proprietors locally was also seen to raise problems. Participants from the voluntary and community sector reported that many proprietors did not want it to be known that sex occurred on their premises so were loath to allow any sexual health promotion on site. The specific referral in the guidance to venues where sex occurs was seen by some to exacerbate this difficulty when promoting HIV testing. The police were also identified as another problematic group inasmuch as they did not see themselves as having a health promotion role. Participants often cited the police as obstacles to health promotion both in public sex environments and public sex venues.

> "Proprietors are difficult because many of them do not want it to be known that sex goes on in the venue. The police will be difficult too because their attitude towards venues (PSVs) are pretty poor – they're very keen on prosecution." (event participant)
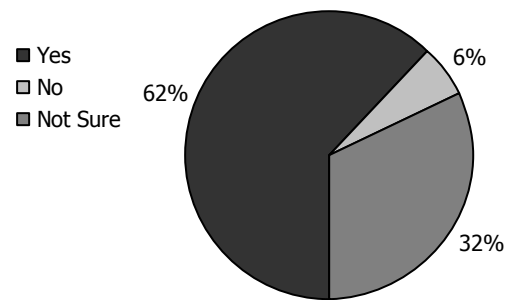
6.5   Impact

In the online survey all participants were asked *If recommendation 3: promoting HIV testing and*

Would Recommendation 3 help to improve local HIV testing services?

- Yes
- No
- Not Sure

75%

9%

16%

reducing barriers, would help to improve local HIV testing services?

Three quarters of online survey respondents agreed that recommendation 3 would help improve local HIV testing services and approximately one-in-ten felt it would not. A sixth were not sure.

When the consultation event participants discussed general implications and outcomes of implementing this recommendation, their discussion fell into the following three themes.

Different Groups of MSM and different venues

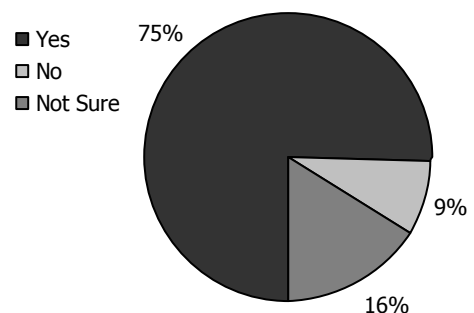The first concerned promoting testing to a range of different men (for example men from different ethnic minorities and different age groups or men who are selling sex). The diversity of the population of MSM means that testing would need to be promoted in a range of settings (including non-commercial gay scene settings such as barbershops or community settings, schools and FE settings etc) using a range of approaches and media.

> "Men who are out on the scene are so much more aware of the risks than those who are not out on the scene. These are the difficult people to reach." (event participant)

Moreover, the motivations of men to test would vary depending on their circumstances. Some men may test when they enter a relationship, younger men may test because they are more sexually active, other men may test in order to engage in unprotected sex with partners of the same serostatus (sero-strategies). Many felt that the guidance could also attend to these more individual motivations to test too.

A range of approaches

Participants at most consultation events were at pains to point out that a range of approaches would need to be employed to promote testing to the diverse population of MSM. The most commonly mentioned distinction here was the difference between promoting the HIV test and removing the obstacles to testing. The former was seen to be relatively straightforward. However, the latter was seen to involve removing structural and social obstacles (for example countering the stigma associated with homosexuality and HIV on a general population level) as well as engaging with psychological issues that some men may have around preserving their health and well-being.

> "…the guidance focuses on leaflets and social marketing without thinking of the psychological reasons why a man won't attend to his health or won't test. It's not holistic health promotion." (event participant)

It was therefore seen as very important that this recommendation mentions the social, structural and psychological barriers to testing as well as specifying a range of health promotion approaches to meet this aim. Many therefore were critical of that they saw to be an over-emphasis on printed media and advertising.

> "We could do it, but will it matter? Its hard to quantify what small and mass media actually does but what it does do is create a residual effect really." (event participant)

Finally, related to the opinion that there should be more involvement of national agents, some participants felt that an integrated national multi-approach programme to promote HIV testing should be recommended

'Essentialising' the HIV test

The final concern came mostly from participants from a GUM background. Although they entirely supported promoting HIV testing, in common with other recommendations (see recommendation 6), they were concerned that promoting HIV testing without the context of sexual health screening more generally could lead to other STIs going undiagnosed.

> "Ideally we want men to test for HIV in the context of a sexual health check. There's a risk to isolating HIV testing and making men think that once they've done an HIV test that's OK whereas they need to also test for other things. We find people with untreated syphilis, LGV and Hepatitis amongst men who have already been tested for HIV." (event participant)

They were therefore eager to explore ways in which the guidance could recommend the promotion of HIV testing within the context of broader sexual health, sexual health screens and perhaps health screens generally.

7 Recommendation 4: Universal HIV testing in sexual health services

Overall, there was consensus that universal opt-out testing to all men accessing sexual health services would normalise and de-stigmatise the test and would therefore lead to an increase in the uptake of HIV testing. However, a sizeable minority of participants raised concerns that universal testing would draw attention and resources away from targeting those at highest risk and pre-and post-test risk reduction interventions. There was therefore some disagreement that universal testing is the best use of resources or that it is cost-effective.

Although the recommendation was clear and easy to understand, this fieldwork identified a need for the guidance to provide a clear definition of what constitutes a sexual health service (such as primary care settings, community settings, educational and custodial settings etc) as well as the specification of clear protocols for offering opt-out testing in the range of settings where sexual health services occur.

7.1 Considering the recommendation in light of current practice

In the online survey all participants were asked *Does recommendation 4: Universal HIV testing in sexual health services, describe new ways of working or new activities in relation to the organisation you work for?*

Under a third of all online survey respondents agreed that recommendation 4 described new ways of working or new activities in relation to the organisation they worked for; twice as many said it did not. One-in-eleven of all respondents were not sure whether recommendation 4 described new ways of working or not.

Does Recommendation 4 describe new ways of working?

- Yes
- No
- Not Sure

61%

30%

9%

Most participants at consultation events were unanimous in their view that some form of offering universal HIV testing in GUM settings was already in place – and that is for all patients, rather than only men. However, to the extent that the recommendation might be interpreted to include an array of other sexual health services (see more discussion on this in the subsequent section) – participants regarded the notion of screening all male attendees (regardless of sexual history or sexuality) as a very new proposal, and one that was broadly welcomed in principle.
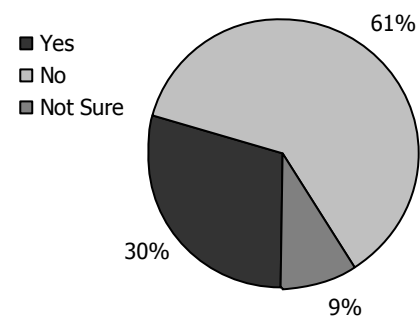
7.2   Content and language

In the online survey all participants were asked *Is recommendation 4: Universal HIV testing in sexual health services, clear and easy to understand?*

Almost all online respondents agreed that recommendation 4 was clear and easy to understand. Less than one-in-fifty, felt it was not clear or were not sure whether recommendation 4 was clear and easy to understand.

Is Recommendation 4 clear and easy to understand?

98%

- ■ Yes
- □ No
- ■ Not Sure

1%—1%
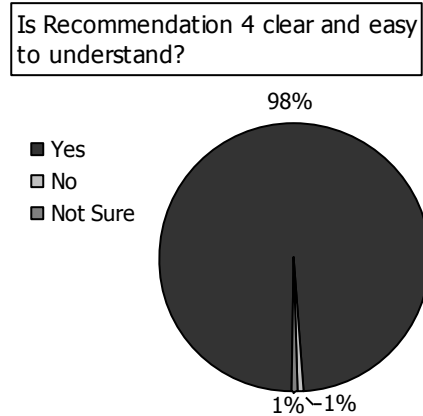
The online findings with regard to the clarity of this recommendation contrast with the discussions that arise at the 6 local events. At every one of those, participants felt that this recommendation required a clear definition of what constitutes a 'sexual health service'. The majority of participants felt that without such a definition, it is difficult to truly understand where recommendation 4 might be expected to apply. Some felt that it might be useful for this recommendation to use the language of level 1, 2 and 3 services, as outlined in other guidance in this area. There were some who assumed that it must only mean GUM services in hospital, while others thought that it could extend as far as community based contraception clinics, or sexual health outreach clinics that are based in further education colleges, and which are essentially tasked with distributing condoms. Many participants also discussed whether or not this recommendation would apply to primary care GP practices who also run sexual health specialist services. Participants at one event pointed out that sexual health services are provided in prisons, in mental health units, and in substance abuse services, but that this recommendation did not specify whether it included such settings. There is nothing in the draft text of recommendation 4 that helps to resolve any of these queries.

7.3   Roles and responsibilities

It was suggested at a number of events that commissioners will be essential in order to ensure that there are enough resources to offer universal testing in this setting, to fund the increased laboratory fees, and to provide training to scale it up. In particular, it was recommended that commissioners' service specifications will need to detail the content of universal testing and the training implications.

## 7.4   Feasibility

In the online survey all participants were asked *Is recommendation 4: universal HIV testing in sexual health services, locally implementable?*

More than three quarters of all online survey respondents agreed that recommendation 4 was locally implementable. One-in-five, felt it was not or were not sure.

Is Recommendation 4 locally implementable?

79%

- ■ Yes
- □ No
- ■ Not Sure

5%

16%
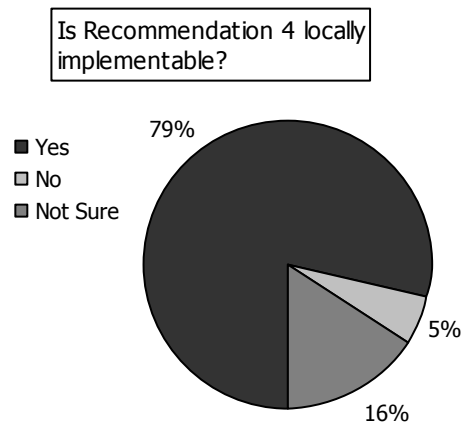
In general, most consultation event participants felt that universal offer of testing to all male sexual health service users would normalise the HIV test, and contribute to de-stigmatising HIV – both very favourable outcomes.

"If you want to normalise it (HIV), don't isolate it. Make it part of everything else." (event participant)

In several consultation events, participants compared this recommendation with the implementation of universal opt-out HIV testing in ante-natal services and with the scaling up of Chlamydia screening undertaken within the past decade. Some felt that these provided models of feasibility that are comparable with what is being suggested in this recommendation.

7.5   Impact

In the online survey all respondents were asked *If recommendation 4: universal HIV testing in sexual health services, would help to improve local HIV testing services?*

Three quarters of all those completing the online survey agreed that recommendation 4 would help improve local HIV testing services and one-in-five felt it would not. One-in-fifteen were not sure.

A range of specific issues arose when participants at consultation events were asked about the specific implications of this recommendation. These are groups under three themes below.

Would Recommendation 4 help to improve local HIV testing services?

- ■ Yes
- ☐ No
- ▨ Not Sure

76%

17%

7%
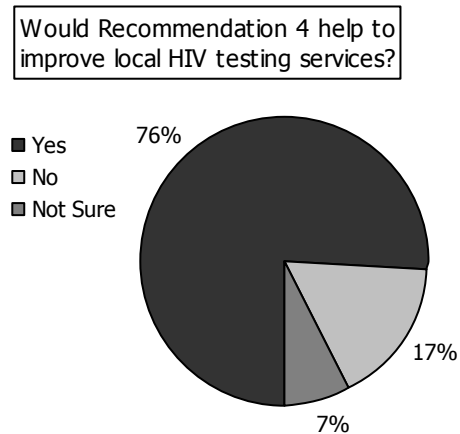
Ensuring informed consent

Participants at four events discussed the need for more detail on the specific means through which opt-out consent is acquired.

"We need to make sure everyone is singing from the same song sheet." (event participant)

It was suggested by some that this might be best clarified verbally, to ensure awareness, while others suggested that all patients receive information about the test in writing. Some participants discussed an assumption among many patients that they have been screened for 'everything', including HIV when they present at sexual health services. It was felt that greater clarity on all fronts about what tests are and are not being done will help to challenge such assumptions, and to improve the standards of consent. Some of these discussions about the presentation of opt-out testing raised themes such as: the need for greater standardisation and less subjectivity regarding how the matter of the test is raised; and greater attention required on the matter of fully-informed consent. A number of participants felt that some sexual health staff were already more or less likely to be inclined to raise HIV testing in a non-threatening, neutral way. It was suggested that reception staff and health advisors may be likely to require extensive training, given their likely involvement in how opt-out testing will be presented to service users. All staff will require the confidence to challenge negative perceptions of testing when raising this topic.

Associated campaigns

Participants attending one event suggested that such a change should be accompanied by information campaigns that let people know what they can expect to be offered when they attend such services, as this was done to support the scaling up of Chlamydia screening.

Normalisation of testing

In general, participants felt that universal offers of testing would help to normalise HIV alongside other STIs for MSM:

> "Should the message here be, 'you're at risk of one, you're at risk of all.'" (event participant)

There were, however, a minority of participants who expressed concern about the implications of this focus on universal opt-out testing. Some felt that routinisation of HIV testing reduces the capacity of the service provider to tailor advice and health promotion according to an individual's needs, as the pre-test discussion will be minimised. Another participant at a separate event felt that this approach which focuses on testing would pull attention and resources away from addressing and investigating complex behavioural issues with regard to risk. They suggested that simply making the HIV test more available to MSM will do little to address the small core who will not test and who continue to take risks. This position was supported with evidence that community-based POCT testing generally fails to produce the HIV positive results that voluntary clinic attendance does.

7.6   Barriers and challenges

Without consistency across services in terms of basic standards of service, some felt that it was difficult to know how this recommendation would be implemented. One event participant pointed out that in their local town, the waiting time for HIV test results is still two weeks. This was set against the majority of areas where the fast test is now standard. The implications of this diversity for a universal offer of tests is extensive.

Participants at two events felt that without a clear cost-benefit breakdown of the advantages of universal offers of testing (with regard to the costs of undiagnosed infection in terms of later treatment and onward transmission), it would be difficult to justify the necessary resources to provide universal HIV testing to all men accessing sexual health services (given the cost implications for training, test provision, extra time per patient, laboratory costs, etc.). Some queried whether such an approach to testing in sexual health services was likely to be cost effective in lower prevalence areas. It was suggested by participants at a separate event that monitoring of positive results from universal screening programmes would help in the overall assessment of its contribution towards addressing undiagnosed infection. Others felt that financial incentives may be necessary to ensure the delivery of universal testing across all sexual health settings and that such incentives might usefully be linked to a take-up target.

Many event participants discussed the extent to which stigma will continue to be a barrier to HIV testing access, offered under any conditions. A voluntary sector provider from a smaller city pointed out that many men will prefer not to have their HIV test undertaken in a local sexual health clinic where they are likely to be well-known, and that they currently may travel elsewhere to be tested for HIV. Therefore, stigma is likely to remain a barrier for the uptake of opt-out testing in some settings. Participants at another event discussed the extent to which such an offer may stigmatise male service

users who may interpret the offer of a test as an implication that they are gay or engaging in homosexual sex.

Finally, there was concern expressed among a small proportion of participants who thought that this recommendation treats male and female service users differently, and they queried how this overlays with the recommendation of universal offers of tests among African male and female service users.

8   Recommendation 5: routine HIV testing in primary care

Overall, the provision of routine testing in primary care settings was supported in terms of increasing access to testing, case finding as well as normalising and hence de-stigmatising the test. However the need to develop clear protocols for offering and administering the HIV test in primary care settings was stressed alongside the need for training for appropriate clinic staff in these settings

Those working within general practice felt that increasing the availability of HIV testing in primary care settings would depend on incentivising general practice and including HIV testing in the Quality and Outcome Framework (QOF) for GPs. Others stressed the need for pilots for delivering HIV testing in general practice alongside the role of enhanced sexual health service GPs in normalising HIV testing in GP practices locally and regionally.

Finally the role for government in developing capacity amongst GPs with regard to HIV testing as well as promoting HIV testing (and sexual health screens) in primary care to the general public was stressed. In this respect, many felt that the guidance could mention national general public campaigns as well as capacity building interventions.

8.1   Considering the recommendation in light of current practice

In the online survey all participants were asked *Does recommendation 5: routine HIV testing in primary care, describe new ways of working or new activities in relation to the organisation you work for?*

Almost two thirds of all online survey respondents agreed that recommendation 5 described new ways of working or new activities in relation to the organisation they worked for; a third felt that either recommendation 5 did not describe new ways of working, or were unsure if it did or not.

Does Recommendation 5 describe new ways of working?

- Yes
- No
- Not Sure

64%

26%

10%
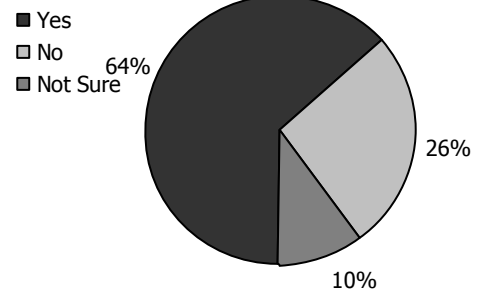
Compared to all other recommendations, consultation event participants described this as the most novel. A few did recognise that the BHIVA HIV testing guidance recommends testing new patients in areas of higher HIV prevalence, but most felt that recommendation 5 takes a step into new territory as far as making HIV testing among MSM in primary care settings routine.

8.2   Content and language

In the online survey all participants were asked *Is recommendation 5: routine HIV testing in primary care, clear and easy to understand?*

Is Recommendation 5 clear and easy to understand?
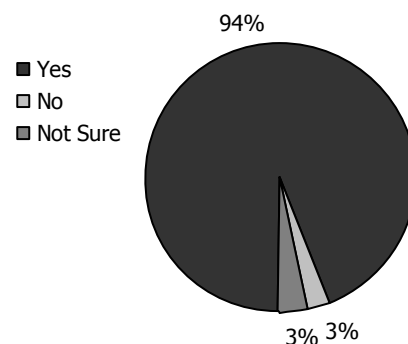
94%

- Yes
- No
- Not Sure

3% 3%

The vast majority of all online respondents agreed that recommendation 5 was clear and easy to understand. A small proportion felt it was not clear or were not sure whether recommendation 5 was clear and easy to understand.

A number of participants across different consultation events felt that while this recommendation seemed to imply that primary care referred exclusively to GP surgeries, they wondered if it was intended to go any further than that (including A&E, dentistry, self-referral to GU, etc.). Someone pointed out that the inferred definition of primary care in this recommendation differed from that offered in NICE's draft African testing guidance and wondered why this was the case.

One event participant appreciated the clarity with which the conditions under which an HIV test was to be offered in this setting were set out. Leaving little to the discretion of the health care provider was thought to be preferable. However, someone at a separate event found the wording slightly vague, and felt that the language regarding who and when to test could be clearer. Others felt there should be more detail in the recommendation about referral pathways to specialists for those who test positive and negative in these settings. These might specify a range of scenarios such as follow-up pathways for reactive or positive results, partner notification, repeat testing and ongoing support.

Participants at four events queried how it might be possible to ascertain the definition of an area with a 'large community of men who have sex with men', and if this related to residence as well as locales where MSM work and / or socialise. Those from cities with large commercial gay scenes pointed to the fact that a good proportion of MSM who access their commercial gay scene will be registered with a local GP some distance away from that scene.

Once again, an event participant felt that there was some discrepancy between this guidance and the BHIVA guidance, where the latter suggests that all those registering at a GP practice where HIV prevalence is high are offered an HIV test, rather than just men MSM.

8.3   Roles and responsibilities

Although the actors identified in the recommendation were judged to be largely appropriate, it was pointed out that perhaps referrals into the voluntary sector would help support those who are reluctant to test in the GP setting. Participants at one event felt that a broader programme of LGBT equalities training provided by the community sector would be a necessary precursor for routine testing of MSM in primary care (see recommendation 8).

Participants across a range of events noted that in reality, it was more likely that practice nurses and healthcare assistants would be the ones who offer the test and possibly deliver the results, however this is not discussed anywhere within the recommendation.

8.4   Feasibility

In the online survey all participants were asked *Is recommendation 5: routine HIV testing in primary care, locally implementable?*

Is Recommendation 5 locally implementable?

■ Yes
□ No
■ Not Sure

18%

47%

35%
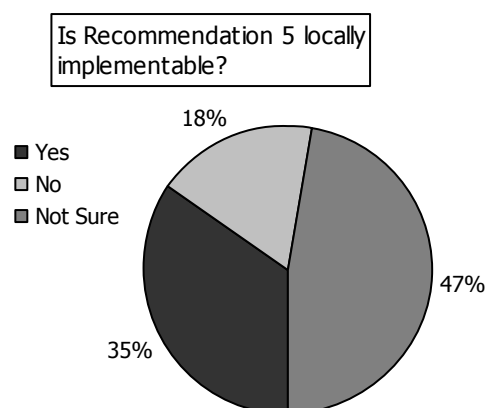
Just under half of all online survey respondents agreed that recommendation 5 was locally implementable. Less than one-in-five, felt it was not, over a third were not sure.

Similarly, there were participants in all consultation events who signalled that full implementation of this recommendation was unlikely, for a wide range of reasons (as detailed further in the sections below). Participants at four separate events discussed their awareness of DH and other pilot programmes that had endeavoured to extend HIV testing in the primary care setting. Without the results of the DH testing pilots, they wondered where the evidence base for recommendations such as this one had come from. Participants at one event said that in one pilot area there had been hardly any take-up of a piloted locally enhanced service because of the extensive training and quality assurance it required. There was concern expressed by a minority of participants that with so little likelihood of implementation, this recommendation might be deemed far too ambitious by its readers, while the majority valued this aspiration greatly, even if they envisage the difficulties with its implementation.

There were some who made note of the comparability of Chlamydia testing in primary care settings, but many of these felt that this programme had been costly and limited in its coverage. Ultimately, many agreed that the minority of GP surgeries where top quality sexual health services and screening were already available through locally enhanced service would function as the early adopters and champions of this recommendation, and that implementation would be slower elsewhere. Participants at events held in low HIV prevalence areas felt it was very unlikely that this recommendation would ever be implemented in their areas, so they felt that discussion of it was largely irrelevant.

8.5   Impact

In the online survey all participants were asked *If recommendation 5: routine HIV testing in primary care, would help to improve local HIV testing services?*

Over three quarters of online survey respondents agreed that recommendation 5 would help improve local HIV testing services and only one-in-fourteen felt it would not. A sixth were not sure.

Would Recommendation 5 help to improve local HIV testing services?

■ Yes
□ No
■ Not Sure

76%

7%

17%

Participants at various events discussed the extensive training needs that the implementation of recommendation 5 would require. It was also felt by a number of participants across events that the staff most likely to actually undertake such tests and deliver results would be practice nurses and healthcare assistants, rather than GPs themselves, meaning that training needs would cut across surgery staff. One participant suggested increased familiarity with the notion of 'task-shifting' elements of HIV testing to such staff as a way of increasing capacity, as has been undertaken with HIV testing and treatment programmes in parts of Africa.

Some consultation event participants felt that an information campaign about expectations of offers of HIV testing at GPs surgeries, accompanied by information about the implications of knowing ones' status early and the realities of living with HIV would support this change in delivery. Others pointed out that the routinising of HIV testing in GP settings should be accompanied by information about the
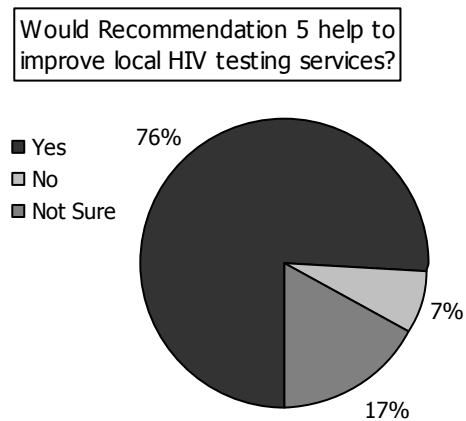
confidentiality of test results in such settings. A number of participants felt that up until this point, there has been too much exceptionalism surrounding HIV testing, and they welcomed the implication in this recommendation that HIV might simply begin to be treated just as any other test in the primary care setting.

Within two separate consultation events participants mentioned their impression that the coalition government will be turning much more towards outcomes measures of interventions, rather than take-up. For this reason, participants argued that a clear cost-benefits argument for GP testing in different settings should be promoted, and that data should be collected on positivity rates among HIV testers in these settings. As a participant at a separate event pointed out, this approach may help to avoid the type of target-driven practices often seen with Chlamydia screening, where the same individuals are repeat tested in order to meet targets, while those at greatest risk may continue to be missed.

8.6   Barriers and challenges

Participants pointed out that as there are very few opt-out models of testing already in place in GP surgeries (for any condition), implementing recommendation 5 implies an entirely new proactive health promotion approach to health for GPs and their service users. A few participants at different consultation events were concerned that endeavouring to gain anything more than a few more positive test results from this method was unlikely. They questioned the capacity for the primary care setting to undertake health promotion (or to make appropriate referrals for this) with those who are in need, but whose test is unreactive or HIV negative. Most participants did not feel that this recommendation offered any tools to counter possible unwillingness on the part of primary care services to undertake this work, and they envisaged that this would be a overriding barrier to its implementation.

A lack of allocated funding and the small amount of time already allocated per patient in overstretched GP surgeries were raised in all consultation events as key barriers to the implementation of this recommendation. There was an overriding perception amongst many participants that the best way to introduce new screens to GP settings is to incentivise them. Yet others pointed out that even with the attachment of financial incentives in the Chlamydia screening programme, there were some GPs who simply would not implement it. In addition to broader programmatic costs, there was considerable discussion at one event about the financial implications of different testing methods in the GP setting (POCT testing versus laboratory-based blood testing). Some felt that although the recommendation appeared to be written with an implied bias towards the use of POCT tests, the expense of these might rule them out. They pointed out that it can be much more cost effective to add HIV testing to a range of other tests requested on a particular blood sample. As a result, it was suggested that the language used in the recommendation may leave it more open as to whether a POCT or venepuncture is used, as this will depend on a range of programmatic and financial factors in each setting.

Concern was expressed about the difficulties of ensuring the commissioning of this entirely new way of working when those commissioning the service being described may be GPs themselves, or if commissioning of public health is moved to Local Authorities. Some felt that this recommendation was unclear about who held ownership for ensuring that routine testing was rolled out in primary care. If it was not to be driven by commissioners, how were GPs expected to have interest in or find out about local prevalence of either HIV or MSM?

Participants at one consultation event wondered if specific arrangements would need to be put into place for GPs who may exercise religious or other objections against undertaking an HIV test (there are some who are exempt from making referrals for abortions on the same grounds), or if this would be any similar sorts of exemptions in the case of HIV testing.

Participants at two different events raised questions about the implications of this recommendation for the provision of testing in areas without high HIV prevalence. Their concern was that such areas would fail to see the type of normalising of HIV, despite the fact that some individuals would benefit from this.

9 Recommendation 6: Outreach rapid point-of-care tests

Overall the provision of HIV testing in non-standard and non-clinical settings was seen as a vital means of increasing the uptake of testing and identifying undiagnosed infection so recommendation 6 was broadly supported. However, like recommendation 3, this recommendation was seen to risk being too specific in the settings and approaches it describes. Participants were clear that testing in community settings encompasses a broad range of approaches to and settings for community testing.

The need for protocols for 'community testing approaches' was also identified to cover training standards, targeting, test administration and clinical governance as well as referral /care pathways.

9.1 Considering the recommendation in light of current practice

In the online survey all participants were asked *Does recommendation 6: outreach rapid point-of care tests, describe new ways of working or new activities in relation to the organisation you work for?*

Just over half of all online respondents agreed that recommendation 6 described new ways of working or new activities in relation to the organisation they worked for; and just over a third said it did not. One-in-eleven of all respondents were not sure whether recommendation 6 described new ways of working or not.

Does Recommendation 6 describe new ways of working?

■ Yes
□ No
■ Not Sure

56%
35%
9%
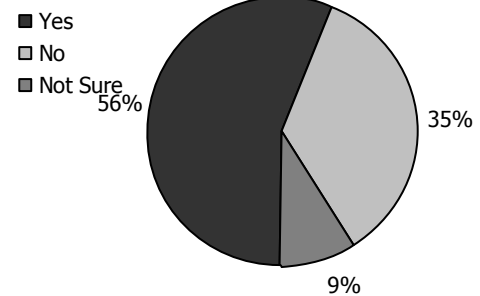
In terms of describing new ways of working, the majority of those participating at consultation events did not feel it was new. Those from urban areas with higher prevalence were already involved in community POCT interventions whereas those in lower prevalence areas had heard of these interventions. What was noteworthy was that the recommendation specified POCT in certain venues. Many felt that this did not necessarily reflect the kind of work around testing that they were engaged with. For example, one area had been running a home sampling programme whilst others were doing testing promotion alongside a centre-based POCT service or were referring into HIV testing as part of a sexual health screening process. Respondents also noted that recommendation six was too literal in that it appeared to focus on administering a test in a setting rather than, or in addition to, providing greater access to testing within a range of settings (for example, free home sampling kits offered online).

9.2 Content and language

In the online survey all participants were asked *Is recommendation 6: outreach rapid point-of care tests, clear and easy to understand?*

Is Recommendation 6 clear and easy to understand?

97%

■ Yes
□ No
■ Not Sure

1% 2%
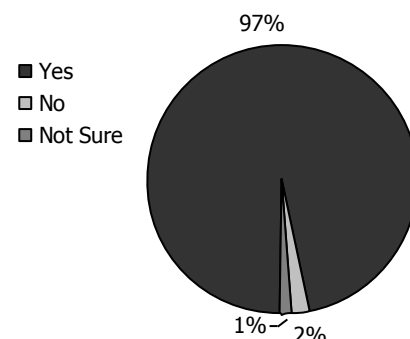
The vast majority of all online survey respondents agreed that recommendation 6 was clear and easy to understand. The small remainder, felt it was not clear, or were not sure whether recommendation 6 was clear and easy to understand.

Overall the recommendation was perceived by event participants to be clear and easy to understand. Some groups felt that the recommendation should mention a range of community-based testing approaches rather than being restricted to POCT. Others felt that the section about referring those unable to consent was unnecessary as they would do this as a matter of course anyway. However, others felt that the recommendation should be more directive about ensuring that referral pathways for this group should be more tightly specified (for example through chaperoning or tracking the individual into the testing service) rather than merely offering information on where tests can be accessed.

9.3 Roles and responsibilities

Overall, respondents felt that the right actors had been identified. Some felt that a coordinating role should be prioritised (perhaps at commissioner level) to deal with the range of actors involved and to assure proper clinical governance and care pathways. In addition, others specified that laboratory personnel should be consulted as POCT is likely to involve an increase in confirmatory tests overall. Finally, some said that gay scene venue owners should be included in the list of those needing to take action. This is because they controlled access to venues where testing might be carried out.

9.4 Feasibility

In the online survey all participants were asked *Is recommendation 6: outreach rapid point-of care tests, locally implementable?*

Less than half of all online respondents agreed that recommendation 6 was locally implementable. One-in-seven felt it was not and a similar proportion to those who believed it was implementable were unsure .

Is Recommendation 6 locally implementable?

- Yes
- No
- Not Sure

14%

43%

43%
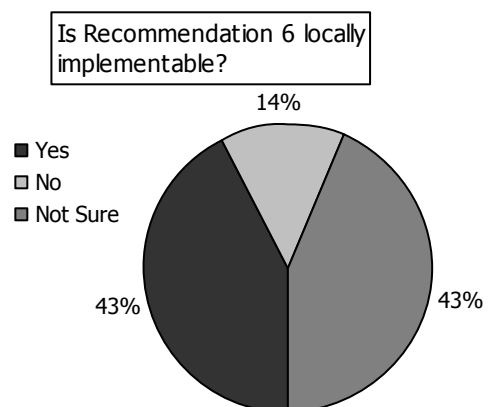
At most of the event participants discussed how interventions around community testing and POCT had been or were being implemented. This led to discussion around the ways community testing might be used and specific practices around POCT. These discussions focused on resources and appropriateness of setting.

At two events, participants highlighted the resource implications of introducing community POCT. That is, although the VCS are willing to develop POCT and GUM clinics are willing to support them, the additional time needed on both sides (for outreach workers to engage in longer interactions with clients, undertake training and follow through on resources and for GUM staff to train and sign off outreach staff and liaise over confirmatory tests) was currently unavailable. Unless there were increases in resources, community POCT would not happen. Commissioners were therefore seen to play a vital role in supporting and coordinating the implementation of this recommendation. Some of those currently engaged in community testing spoke of difficulties with getting GUM staff to sign off on

testing or being somewhat concerned about clinical governance of the test generally due to lack of time and resources.

Those involved in community health promotion expressed a range of opinions regarding how this recommendation should be implemented locally. Many felt that it would be inappropriate to carry out POCT in scene venues or PSEs as this would be too intrusive for men who are socialising or engaging in sex. They tended to favour instead either self-sampling distribution or chaperoning men into a centre-based testing service open whilst the outreach was occurring.

> "What we are doing in [area] is working brilliantly, we have a static site but we have outreach workers bringing them in." (event participant)

Where administering tests *in situ* was discussed, there was much interest in the practicalities of managing multiple tests and how to engage the client whilst waiting for the result. With regard to the latter point some felt that the 20 minutes or so necessary to obtain the result was a valuable opportunity to engage the individual in sexual health promotion interventions.

Others felt that POCT as specified in the recommendation would only be appropriate in a very limited number of sites In conclusion therefore, although they entirely supported this recommendation, many felt that it was too specific as regards where and how POCT should be used. That is, the guidance should refer to a range of testing approaches to be used in a range of community settings.

> "We need a multiplicity of settings for MSM point of care testing, people don't want to go to clinics but they don't all want to go to saunas I know in [area] you have to pay to go into the sauna to access the test." (event participant)

Participants were also very mindful of the need to coordinate community testing with GUM. For example, ensuring that the client with a reactive test can access a confirmatory test quickly. Therefore the timing of community POCT was considered crucial and there may be a need for local GUM services to take account of community testing in the times and ways they deliver their services.

9.5   Impact

In the online survey all respondents were asked *If recommendation 6: outreach rapid point-of care tests, would help to improve local HIV testing services?*

Almost three quarters of all online respondents agreed that recommendation 6 would help improve local HIV testing services and only one-in-twelve felt it would not. A sixth were not sure.

Would Recommendation 6 help to improve local HIV testing services?

■ Yes
□ No
■ Not Sure

74%
8%
18%

Among those participating in the consultation events, the recommendation was generally supported for three reasons. First, it sought to increase the range of sites where men can access testing. Second, it allowed health promoters to target men who would not normally be amenable to testing or who might not access it. Third, it prioritised the
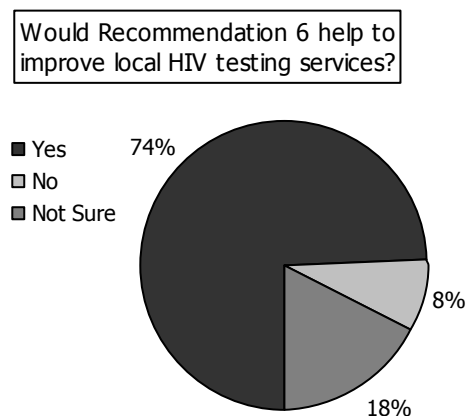
integration of face to face health promotion with testing. That is, allowed a greater focus on the individual during the test, why he might be testing and what the implications of a positive or negative test result was for him. These benefits were weighed against a number of concerns presented under the following headings.

Resources

Respondents from both the VCS and other sectors were very mindful of the resource implications of widening community POCT. They stressed the increased competency and capacity required of community workers (training around administering the test, ensuring and coordinating care and referral pathways and greater time spent with clients). Others stressed the resource implications for GUM clinics to work in tandem with VCS services to ensure a high standard of appropriate service delivery.

Coordination and governance

Linked to concerns about resources were concerns that POCT and any other community testing service should be delivered to an excellent standard. Therefore participants in all groups raised the issues of coordination, clinical governance and care/referral pathways. Coordination was seen as essential to rolling out POCT. The main concerns here centred on the capacity of POCT to raise numbers of 'false positive' tests that would need to be quickly dealt with by GUM as well as men who might be 'lost to treatment' if the care pathway from community setting to GUM/HIV specialist service was faulty.

> "We had three cases of false positives and we questioned the service and we realised it is because of point of care testing, because it is not clinically set up." (event participant)

Concerns over clinical governance focused on the potential for increasing the numbers of individuals who could administer tests in a range of settings. Community health promoters were concerned about how they assessed a clients suitability for a test, both in terms of their relative risk factors and their capacity to consent to taking the test (for example, assessing how inebriated a person needs to be before judging him to be unable to consent).

Other concerns were raised about the environment within which the test would be administered being entirely different from a clinical setting. How would this impact on the ways in which information about the test would be imparted?

> "From our own experience of outreach testing pilots one of the issues has been the quality assurance of being able to deliver the information to people and that's in a static space a kind of quasi clinical setting as opposed to being out in a venue where there is noise and all these distractions." (event participant)

Others expressed concerns about the logistics of testing. For example, retention and storage of tests, proper confidential data management etc.

> "I think its not enough to give people to use them, they need to be documented and the virology department has to be sending your samples down for you to check against. There should be a register where you record lot numbers expiry dates. Just to have someone in the GU to give you the tests and sign you off as competent is not enough." (event participant)

In short therefore, some workers felt that there was a need to clarify and tighten up the guidelines on competency of doing the test.

A final concern involved measuring outcomes and effectiveness of community POCT. Community workers were keen to establish indicators for this intervention. For example, should the output be measured in number tests distributed or number returned or number of reactive tests?

'Exceptionalising' and normalising the HIV test

In several groups, concerns were raised about the prospect of 'exceptionalising' the HIV test by offering it without the context of a sexual health screen or a general health check. In common with concerns over universal testing, some GUM staff mentioned the need to ensure that men also test for other STIs and do not see an non-reactive test as a sexual health 'all clear' These concerns were echoed by many community health promoters who were keen to see the POCT administered alongside other STI tests.

In other groups, participants raised the question of 'normalising' HIV tests within general health screens. They pointed to the established practice of offering general health screens (diabetes, blood pressure etc) in community settings and the virtue of integrating a POCT alongside a sexual health screen within such an encounter. Others felt that if community health promoters were going to embark on HIV testing, they should be competent to discuss and refer on general health also.

> "In terms of 'Tesco Health' [the idea of an easily available health screen at supermarkets] its good to get people who don't use kind of mainstream services they can utilise and get a more generic kind of testing, but its important that the person doing the generic assessment is skilled up with the competency that you need, and can talk about anything such as high blood pressure, cholesterol and HIV." (event participant)

Multiplicity of approaches

Participants in all groups were clear that POCT tests in sexualised settings should be seen as only one component in a range of approaches to community testing. These should include self or home sampling, non-clinic centre-based testing, accompanying or chaperoning clients to GUM clinics for tests as well as promoting and normalising HIV testing within commercial and community settings.

> "Why only saunas and sex clubs? I think loads of venues will benefit." (event participant)

Others felt that the range of settings recommended could be broadened. The specification of venues where sex occurs led some to conclude that the guidance was referring only to gay scene settings and saunas; venues not frequently attended by their own client groups. One respondent mentioned gyms as more appropriate to the men he targets (younger MSM) while another mentioned barber shops for men from certain BME backgrounds.

> "A sauna is not the place for it to happen neither is a PSE , places like sun tan salons, barber shops, you know and it becomes part of the healthy 'take care of yourself' campaign which would be the way to do it as a lot of guys will not identify as gay and they will not talk about sexual behaviour even in a GUM." (event participant)

10 Recommendation 7: Repeat testing

Overall, recommendation 7 received majority support as a means of increasing early diagnosis and identifying men at risk for other interventions. However, it was emphasised that the guidance should make clear the aim and purpose of the recommendation. That is, that repeat testing should not be seen as an appropriate or only intervention for men who take repeated risks or men who test repeatedly despite little or no risk (the 'worried well').

As in other recommendations the need for protocols regarding the offer and follow-up of repeat testing in a range of settings was stressed. These protocols should specify how to identify men for repeat tests, how to present repeat tests to the user and why the user is being advised to test again. They should also specify a range of approaches and methods for follow-up. The need for clearer guidance on the window period was also stressed: how it varies for different testing technologies and how to present this information to the user.

10.1 Considering the recommendation in light of current practice

In the online survey all participants were asked *Does recommendation 7: Repeat testing, describe new ways of working or new activities in relation to the organisation you work for?*

Three-in-ten online survey respondents agreed that recommendation 7 described new ways of working or new activities in relation to the organisation they worked for; and just under two thirds said it did not. One-in-every ten respondents were not sure whether recommendation 7 described new ways of working or not.

Does Recommendation 7 describe new ways of working?

■ Yes
□ No
■ Not Sure

62%
28%
10%
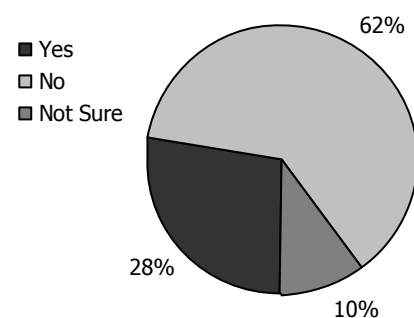
Although the concept of repeat testing was not seen as new at the events, participants in several groups felt that in services other than GUM this would be an innovation. However respondents from GUM backgrounds also pointed out that this was by no means normal or universal practice (see the section on implementation below).

Participants in three groups felt that this recommendation was at odds with previous BHIVA guidance. The main difference is that they perceive that BHIVA recommends annual testing for all MSM regardless of risk, but that this recommendation specifies an element of risk assessment.

> "However, in my view this is not consistent with the BHIVA guidelines which suggests annual plus testing for sexually active MSM without particular assessment of the level of risk. So this is going back to an earlier concept of self or joint risk assessment to how risky is your sex."
> (event participant)

The guidance was therefore perceived to risk being slightly retrogressive in that it was seen to re-introduce an element of risk assessment around the need to repeat test. Some felt that this aspect might introduce complications and possible barriers to testing (however, see discussion on implications below).

10.2   Content and language

In the online survey all participants were asked *Is recommendation 7: Repeat testing, clear and easy to understand?*

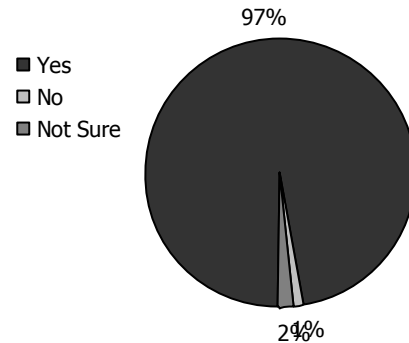The vast majority of all online respondents agreed that recommendation 7 was clear and easy to understand. The small minority remaining either felt it was not clear, or were not sure whether recommendation 7 was clear and easy to understand.

Is Recommendation 7 clear and easy to understand?

97%

■ Yes
□ No
■ Not Sure

2% 1%

Although event participants also judged this recommendation to be clear and easy to understand, the perceived difference with the BHIVA guidance led to some confusion expressed during subsequent discussions. Some participants wondered whether it was recommending annual testing for all men with more frequent testing recommended for men judged to be at higher risk of exposure. Some participants also felt there was a need for greater clarity about how increased risk was to be assessed in practice.

> "[There's a need for] clarity of terms: multiple sexual partners – how many? Risky practices – such as? Serodiscordant sex – how do I know?" (event participant)

Another potential confusion emerged around the notion of recommending testing around risk. In some senses, it was seen as at odds with other recommendations around testing. Some participants felt that this could be cleared up with an articulation of the purpose of this recommendation.

> "Are we trying to test everyone or just those who never test, or just those who are at high risk. Ideally the latter two of those, but without a risk assessment how do you know high risk, and in earlier guidance when saying 'test all men', how do you then know which men to recommend a repeat test to? All within a finite set of resources. And how do you say to low risk men not to test?" (event participant)

Participants in two groups were struck by the use of the word barebacking with one group objecting strongly, as it was perceived to be a colloquialism and a term loaded with political and social meanings

> "I have a curiousness with the term 'barebacking'…in the rest of the guidance there don't have any colloquial expressions of this and I'm just curious why it's in there, particularly considering the number of different audiences this will go to. I think it's a really emotive, challenging, difficult term…I really object to it to be honest." (event participant)

This group recommended replacing this with a more neutral term such as unprotected sex, unprotected anal intercourse or sex without condoms.

10.3   Roles and responsibilities

Participants in all groups were clear as to the appropriateness of the actors specified in the recommendation. However, they thought that the recommendation would have very different implications for different actors. Specifically, respondents were thinking about sexual health services outside of GUM (CASH services or specialist/enhanced primary care for example). That said, participants supported the breadth of actors specified

10.4   Feasibility

In the online survey all participants were asked *Is recommendation 7: Repeat testing, locally implementable?*

More than four fifths of all online survey respondents agreed that recommendation 7 was locally implementable. A very small proportion felt it was not, with the remaining one sixth being not sure.

Is Recommendation 7 locally implementable?

- ■ Yes
- □ No
- ■ Not Sure

83%

3%

14%

Event participants, and especially those from clinical settings were keen to know what innovations to their practice the recommendation was specifying. That is, although they would recommend repeat testing, it is, at present, an ideal. Moreover, the perceived (re)introduction of a risk assessment exercise around repeat testing was seen by some to possibly present even more barriers to testing.

> "You're doing well if they [GUM] test them once. It's going to be hard for them…we were saying earlier just to test all men…you don't know then what their risk is. So this means that you've got to get into all that [risk assessment] and I think the more complex you make it for them, the less likely they are to test anyone at all". (event participant)

There was much discussion at the small groups about what this recommendation would look like in practice therefore. For example does recommending repeat testing mean merely advising the patient to come back to test, setting an appointment for him or sending out reminder letters or texts etc? However, others welcomed this non-specificity as it allowed them to respond according to their resources.

> "There are many levels you can take this on. You can recommend or fix them an appointment – you can take this as far as you like". (event participant)

What this discussion did show was a marked variation in current practice in GUM settings as regards repeat testing (especially in the window period). Some had methods of follow up such as sending text reminders etc while others merely recommended that the patient re-attend for a test.
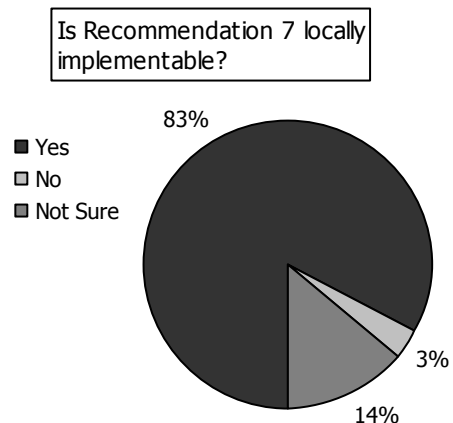
Finally, some were concerned about setting up expectations around re-testing and these expectations not being met.

> "If we set up (follow up) appointments in the first 3 months and we get loads of DNAs (do not attend?), that's going to weaken it (current practice)". (event participant)

Others felt that it should be a matter of professional judgement how the procedure for re-testing should be managed.

> "I think it's important for the practitioner doing the screening to have the ability to assess the capacity of the person, whether they have the capacity to come back within three months. Have the responsibility for that or whether it's up to the practitioner to say, 'here's an appointment to come back in three months". (event participant)*

10.5 Impact

In the online survey all participants were asked *If recommendation 7: Repeat testing, would help to improve local HIV testing services?*

Almost three quarters of online respondents agreed that recommendation 7 would help improve local HIV testing services and only one-in-twenty felt it would not. A fifth were not sure.

When implications of this recommendation were discussed at the events, the following concerns emerged

Would Recommendation 7 help to improve local HIV testing services?

■ Yes
□ No
■ Not Sure

72%

15%

13%
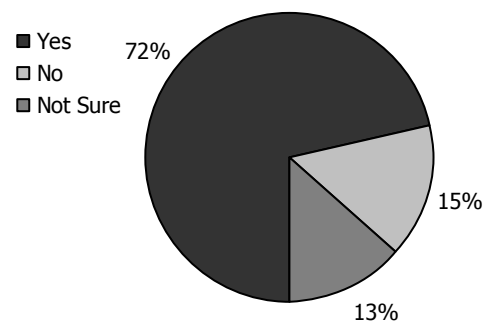
The window period and risk assessment

The most commonly discussed implication of this recommendation was its reference to the window period. Although participants understood the reference to this being as long as 3 months, they were keen to see the recommendation being more specific about how the window period varies with the use of different testing technologies. This was considered important as three months was considered too long to get men back in for a confirmatory test.

> "The window period has prevented men from getting tested when they are at their most anxious and three months later they think, 'I'm probably ok'. They're really important about being a barrier to men actually testing during that period when they are most anxious about that risk they have just undergone. So we do need to crack that somehow". (event participant)

Participants acknowledged that there was much confusion regarding how the window period should be described and at what length it should be set, but they would like to see any new guidance being more specific on this point.

> "[I] get the feeling that there was this issue that they [authors of recommendation] didn't want to talk about, because it is complex, but I think this is something that a lot of people struggle to understand and I imagine that includes some providers about what is the window period? Which tests are we talking about? And we're still struggling. There's no clear message that gets communicated". (event participant)

Others were more doubtful that definitive guidance on the window period was possible as testing technologies were changing all the time. They therefore proposed recommending that those administering the test be aware of the window period for that test, communicate this to the patient and schedule follow-up accordingly.

> "I guess it's the person testing knowing what that test is about and trying to explain it to that person sitting in front of them in the clearest terms they can to their level of understanding". (event participant)

There was some concern in two groups about unintended outcome. Although participants understood that the aim was to get men at higher risk to test more frequently, some were concerned about the capacity to identify these men and how this should be balanced with the imperative to increase testing overall.

> "There's a limited amount of time and money to do this sort of thing and the question is, can you identify people who are at ongoing high risk who you should test rather than going after people who have never had a test?" (event participant)

Some respondents also mentioned the possibility that unless risk assessment was done well and universal testing also promoted, that a repeat testing strategy may result in the repeated testing of a few hundred individuals within a population (all MSM) of tens of thousands.

Repeat testing as a health promotion intervention

Respondents in several groups mentioned the health promotion value of repeat testing. That is, the second test after the expiration of the window period was often seen as an opportune time to discuss the patient's risk taking activity and behaviours.

> "If you're able to make follow up appointments, you could have longer time slots to look at behaviour change". (event participant)

As such, they would like to see the recommendation make reference to the role of repeat testing as a health promotion intervention in itself.

10.6   Barriers and challenges

Not surprisingly, the question of resources and investment was raised at most events. Such resources depended on the way in which the recommendation was implemented. According to most participants' understanding of the recommendation, GUM clinics would need to take a far more proactive approach to locating, contacting and reminding men to attend for a second or periodic test. This would involve much more administrative time than is currently used.

The question of resources became more marked when participants discussed primary care or acute care implementing a re-test approach. Routine testing in primary care was not seen as feasible unless practices were incentivised to carry out testing. This point became more pressing when considering the potential of primary care settings to implement a policy of repeat testing with patients. Again, the question of simply repeat testing a relatively small group of low-risk men in GP surgeries was raised. This tendency may be exacerbated by incentivisation. That is, practices may simply identify a core group of patients that they test regularly thus meeting their requirements to carry out HIV testing whilst not putting energies into identifying other patients at risk to test.

11 Recommendation 8: training

Overall, recommendation eight was supported universally as training was seen to be vital in underpinning all other recommendations and improve testing services.

However concerns around the implementation of recommendation 8 were raised throughout the fieldwork. Training for GPs was seen as vital but difficult and resource intensive to implement. Moreover, the integration of training into pre-existing service training or continuing professional development training was seen as being preferable to developing stand alone training.

As in other recommendations, the need for the development of protocols for training (to include quality control procedures, curriculum development, monitoring and learning outcomes) was stressed. The need to involve service users and MSM living with HIV in the development and delivery of training was also stressed

11.1 Considering the recommendation in light of current practice

In the online survey all respondents were asked *Does recommendation 8: Training, describe new ways of working or new activities in relation to the organisation you work for?*

Half of all online survey respondents agreed that recommendation 8 described new ways of working or new activities in relation to the organisation they worked for; and just over a third said it did not. One-in-seven of all respondents were not sure whether recommendation 8 described new ways of working or not.

Does Recommendation 8 describe new ways of working?

Participants at the consultation events recognised that this recommendation referred to training for GUM staff, primary care staff and voluntary/community sector. The training described was not considered novel in the case of GUM staff. However, in several groups participants commented on the quality of this training and whether it was consistent.

> "In GU, it depends if the training is universal. For example if it's reception staff too then this is a new way of working". (event participant)

Participants in all six events identified this recommendation to be novel in the case of primary care staff and VCS workers. For primary care staff it was considered highly aspirational and a major departure from current practice. Participants described this as constituting a 'sea change' or a 'whole new mindset' for primary care practitioners. However, those primary care practitioners we interviewed felt that implementing this recommendation for primary care was possible, although perhaps not universally (see implementation below).
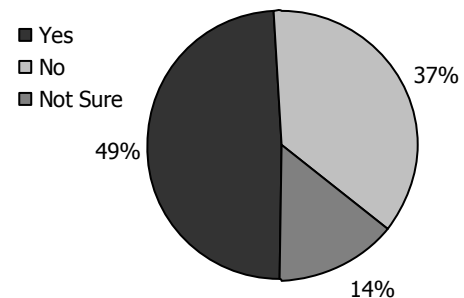
The recommendation for VCS staff was considered to be novel inasmuch as it specified training around administering point of care tests (POCT). For those not currently engaged in this activity, this was seen as a significant departure from current practice.

11.2   Content and language

In the online survey all participants were asked *Is recommendation 8: Training, clear and easy to understand?*

The vast majority of all respondents agreed that recommendation 8 was clear and easy to understand. The small remainder felt that recommendation 8 was either not clear, or they were not sure if it was clear and easy to understand or not.

Is Recommendation 8 clear and easy to understand?

97%

- Yes
- No
- Not Sure

2% 1%
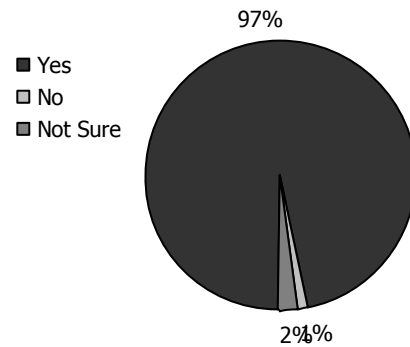
As with some other recommendations, although consultation event participants felt that the recommendation was clearly written and they could understand it, discussion revealed some confusion around the implications of the recommendation and some felt that the recommendation needed more detail. This was particularly stressed with regard to the types of training appropriate, how such training might be delivered and at what level. For example, participants immediately asked questions about the learning objectives associated with such training and who would be best placed to develop and deliver such training.

Some felt that the order in which the recommendations were placed might put off GP practitioners. The fact that primary care training came after GUM and specifies that primary care practitioners should be trained to the same levels of GUM staff with *additional* competencies was seen as unreasonable when in fact the additional competencies described for primary care staff were those one would expect as a matter of course from GUM staff.

> "The way it looks with the bullet points at the moment is that PC practitioners are expected to do everything that GU staff do plus a whole load of other stuff. Actually, that's the wrong way round." (event participant)

Finally, others felt that there was a need to specify these competencies for all three groups.

> "…the first 2 points underneath Primary Care (undergo comprehensive training in suitable techniques for post-test discussions, including giving positive test results and post-test health promotion; be trained to provide appropriate information and interventions for men who test negative) also need to be in the community [sector]. They absolutely have to be able to do all those things." (event participant)

11.3   Roles and responsibilities

Overall participants in all groups felt that the right actors had been identified. However, in most of the groups, participants felt that there was a need to prioritise certain actors who should take the lead and who were indispensable. This was because implementing this recommendation requires coordination

and governance as to the consistency and quality of training. The fact that training was often not prioritised in planning and commissioning services was seen as a clear need to define roles and responsibilities more clearly with regard to this recommendation.

> "My concern is that with training, the first thing to always go when there is no time, there's no money and it's not a priority." (event participant)

This coordinating role was often ascribed to service planners and commissioners. However, the notion of a governance lead was also mentioned, especially in the administration of tests in non clinic settings.

11.4   Feasibility

In the online survey all participants were asked *Is recommendation 8: Training, locally implementable?* Less than half of all online survey respondents agreed that recommendation 8 was locally implementable. One-in-ten, felt it was not and a similar proportion to those agreeing were unsure.
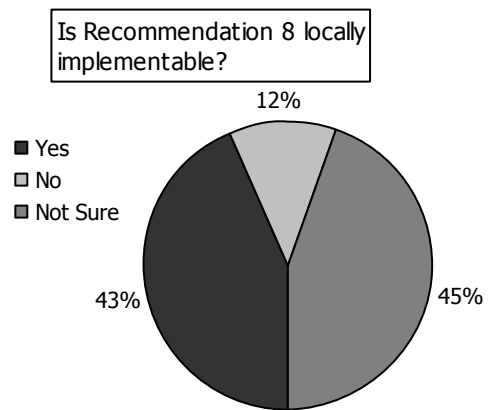
When event participants discussed local implementation, the major concern in all groups was how this training should be developed and delivered

Is Recommendation 8 locally implementable?

■ Yes
□ No
■ Not Sure

12%

45%

43%

on the ground. The first tension identified here was that the recommendation specified training in clinical procedures on the one hand (administering tests) and experiential training and listening skills on the other. The two areas required very different approaches and learning styles. Moreover, for many, the voluntary/independent sector was seen as the most appropriate sector within which to develop the latter. However, the former needed to come from a clinical source.

Participants frequently suggested integrating this training into current basic and CPD training protocols. Others suggested integrating this training into things like motivational training for GPs and practice nurses or diversity training for administrative staff.

> "It's like diversity training…if you build it into general training and professional development." (event participant)

Integrating this training had the advantage of ensuring that this training was mandatory and standardized rather than being seen as an optional extra that many would forgo when faced with managing limited resources. Moreover, it reduced the training burden on staff and would make it seem more acceptable to disciplines whose core activity was not sexual health (such as primary care providers). Finally some participants mentioned using pre-existing training structures but also stressed the need to monitor the impact of such training.

> "In [name of area] we have as part of primary care the protected learning scheme for PC practitioners. [This is protected time for PC practitioners to attend additional training]. What we don't have is any evidence of how this translates into practice when people go back to their own individual practices. And also what's interesting is that reception staff and auxiliary

staff are often really engaged with delivering that agenda but how is that maximised and carried forward?" (event participant)

Many participants stressed that the non clinical training (for example that on diversity, listening and discussing sexual risk) should be developed with specific reference to wider social and cultural issues mediating risk-taking amongst MSM. Therefore, factors (both positive and negative) that may play a part in risk taking should be covered

[The training needs to give] "an understanding of the wider social issues that lead people to services. [There's] no mention of other issues, for example: substance misuse, abusive relationships". (event participant)

In addition, training should take account of the various groups of MSM who may not access services for a range of cultural or social reasons. This should include increased stigma around homosexuality within certain cultural or ethnic populations or an awareness of how age can mediate a man's perception of his own sexual identity or sexual risk.

Finally several participants mentioned the desirability of involving members of the target or user group in the design and or delivery of this training.

11.5   Impact

In the online survey all participants were asked *If recommendation 8: Training would help to improve local HIV testing services?*

The majority of online survey respondents agreed that recommendation 8 would help improve local HIV testing services and only one-in-twenty five felt it would not. One-in-ten were not sure.

Event participants welcomed recommendation 8. They felt that appropriate training was key to improving the appropriateness of services to MSM and hence reducing undiagnosed infection

Would Recommendation 8 help to improve local HIV testing services?

■ Yes
□ No
■ Not Sure

86%

4%

10%

Groups discussing the implications of this recommendation tended to focus on issues of quality control and consistency. Participants in all consultation groups highlighted the need for the development of core standards and outcomes nationally accompanied by proper local needs assessment and monitoring. Standardisation was seen as key in order to cut down on regional variation or variation of quality between the various professions and stakeholders identified as possible recipients of training.

In addition, clear ownership and coordination of training was also stressed as many participants felt that otherwise training would not be prioritised. This was allied with the need for local monitoring and assessment of training need.

"There also has to be a local mapping. That training needs to be up to date with what services are out there to refer people to. And again, someone needs to own that and keep the databases up to date." (event participant)

11.6 Barriers and challenges

We asked participants to think about the barriers and challenges to implementing this recommendation. Three issues emerged: the increased burden of training on certain staff, lack of resources and finally the wording of the recommendation itself.

In terms of burden, non clinical or administrative staff were seen as the most difficult to draw into training. Beyond the provision of basic diversity training, many participants felt that it would be difficult to justify this type of training for such staff.

For many, a simple lack of resources were seen to be a major barrier to implementation. At a time when resources were shrinking, arguing for an extension to training is difficult. In view of this, some felt that the economic argument behind such training should be stressed.

"All people, clinical and non clinical working in HIV services need to be trained regardless of the cost implication because the public health cost of not doing something is much greater". (event participant)

Finally, some mentioned the risk of overstating the need for such training. That is, lack of training may be perceived, especially by primary care providers, as a reason not to offer HIV testing and could then act as a barrier. As mentioned above, the impression given by the positioning and wording of the recommendation around competencies in primary care (that they should be above those of GUM) in itself could risk overstating the extent of training required.

"For primary care, I'm not sure about the first two bullet points. I think this will be seen as a barrier'. The word 'comprehensive' may be a barrier in itself. Training is training and should be comprehensive anyway". (event participant)

In the absence of making it mandatory, one way of increasing the uptake of training would be to incentivise staff whose core function was not clinical or who did not specialise in sexual health. This could be in the form of incentives or payments for a practice or could be linked to individual CPD or progression.

12 Conclusions

In this chapter we present a summary of findings and conclusions starting with overall or general conclusions regarding the guidance as a whole. In the first section (12.1), we refer to findings generated from the online survey, the participative events and the interviews. In sections 12.2-12.9 we present more detailed conclusions for each recommendation in turn. For these sections we refer only to our qualitative findings. That is, those generated by the participative events and interviews

12.1 General Conclusions

In this section, we summarise findings from the online survey before moving on to findings from the participative events and interviews.

General conclusions from the survey

The following table provides a summary of findings from the online survey. This allows us to better understand how the recommendations were viewed comparatively.

% of respondents who agreed that relevant recommendation:	Is clear and easy to understand	Describes new ways of working or new activities in relation to the organisation you work for	Would help to improve local HIV testing services	Is locally implementable
Rec 1: Planning services	93	40	75	53
Rec 2: Integrated care pathways	98	30	81	73
Rec 3: Promoting HIV testing and reducing barriers	97	33	75	62
Rec 4: Universal HIV testing in sexual health services	98	30	76	79
Rec 5: Routine HIV testing in primary care	94	64	76	35
Rec 6: Outreach rapid point-of-care tests	97	56	74	43
Rec 7: Repeat testing	97	28	72	83
Rec 8: Training	97	49	86	43

The overwhelming majority of online survey respondents found the recommendations to be clear and easy to understand.

A majority of respondents felt that each of the recommendations or its implementation would help to improve local HIV testing services. Recommendations relating to training and integrated care pathways were most favoured by online respondents.

The perceived potential for implementation varied by recommendation. Recommendation 5 and 6 were perceived to be implementable by only a minority of the sample whereas recommendations 1, 4 and 7 were most commonly rated as implementable.

With regard to what was perceived to be new in the recommendations, recommendations 5: Routine HIV testing in primary care and recommendation 6: Outreach rapid point-of-care tests were considered as a new way of working by a majority of respondents and participants.

General conclusions from participative events and interviews

In general, the recommendations were supported by participants and interviewees. They were considered to be clear and easy to understand. If implemented, they were also considered to have the potential to improve HIV testing services for MSM. Finally, the majority of the recommendations were perceived to be implementable.

Both event participants and interviewees perceived some ***gaps or omissions*** in the recommendations.

In terms of target groups and responsible actors, the guidance was not seen to take account of the needs of men in custodial or cared-for settings. This was stressed alongside the need to involve those planning and running these services. In addition, participants stressed the need to include educational settings in the guidance.

In terms of approaches, event participants felt that the value of a range of community health promotion interventions for work with men who engage in high risk should be included in the guidance (for example small group or one-to-one work). The role of such interventions in reducing the barriers to HIV testing, promoting testing and providing post-test support and reflection (whether the test is positive or negative) was stressed.

The role of leader, responsible party or coordinator was stressed by event participants and interviewees with regard to most of the recommendations. They felt that without clearly defined leadership, implementation cannot be assured and the quality of any interventions and actions implemented will be in question.

Participants in events felt that local implementation of the recommendations would benefit substantially from the support of a range of national centrally coordinated interventions including general population campaigns, campaigns for MSM and capacity building campaigns with key professional groups (such as general practitioners). Central government or national organisations were identified as those who should be responsible for implementing these interventions.

In terms of ***implementability***, the following considerations emerged from both the events and the interviews.

In general, participants and interviewees saw the recommendations as 'future proof' with regard to pending changes to public spending, scrutiny and oversight – particularly in the area of public health commissioning. However, the need to revisit the guidance once changes had been announced and new structures have 'bedded in' was stressed at events.

The greatest perceived barriers to implementing the guidance overall were lack of current resources, future reduction in resources and funding, societal stigma and existing negative professional attitudes.

In terms of **clarity**, two concerns were identified by event participants and interviewees.

Overall, participants in interviews would like to see greater clarity and consensus regarding the aim of increasing HIV testing among MSM. That is whether this was case finding and treatment and/or opportunities to carry out HIV promotion interventions with those at highest risk. Some felt that the guidance would benefit by reference to the role of 'testing and treatment for prevention'. That is, testing to identify infection and risk as well as treatment to reduce population viral load and hence transmission.

Many participants and interviewees felt that the guidance differed from that issued by other bodies (such as BHIVA/BASHH) in some key respects. They felt that the guidance would benefit from being consonant with such other guidance.

Finally, one possible ***negative outcome*** of implementing the guidance was identified by group participants and interviewees. This was the potential risk of promoting HIV testing in isolation or without the context of a more general sexual health screen. Specifically those from clinical backgrounds were concerned that aim of testing for HIV only may lead to undiagnosed/untreated STIs. These are detrimental to health and will impact on susceptibility to HIV infection and infectiousness of those with HIV.

12.2   Recommendation 1

The recommendation regarding service planning was broadly supported by event participants and interviewees. Although the majority of areas where we held events already have informal coordination, there was consensus that formalising and documenting these processes would lead to improvements in service coordination and delivery. The need for clearer leadership in this respect was noted as was the inclusion of input from front-line workers and people with HIV.

12.3   Recommendation 2

The recommendation on integrated care pathways was broadly supported by event participants and interviewees. Although the majority of areas where we held events already have care pathways from the voluntary sector and other settings into GUM clinics in place, there was consensus that formalising and documenting these processes would lead to improvements in service delivery.

Care pathways from GUM to the voluntary sector were seen to be less evolved as were those to and from the voluntary sector and primary care settings. Moreover, care pathways for men who test negative (for example into community health interventions or psychological services) were seen to be largely absent. The need to develop these pathways was stressed.by many event participants.

Gay supportive psychology and counselling services were seen by event participants and interviewees as vital to work with groups of men at risk. However, many reported these services to be insufficient in all areas and largely absent in rural areas.

12.4   Recommendation 3

There was consensus amongst event participants and interviewees that the appropriate promotion of HIV testing in a range of settings was both desirable and would most likely lead to an increase in the uptake of HIV testing. Although the majority of areas in which we held events already carry out this kind of work, a better resourced and more focused approach was seen as having potential benefit.

Event participants and especially those from the community sector pointed out that there are a wide range of venues in which this work could be carried out (for example, broader community settings that are not places where sex or risk occurs) as well as a range of approaches to promoting testing (for example small group or face to face work as well as structural interventions to remove barriers to testing). These participants would like to see these approaches supported by the guidance alongside social market, advertising and materials etc.

The same participants stressed the need to encompass a range of groups of MSM (such as older men, young men, men from certain cultural ethnic or cultural backgrounds) in this work and to tailor interventions accordingly.

Promotion of HIV testing is only possible where a range of tests (such as fast tests and POCT) are available in a range of settings (such as GUM, primary care and community settings). In some areas, participants reported that this provision is not currently available. They therefore questioned the merit of promoting HIV testing in these areas.

Participants and interviewees stressed the potential role of government and national organisations in both promoting HIV testing to MSM and in reducing the barriers to accessing tests in a range of settings. They felt that the guidance should refer to and support these national interventions.

12.5   Recommendation 4

The overwhelming majority of participants and interviewees agreed that universal opt-out testing to all men accessing sexual health services would normalise and de-stigmatise the test and would therefore lead to an increase in the uptake of HIV testing. Although universally offering an opt-out test is perceived to be normal practice in GUM settings, participants at most events pointed out that there are no clear protocols for doing so.

A sizeable minority of participants raised concerns that universal testing would draw attention and resources away from targeting those at highest risk and pre-and post-test risk reduction interventions. There was therefore some disagreement that universal testing is the best use of resources or that it is cost-effective.

Participants and interviewees stressed the need to provide a clear definition of what constitutes a sexual health service (such as primary care settings, community settings, educational and custodial settings etc) as well as the specification of clear protocols for offering opt-out testing in the range of settings where sexual health services occur. They felt that this should attend particularly to issues of consent and confidentiality.

12.6   Recommendation 5

The provision of routine testing in primary care settings was generally supported by event participants and interviewees in terms of increasing access to testing, case finding as well as normalising and

hence de-stigmatising the test. However the need to develop clear protocols for offering and administering the HIV test in primary care settings was stressed alongside the need for training for appropriate clinic staff in these settings

Many participants and in particular interviewees working in general practice felt that increasing the availability of HIV testing in primary care settings would depend on incentivising general practice and including HIV testing in the Quality and Outcome Framework (QOF) for GPs.

Participants and interviewees also stressed the need for pilots for delivering HIV testing in general practice alongside the role of enhanced sexual health service GPs in normalising HIV testing in GP practices locally and regionally.

Finally participants emphasised the role for government in developing capacity amongst GPs with regard to HIV testing as well as promoting HIV testing (and sexual health screens) in primary care to the general public. In this respect, they felt that the guidance could mention national general public campaigns as well as capacity building interventions.

12.7   Recommendation 6

Participants and interviewees broadly welcomed this recommendation . The provision of HIV testing in non-standard and non-clinical settings was seen as a vital means of increasing the uptake of testing and identifying undiagnosed infection.

However, participants also felt that the recommendation may be too specific saying that testing in community settings encompasses a broad range of approaches (including offering POCT *in situ* but also accompanying men to static sites for testing or distributing self-sampling kits to men). Such testing can also happen in a range of venues in addition to those where sex occurs. They felt that the recommendation could be reworded to encompass this broader range of approaches.

Participants and interviewees also stressed the need to develop clear protocols for a range of 'community testing approaches'. This should include training of workers, targeting men for tests, administering the test, ensuring clinical governance as well as clear referral /care pathways.

12.8   Recommendation 7

Repeat testing was supported by the majority of participants and interviewees as a means of increasing early diagnosis and identifying men at risk for other interventions. However, participants in all groups emphasised the need to be clear why repeat testing was recommended. That is, it should not be seen as an appropriate or only intervention for men who take repeated risks. A range of other interventions should be available to those men who repeatedly take risks and test as well as those who test repeatedly despite little or no risk (the 'worried well').

Participants stressed the need for clear protocols regarding the offer and follow-up of repeat testing in a range of settings. These protocols should specify how to identify men for repeat tests, how to present repeat tests to the patient and why the patient is being advised to test again. They should also specify a range of approaches and methods for follow-up.

Participants in several groups stressed the need for clearer guidance on the window period: how it varies for different testing technologies and how to present this information to the patient.

12.9   Recommendation 8

Recommendation eight was supported universally in groups and amongst interviewees as training was seen to be vital in underpinning all other recommendations and improving testing services.

Participants and interviewees saw training for GPs as vital but difficult and resource intensive to implement. Training for VCS was also seen as vital but less difficult to implement.

The need for the development of clear protocols for training was stressed. This should include quality control procedures, curriculum development, monitoring and should specify learning outcomes.

The integration of training into pre-existing service training or continuing professional development training was seen as being preferable to developing stand alone training.

Participants and interviewees, and especially those from the voluntary and community sector, stressed the need to involve service users and MSM living with HIV in the development and delivery of training.

Finally participants were concerned that a perceived lack of 'intensive' training should not be seen as a reason not to offer HIV testing in non clinical or non-sexual health settings. However, this must be balanced with the need to ensure quality and clinical governance in non-clinic settings.

Appendix A Recruitment procedures, consent and confidentiality

Recruitment

Participants for workshops, web survey and telephone interviews were recruited through purposive sampling from pre-existing databases held by the partner agencies and others.

Sigma Research has a long history of community-based research and professional consultation within the sector and actively maintains and updates extensive contact databases with key contacts across all regions of England. In addition to this, Sigma has more than 675 subscribers to its website subscribers email list. These lists are comprised of:

- NHS staff (including commissioners, consultants, GU service providers and sexual health managers).
- Gay men's HIV voluntary sector agencies across England, including more than 120 collaborators with Sigma's annual *Gay Men's Sex Survey* and more than 60 collaborators within our surveys of African people and HIV.
- Local Authority staff (including commissioners and providers of housing and social care for populations with and affected by HIV).
- HIV voluntary sector agencies.

Database contacts and web-based email subscribers are accustomed to receiving and responding to periodic communications from Sigma Research regarding: publication and policy consultations, dissemination events, and workforce development events.

In addition to Sigma's own contact databases, NAM's role as a provider of expert HIV treatment information means that they have extensive and reliable contacts with GU and HIV clinical service providers nationwide. They rely upon this contact network for the distribution of their printed and online resources, as well as their community and provider consultation events and debates.

Recruitment to the consultation events became increasingly targeted – particularly once the 6 consultation event locations were chosen in collaboration with programme leads at NICE. We ensured a balance between areas of higher and lower HIV prevalence, as well as areas with larger and smaller gay commercial scenes. Selection of the 6 workshop event locations also ensured that we did not overlap too extensively with concurrent NICE consultation events on the African HIV testing guidance, as we aimed to avoid overloading certain areas with consultations.

Purposive sampling was undertaken to ensure representation from agencies and individuals with relevant experience of issues around HIV testing for MSM from a broad geographical area (starting with a focus in and near the 6 event locations), and equality issues were carefully attended to when constructing our sample. That is, we ensured representation from those working with specific groups of MSM who might be considered to be disadvantaged or have particular needs or circumstances (these groups include BME and migrant MSM, young MSM, MSM with low educational qualifications, behaviourally bisexual MSM and MSM with English as a second language).

Once an ideal sample for event participation was identified in (or within an hour's travel to) each of the 6 location, identified individuals received email invitations to participate. Recruitment was controlled to ensure an appropriate mix of individuals from different professional groups or sectors, and where a person was unable to attend, they were asked to nominate a colleague who might be able to attend in their place.

In total, 104 registered to attend the 6 consultation events, and 89 actually attended on the day.

Recruitment to the online survey began once attendance at the consultation events was saturated. The online survey was available from Noon on Thursday 21st October to 5pm on Wednesday 10th November 2010. It was promoted by:

- Email invitations to all of those on the original events sample list who were not able to attend;
- An email to the 695 people signed-up to the Sigma Research subscribers e-list;
- Inclusion in NAM's HIV Weekly email newsletter, and an email to a targeted subset of its e-list of HIV professionals;
- An email to all of the members of the National AIDS Trust's policy forum e-list;
- An email to the England HIV and Sexual Health Commissioners' Group; and
- An internal staff email forwarded to all Terrence Higgins Trust employees in England.

In total 183 people completed the survey, of which 7 were excluded from subsequent analysis as they did not work in England. Further information on the composition of the sample is given in section 2.3.

Consent and confidentiality

We always seek informed consent at various stages during the recruitment and fieldwork stages and adhere to ethical standards at all times. We take very seriously the confidentiality and anonymity of research participants who take part in any of our studies. We took special care to assure participants of the confidentiality of their participation at several stages of the recruitment and fieldwork process, and explained procedures for data storage, analysis and reporting. Fully informed consent was obtained from all respondents prior to participative workshops, interviews and undertaking the online survey, with information about the study provided in advance.

NatCen is notified under the Data Protection Act (Registration Number Z6133294). All staff and interviewers are made aware of the obligations this places on us. The importance of maintaining confidentiality is stressed in formal training events and is reinforced through occasions such as project-specific briefings of interviewers and coding staff. Staff undertake to abide by relevant codes of practice relating to social research and statistics, which include explicit clauses on confidentiality. It is a disciplinary offence for any individual to access identifiable data that is not necessary for his or her NatCen work.

Nominated individuals are responsible for Information Security and Data Protection and these people are supported by specific departmental representatives who have responsibility for their individual departments. Part of this responsibility includes ensuring security and confidentiality is maintained on an ongoing basis.

NatCen has developed a set of ISO27001 'Information Security Management' compliant procedures to ensure all data held by NatCen is stored and managed in a secure and controlled way.

Appendix B   Sample workshop plan and further details

Birmingham						
04th October 2pm-5pm						

Time	Activity	Peter	Catherine	Gary	Documents/Materials Required	NICE Rep
1.45-2.00	**Registration** *Participants given name badge and pack. Participants asked to fill out 1st ranking form. Participants sit at their allocated tables.*	Meet and Greet/ Register	Meet and Greet/ Register	Register	Conference pack - Full recommendation document - 1 per page print out of recommendations - Ranking form (Relevance), - Ranking form (Feasibility) - Feedback form, - Information sheet	
2.00 – 2.20	**Welcome and Introductory Presentation** *PPT presentation covering the process, target groups and covering all eight findings.*	Presenting	Presenting	Register latecomers	Presentation slides Projector & Screen	
2.20-2.35	**General Discussion** *The purpose of this is to ask general questions about the process. Also allows us to identify and park/allocate/ specific issues.*	Facilitating or Scribing	Facilitating or Scribing	Checking recorders Scribing	4-5 Recorders. Scribing paper and pen.	Answer questions.
2.35-3.00	**1st Small Group Discussion** *(Recs 2,4,5,6)* Each group assigned a recommendation (see chart x). Discuss (a) novelty (b) feasibility (c) implementability in local context. Then derive headline findings and narrative under each key heading.	Facilitating small group discussion	Facilitating small group discussion	Distributing sheets, Scribing, Checking recorders.	4-5 Recorders 4 x A3 Proforma sheets 4 x Individual aim sheets	
3.00-3.45	**Feedback: Recs 2,4,5&6** Feedback and facilitated whole group discussion.	Facilitating or Scribing	Facilitating or Scribing	Checking recorders, Scribing, Collecting pro-formas	Flipchart and pens	
3.45-4.00	**Tea/Coffee**	Prep next session, Collecting ranking sheets	Prep next session, Collecting ranking sheets	Prep next session, Collecting ranking sheets		
4.00-4.25	**2nd Small Group Discussion** *(Recs 1,3,7, 8)* Each group assigned a recommendation (see chart x). Discuss (a) novelty (b) feasibility (c) implementability in	Facilitating small group discussion	Facilitating small group discussion	Distributing sheets, Scribing, Checking recorders.	4-5 Recorders 4 x A3 Proforma sheets 4 x Individual aim sheets	

	local context. Then derive headline findings and narrative under each key heading.					
4.25-4.50	**Feedback: Recs 1,3,7&8.** Feedback and facilitated whole group discussion.	Facilitating or Scribing	Facilitating or Scribing	Checking recorders, Scribing, Collecting pro-formas	Flipchart and pens	
4.50 – 5.00	**Closing Remarks** Final General Discussion Remind to fill ranking before they leave Present next steps Promote Survey Thank participants	Facilitating or Scribing	Facilitating or Scribing	Collect ranking sheets. Hand out survey info slip.	Online information slip	Answer Questions

Composition and data capture

Workshop sizes varied between 13 and 23 participants, allowing for a multi-formatted workshop including some whole-group discussions as well as smaller break-out groups. Participants were emailed a copy of the draft guidance in full once they confirmed their attendance at the event. They were given printed copies of the recommendations as they registered on the day. The workshops were jointly facilitated by the lead researchers from NatCen and Sigma Research, with administrative and facilitation support also provided by other members of the NatCen research team. The workshop events were structured, in accordance with NICE guidance, to address key questions while exploring the draft guidance and its recommendations, including: content and scope, practice implications and impacts. Following the initial presentation, participants were invited to give their over-arching impression of the draft guidance. This allowed us to elicit unprompted responses to the document as a whole.

Large and small group discussions were audio-recorded, and large feedback discussions were also annotated by members of the research team. Small group work discussions focused around the completion of a question template, which served to focus conversation, as well as providing a scribed summary of the break-out discussions.

Break out groups

Purposeful sampling of participants taking part in the overall group and the smaller break-out groups were the key to the success of the participative workshops. The research team pre-selected which individual participants would join a particular small group discussion on a specific recommendation. This allowed us to ensure that those groups provided us with the perspective of a range of specific disciplines, sectors or approaches (for example the VCS perspective, the GUM perspective, the strategic or commissioning perspective, the perspective of counsellors / psychologists etc). This required taking a flexible approach to small group composition, purposively subdividing our larger group according to (a) numbers of attendees we achieved from each profession or sector and (b) the role of the individual within his or her sector. As the workshops progressed, we monitored the range of group perspectives we elicited and arranged participation in subsequent small group discussions accordingly. Research facilitators circulated among the small groups in order to assist with queries, and to keep the conversation focused on the questions provided on the question form for the single recommendation being discussed by that small group.

Appendix C Sample small group form

Names of people in your group:

_____
_____
_____
_____
_____

Increasing the uptake of HIV testing to reduce undiagnosed infection and prevent transmission among MSM
Breakout Group Discussion

Recommendation 1: planning services
Summary points:
- Strategic planning to encourage MSM to test with input from an array of stakeholders.
- Inform planning with existing strategic frameworks such as 'Making it Count' (Hickson *et al*. 2003)
- Employ needs assessment, service mapping and outcome evaluation to inform commissioning.
- Ensure the strategy attends to the needs of diverse groups, with particular attention for those in greatest need, and that it is regularly evaluated.

---

1. Does this recommendation describe new ways of working or new activities? What?

_____
_____

2. Does your group consider this recommendation to be clear and easy to understand?

_____
_____

3. Consider who it is that should 'take action'. Is the recommendation relevant and appropriate for people in those roles?

_____
_____

Does your group feel that this recommendation is implementable? Why or why not?

_____

_____

Implications and outcomes: How might this recommendation build on, weaken or improve current practice? What are the implications of this?

Barriers and challenges: - What are the barriers to and opportunities for implementing this recommendation?
-Are their particular groups of service users and/or professionals who would find the activity associated with this recommendation either impractical or inaccessible?
-What resource implications may this recommendation carry with it?

Appendix D Online survey text

National Institute for Health and Clinical Excellence

NatCen **Sigma** RESEARCH **nam**

Increasing the uptake of HIV testing to reduce undiagnosed infection and prevent transmission among MSM

On 27 September 2010, the National Institute for Clinical Excellence (NICE) released a draft public health guidance: Increasing the uptake of HIV testing to reduce undiagnosed infection and prevent transmission among MSM. The draft guidance is available in full on the NICE website:

http://www.nice.org.uk/guidance/index.jsp?action=folder&o=50929 The National Centre for Social Research, Sigma Research and NAM have been commissioned to undertake a consultation among professionals in the HIV prevention, care and treatment sector to test the draft's novelty, useability and feasibility. If you have already or are planning to attend a face-to-face consultation event (administered by NatCen), please do not complete this survey. It is designed for those unable to attend one of the six events being held in Birmingham, Sheffield, York, Brighton, Liverpool and London in the next few weeks. As you proceed, the text of a single draft recommendation will appear in full, prior to a set of questions about it. There are eight draft recommendations in total. We anticipate that this survey should take you no more than 20 minutes to complete (and probably less time for those who are already familiar with the draft guidance). Your responses are entirely anonymous, and we ensure that no individual will be identified in any report we publish. Please contact catherine.dodds@sigmaresearch.org.uk if you have any questions about this process or the content of this survey.

[text of **Recommendation 1: planning services** inserted here]

4. Is **Recommendation 1: planning services** clear and easy to understand?
    □ *Yes*
    □ *No*
    □ *Not sure*

5. Does **Recommendation 1: planning services** describe new ways of working or new activities in relation to the organisation you work for?
    □ *Yes*
    □ *No*
    □ *Not sure*

6. Do you feel that **recommendation 1: planning services** would help to improve local HIV testing services?

□ *Yes*

□ *No >please say why not* _____

□ *Not sure*

7. In your opinion, is **recommendation 1: planning services** locally implementable?

□ *Yes*

□ *No*

□ *Not sure*

Please say why you gave the answer above

_____

_____

_____

8. Do you have any further comments about **recommendation 1: planning services**?

[text of **Recommendation 2: integrated care pathways** inserted here]

9. Is **recommendation 2: integrated care pathways** clear and easy to understand?

□ *Yes*

□ *No*

□ *Not sure*

10. Does **recommendation 2: integrated care pathways** describe new ways of working or new activities in relation to the organisation you work for?

□ *Yes*

□ *No*

□ *Not sure*

11. Do you feel that **recommendation 2: integrated care pathways** would help to improve local HIV testing services?

□ *Yes*

□ *No > Please say why not:*

_____

□ *Not sure*

12. In your opinion, is **recommendation 2: integrated care pathways** locally implementable?

□ *Yes*

□ *No*

□ *Not sure*

Please say why you gave the answer above:

_____

_____
_____

13. Do you have any further comments about **recommendation 2: integrated care pathways**?

[text of **Recommendation 3: promoting HIV testing and reducing barriers** inserted here]

14. Is **recommendation 3: promoting HIV testing and reducing barriers** clear and easy to understand?
    □ *Yes*
    □ *No*
    □ *Not sure*

15. Does **recommendation 3: promoting HIV testing and reducing barriers** describe new ways of working or new activities in relation to the organisation you work for?
    □ *Yes*
    □ *No*
    □ *Not sure*

16. Do you feel that **recommendation 3: promoting HIV testing and reducing barriers** would help to improve local HIV testing services?
    □ *Yes*
    □ *No > Please say why*
    not_____
    □ *Not sure*

17. In your opinion, is **recommendation 3: promoting HIV testing and reducing barriers** locally implementable?
    □ *Yes*
    □ *No*
    □ *Not sure*
    Please say why you gave the answer above:
    _____
    _____
    _____

18. Do you have any further comments about **recommendation 3: promoting HIV testing and reducing barriers**?

[text of **Recommendation 4: universal HIV testing in sexual health services** inserted here]

19. Is **recommendation 4: universal HIV testing in sexual health services** clear and easy to understand?
□ *Yes*
□ *No*
□ *Not sure*

20. Does **recommendation 4: universal HIV testing in sexual health services** describe new ways of working or new activities in relation to the organisation you work for?
□ *Yes*
□ *No*
□ *Not sure*

21. Do you feel that **recommendation 4: universal HIV testing in sexual health services** would help to improve local HIV testing services?
□ *Yes*
□ *No > Please say why*
not:_____
□ *Not sure*

22. In your opinion, is **recommendation 4: universal HIV testing in sexual health services** locally implementable?
□ *Yes*
□ *No*
□ *Not sure*
Please say why you gave the answer above:

_____
_____
_____

23. Do you have any further comments about **recommendation 4: universal HIV testing in sexual health services**?

[text of **Recommendation 5: routine HIV testing in primary care** inserted here]

24. Is **recommendation 5: routine HIV testing in primary care** clear and easy to understand?
□ *Yes*
□ *No*
□ *Not sure*

25. Does **recommendation 5: routine HIV testing in primary care** describe new ways of working or new activities in relation to the organisation you work for?
□ *Yes*
□ *No*
□ *Not sure*

26. Do you feel that **recommendation 5: routine HIV testing in primary care** would help to improve local HIV testing services?
□ *Yes*
□ *No > Please say why*
not:_____
□ *Not sure*

27. In your opinion, is **recommendation 5: routine HIV testing in primary care** locally implementable?
□ *Yes*
□ *No*
□ *Not sure*
Please say why you gave this answer:

_____
_____
_____

28. Do you have any further comments about **recommendation 5: routine HIV testing in primary care**?

[text of **Recommendation 6: outreach rapid point-of-care tests** inserted here]

29. Is **recommendation 6: outreach rapid point-of-care tests** clear and easy to understand?
□ *Yes*
□ *No*
□ *Not sure*

30. Does **recommendation 6: outreach rapid point-of-care tests** describe new ways of working or new activities in relation to the organisation you work for?
□ *Yes*
□ *No*
□ *Not sure*

31. Do you feel that **recommendation 6: outreach rapid point-of-care tests** would help to improve local HIV testing services?
□ *Yes*
□ *No > Please say why*
not:_____
□ *Not sure*

32. In your opinion, is **recommendation 6: outreach rapid point-of-care tests** locally implementable?
□ *Yes*
□ *No*

□ *Not sure*
Please say why you gave this answer above:

_____

_____

_____

33. Do you have any further comments about **recommendation 6: outreach rapid point-of-care tests**?

[text of **Recommendation 7: repeat testing** inserted here]

34. Is **recommendation 7: repeat testing** clear and easy to understand?
    □ *Yes*
    □ *No*
    □ *Not sure*

35. Does **recommendation 7: repeat testing** describe new ways of working or new activities in relation to the organisation you work for?
    □ *Yes*
    □ *No*
    □ *Not sure*

36. Do you feel that **recommendation 7: repeat testing** would help to improve local HIV testing services?
    □ *Yes*
    □ *No > Please say why not:*
    _____
    □ *Not sure*

37. In your opinion, is **recommendation 7: repeat testing** locally implementable?
    □ *Yes*
    □ *No*
    □ *Not sure*
    Please say why you gave this answer:

    _____

    _____

    _____

38. Do you have any further comments about **recommendation 7: repeat testing**?

[text of **Recommendation 8: training** inserted here]

39. Is **recommendation 8: training** clear and easy to understand?
    □ *Yes*

□ *No*

□ *Not sure*

40. Does **recommendation 8: training** describe new ways of working or new activities in relation to the organisation you work for?

□ *Yes*

□ *No*

□ *Not sure*

41. Do you feel that **recommendation 8: training** would help to improve local HIV testing services?

□ *Yes*

□ *No > Please say why not:_____*

□ *Not sure*

42. In your opinion, is **recommendation 8: training** locally implementable?

□ *Yes*

□ *No*

□ *Not sure*

Please say why you gave this answer:

_____

_____

_____

43. Do you have any further comments about **recommendation 8: training**?

OVERALL COMMENTS

44. What do you consider the main barriers to implementing these recommendations?

45. Which professional groups do you think will find these recommendations hardest to implement?

□ *Clinical staff in A&E*

□ *Clinical staff in genitourinary medicine*

□ *Clinical staff in specialist sexual health services*

□ *Clinical staff in walk-in centres, health centres and community clinics*

□ *Commissioners for sexual health and local sexual health networks*

□ *Commissioners for public health*

□ *Commercial venue owners*

□ *Commercial venue staff*

□ *Community workers and other detached staff*

□ *Directors of public health*

□ *General practitioners*

□ *Health promoters*

□ *Local authority staff with remit for health promotion among MSM*

□ *Media outlets targeting MSM*

□ *Primary care staff*

□ *Primary care practice managers*

□ *Primary care practice nurses*

□ *Public health specialists*

□ *Public health consultants*

□ *Service managers in genitourinary medicine*

□ *Service managers in sexual health services*

□ *Service managers in primary care*

□ *Trainers responsible for continuing professional development in the health sector*

□ *Voluntary sector staff with a remit for health promotion among MSM*

46. Do you think the costs associated with these recommendations are worthwhile in relation to the potential service improvement?
   □ *No*
   □ *Yes*
   □ *Not sure*

ABOUT YOU

47. Which of the following roles do you carry out? (tick as many as apply)
   □ *Health promoter*
   □ *Staff at an HIV or MSM voluntary sector agency*
   □ *Volunteer at an HIV charity*
   □ *Administration / managerial duties*
   □ *Counsellor / psychiatrist*
   □ *Researcher*
   □ *Policy officer / policy maker*
   □ *Consultant > what type?_____*
   □ *Commissioner > of what? _____*
   □ Nurse > *what type*? _____
   □ General practitioner
   □ A&E clinician
      □ Other> *please say what _____*

48. In which strategic health authority area do you carry out your work? (tick as many as apply)
   □ *East of England*
   □ *East Midlands*
   □ *London*
   □ *North East*
   □ *North West*

□ *South Central*

□ *South East Coast*

□ *South West*

□ *West Midlands*

□ *Yorkshire and the Humber*

□ *National (across England as a whole)*

49. What environment would you say your work is mainly carried out in?
    □ *Urban*
    □ *Rural*
    □ *Even mix between the two*

50. Is there anything further that you would like to say about the recommendations, this questionnaire or the broader consultation process?

Appendix E Interview topic guide

P3046: Testing NICE Guidance for HIV Testing with MSM.

Topic Guide for phone interviews with GPs

Purpose of Interview
To briefly gain GPs opinions on the novelty (newness), implementability and feasibility of the 8 recommendations that make up the NICE Guidance.

Before the interview starts:

Check the recorder is on.

Remind respondent that the interview is entirely confidential. We will not name them in any report and will not used attributable or identifiable quotes.

Check with respondent that it is OK to record the interview.

Let them know structure of interview (that we'll be going through each recommendation and asking the same set of questions for each)- This will allow them to save their burning comments on a particular recommendation for that recommendation. Also, if they have little to say on a particular recommendation, that's fine too. It means more time to spend on the rec they are interested in!

Be aware that they will have most to say about recommendation 5.

Clarify our role – we are testing the guidance. We did not draft it and we are entirely independent of NICE

Recommendation 1: Planning Services

1.1 Have you had a chance to read this recommendation?
      If not recap (take text from the event presentation slide)

1.2 Before I ask you about implementing recommendation 1, I just want to check, is the recommendation clear and easy to understand?
      Probe: Why do you say that?

1.3 Does recommendation 1 describe **new ways of working or new activities** in relation to Primary Care services?
      Prompt: Does this describe new ways of working for YOU?

Probe: What is new?
Probe: Why do you say that?

1.4 Do you feel that recommendation 1 would **help to improve local HIV testing services**?
Probe: Why do you say that?

1.5 In your opinion, is recommendation 1 **locally implementable**?
Probe: Why do you say that?
Prompt: What would you say the main barriers are to implementing recommendation 1
Prompt: What would you say are the main facilitators to implementing recommendation 1

1.6 Do you have **any other comments** about recommendation 1?

Recommendation 2: Integrated care pathways

2.1 Have you had a chance to read this recommendation?
If not recap (take text from the event presentation slide)

2.2 Before I ask you about implementing recommendation 2, I just want to check, is the recommendation clear and easy to understand?
Probe: Why do you say that?

2.3 Does recommendation 2 describe **new ways of working or new activities** in relation to Primary Care services?
Prompt: Does this describe new ways of working for YOU?
Probe: What is new?
Probe: Why do you say that?

2.4 Do you feel that recommendation 2 would **help to improve local HIV testing services**?
Probe: Why do you say that?

2.5 In your opinion, is recommendation 2 **locally implementable**?
Probe: Why do you say that?
Prompt: What would you say the main barriers are to implementing recommendation 2
Prompt: What would you say are the main facilitators to implementing recommendation 2

2.6 Do you have **any other comments** about recommendation 2?

Recommendation 3: Integrated care pathways

3.1 Have you had a chance to read this recommendation?
      If not recap (take text from the event presentation slide)

3.2 Before I ask you about implementing recommendation 3, I just want to check, is the recommendation clear and easy to understand?
      Probe: Why do you say that?

3.3 Does recommendation 3 describe **new ways of working or new activities** in relation to Primary Care services?
      Prompt: Does this describe new ways of working for YOU?
      Probe: What is new?
      Probe: Why do you say that?

3.4 Do you feel that recommendation 3 would **help to improve local HIV testing services**?
      Probe: Why do you say that?

3.5 In your opinion, is recommendation 3 **locally implementable**?
      Probe: Why do you say that?
      Prompt: What would you say the main barriers are to implementing recommendation 3
      Prompt: What would you say are the main facilitators to implementing recommendation 3

3.6 Do you have **any other comments** about recommendation 3?

Recommendation 4: Universal Testing in Sexual Health Services

4.1 Have you had a chance to read this recommendation?
      If not recap (take text from the event presentation slide)

4.2 Before I ask you about implementing recommendation 4, I just want to check, is the recommendation clear and easy to understand?
      Probe: Why do you say that?

4.3 Does recommendation 4 describe **new ways of working or new activities** in relation to Primary Care services?
      Prompt: Does this describe new ways of working for YOU?
      Probe: What is new?
      Probe: Why do you say that?

4.4 Do you feel that recommendation 4 would **help to improve local HIV testing services**?

Probe: Why do you say that?

4.5 In your opinion, is recommendation 4 **locally implementable**?
Probe: Why do you say that?
Prompt: What would you say the main barriers are to implementing recommendation 4
Prompt: What would you say are the main facilitators to implementing recommendation 4

4.6 Do you have **any other comments** about recommendation 4?

Recommendation 5: Routine Testing in Primary Care

5.1 Have you had a chance to read this recommendation?
If not recap (take text from the event presentation slide)

5.2 Before I ask you about implementing recommendation 5, I just want to check, is the recommendation clear and easy to understand?
Probe: Why do you say that?

5.3 Does recommendation 5 describe **new ways of working or new activities** in relation to Primary Care services?
Prompt: Does this describe new ways of working for YOU?
Probe: What is new?
Probe: Why do you say that?

5.4 Do you feel that recommendation 5 would **help to improve local HIV testing services**?
Probe: Why do you say that?

5.5 In your opinion, is recommendation 5 **locally implementable**?
Probe: Why do you say that?
Prompt: What would you say the main barriers are to implementing recommendation 5
Prompt: What would you say are the main facilitators to implementing recommendation 5

5.6 Do you have **any other comments** about recommendation 5?

Recommendation 6: Outreach Rapid Point-of-Care Tests

6.1 Have you had a chance to read this recommendation?
If not recap (take text from the event presentation slide)

6.2 Before I ask you about implementing recommendation 6, I just want to check, is the recommendation clear and easy to understand?

> *Probe: Why do you say that?*

6.3 Does recommendation 6 describe **new ways of working or new activities** in relation to Primary Care services?

> *Prompt: Does this describe new ways of working for YOU?*
> *Probe: What is new?*
> *Probe: Why do you say that?*

6.4 Do you feel that recommendation 6 would **help to improve local HIV testing services**?

> *Probe: Why do you say that?*

6.5 In your opinion, is recommendation 6 **locally implementable**?

> *Probe: Why do you say that?*
> *Prompt: What would you say the main barriers are to implementing recommendation 6*
> *Prompt: What would you say are the main facilitators to implementing recommendation 6*

6.6 Do you have **any other comments** about recommendation 6?

Recommendation 7: Repeat Testing

7.1 Have you had a chance to read this recommendation?

> If not recap (take text from the event presentation slide)

7.2 Before I ask you about implementing recommendation 7, I just want to check, is the recommendation clear and easy to understand?

> *Probe: Why do you say that?*

7.3 Does recommendation 7 describe **new ways of working or new activities** in relation to Primary Care services?

> *Prompt: Does this describe new ways of working for YOU?*
> *Probe: What is new?*
> *Probe: Why do you say that?*

7.4 Do you feel that recommendation 7 would **help to improve local HIV testing services**?

> *Probe: Why do you say that?*

7.5 In your opinion, is recommendation 7 **locally implementable**?

> *Probe: Why do you say that?*

Prompt: What would you say the main barriers are to implementing recommendation 7?

Prompt: What would you say are the main facilitators to implementing recommendation 7?

7.6 Do you have **any other comments** about recommendation 7?

Recommendation 8: Training

8.1 Have you had a chance to read this recommendation?
　　　If not recap (take text from the event presentation slide)

8.2 Before I ask you about implementing recommendation 8, I just want to check, is the recommendation clear and easy to understand?
　　　Probe: Why do you say that?

8.3 Does recommendation 8 describe **new ways of working or new activities** in relation to Primary Care services?
　　　Prompt: Does this describe new ways of working for YOU?
　　　Probe: What is new?
　　　Probe: Why do you say that?

8.4 Do you feel that recommendation 8 would **help to improve local HIV testing services**?
　　　Probe: Why do you say that?

8.5 In your opinion, is recommendation 8 **locally implementable**?
　　　Probe: Why do you say that?
　　　Prompt: What would you say the main barriers are to implementing recommendation 8
　　　Prompt: What would you say are the main facilitators to implementing recommendation 8

8.6 Do you have **any other comments** about recommendation 8?

9: Concluding Questions

9.1 Finally, overall, what kind of impact do you think these recommendations will make on increasing HIV testing among MSM in your area?
　　　Why do you say that?

9.2 Which professional groups (for example GUM, the voluntary Sector, Primary Care) do you think will have most difficulty implementing these recommendations?

Why do you say that?

9.3 Thinking about the costs of implementing these recommendations, do you think the costs associated with these recommendations are worthwhile in relation to the potential service improvement?

Why do you say that?

9.4 Before we finish, do you have any other comments on these recommendations?

For information:

- We are reporting on this process to NICE on 23rd Nov.
- PHIAC meets on 10th Dec to consider this research amongst other things.
- NICE is running their own public consultation (available on their website)
- The guidance should be finalised and public in March 2011
- The report of this research will be available on NatCen, Sigma Research and NICE websites.

- Thank respondent
- Turn off taperecorder