NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

HIV testing: encouraging uptake

Date of quality standards advisory committee post-consultation meeting:
17 May 2017

2 Introduction

The draft quality standard for HIV testing was made available on the NICE website for a 4-week public consultation period between 27th March and 21st April. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 18 organisations, which included service providers, commissioners, national organisations, professional bodies and others.

This report provides the quality standards advisory committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the committee as part of the final meeting where the committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the committee should read this summary alongside the full set of consultation comments, which are provided in appendices 1 and 2.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be to be for these to be put in place?

3. Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

6. Do you have an example from practice of implementing the NICE guideline that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

Stakeholders were also invited to respond to the following statement specific questions:

4. For draft quality statement 3: We have identified indicator conditions that could be a priority for local measurement from the longer list of indicator conditions identified by HIV in Europe. Will it be practical to implement this?

5. For draft quality statement 6: The 3-month timescale included in the process measure is derived from the British HIV Association HIV partner notification standards for sexual health services and is included to aid measurability. Is this timescale an appropriate focus for quality improvement in all settings responsible for contacting people who may be at risk following a diagnosis of HIV?

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- There was general support for the quality standard and the areas identified for quality improvement.
- There were mixed opinions on the focus on areas with a high prevalence of HIV:
  - Focusing on these areas may make it more difficult to encourage healthcare professionals to increase HIV testing in lower prevalence areas with high rates of late diagnosis.
  - The acceptability of offering HIV tests simply because of where people live was questioned.
  - Raising awareness in high prevalence areas may eventually increase self-referral in other areas/populations.
- Stakeholders had different views on the best approach to offering an HIV test:
  - Some supported 'opt-out' HIV tests and informing clinicians that pre-test counselling is no longer required.
  - Others were concerned that making HIV testing more routine will compromise the process of decision making and mean that patients will not be able to give genuine informed consent.
- There were some general suggestions for improvements to the quality statements:

- The wording ‘offered an HIV test’ should be replaced with a more prescriptive term such as ‘have an HIV test’, ‘are tested for HIV’ or ‘are recommended to have an HIV test’.
- Structure measures could focus on ensuring that processes are in place that are searchable.
- The Sentinel surveillance of blood borne virus testing is not an appropriate data source.
- There should be more emphasis on the role of GUM/sexual health services.

Consultation comments on data collection

- The genitourinary medicine clinic activity dataset (GUMCADv3) may be a suitable data source for some measures.
- Electronic patient records and Order-Comm systems may need to be modified in general practice and hospitals in order to collect the data required.
- There is potential to include some of the measures in Public Health England datasets such as HARS.
- There was a request for NICE to provide common codes for local audits.

Consultation comments on resource impact

- There was some concern that the current complexity of sexual health commissioning will mean that it is difficult to fund improvements in HIV testing, particularly in hospitals and primary care settings. It was suggested that, given current financial pressures, local authorities may not be able to afford to fund improvements in HIV testing, and therefore collaborative commissioning and agreement will be required.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

Adults and young people admitted to hospital or who attend an emergency department are offered an HIV test in areas of extremely high HIV prevalence or in areas of high HIV prevalence if they have a blood test.

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- Statement
  - It needs to be clearer that testing is recommended for all elective and emergency admissions.
  - The statement should be extended to include all outpatient settings and indicator conditions.
  - Testing for other blood borne viruses such as hepatitis C should be included.
- Measures
  - It is feasible to collect the data.
  - The denominator for the process measures requires disclosure of known HIV status which could be a barrier to the routine offer of a test in an emergency setting.
  - The text in the data source section for the process measures should be revised as it indicates that almost all patients attending A&E could be excluded.
  - There were different opinions on whether a measure of the offer of a test should also be included. Some felt that it would be difficult to measure but others suggested that it is important because some people will not accept the offer of a test.
- Audience descriptors
  - It would be helpful to include specific suggestions for hospital services and departments that should offer HIV testing such as medical admissions units, haemotology, ENT and dermatology.

- There should be more emphasis on adopting an opt-out approach (e.g. with signs on the walls) as otherwise the perceived need to ask the patient for permission will remain a barrier to increased testing.
- It should be clear that:
  - ◊ processes need to be in place in case the person is discharged prior to the test result being available.
  - ◊ care pathways should be in place for those who test positive.
- Local authorities should be included as a commissioner and they should work jointly with CCGs to fund HIV testing.
- There was concern about using the term ‘high-risk’ rather than ‘high prevalence’ in the descriptor for patients.

5.2 Draft statement 2

Adults and young people in areas of high or extremely high HIV prevalence are offered an HIV test by their GP when registering or when having a blood test if they have not had an HIV test in the last 12 months.

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- Statement
  - Concern about including a quality statement on screening procedures that are outside the General Medical Services contract.
  - Concerns about implementation and funding:
    - Local experience suggests that it may be difficult to implement HIV testing at GP registration.
    - Due to the patient profile routine testing of people having a blood test at their GP surgery could be a waste of resources and it would be better to adopt a more targeted approach.
    - There were concerns about resource impact and in particular the impact on pathology contracts. It was suggested that evidence of successful UK funding models for this statement are needed.
  - Testing for hepatitis C should be included.
  - There was a suggestion for an alternative statement for GP surgeries in high prevalence areas that highlights all the situations when HIV testing should be offered (also including sexual health/contraception care, indicator conditions, at risk groups and repeat testing).
- Measures
  - It may not be feasible to measure the offer of a test.
  - An additional measure on uptake of HIV testing at registration should be included.
  - There was support for the measure of HIV testing rate per 1000 patients as an integrated measure of performance and a suggestion that this could be used for benchmarking.

- Audience descriptors
  - It is important to ensure that GP practices are aware of local HIV prevalence and that they are offered support to implement routine HIV testing such as training.
  - Opt-out testing should be recommended as clinicians may not be comfortable offering a test.
  - Local authorities should be included as a commissioner and funding expectations should be clear e.g. collaborative commissioning.
  - Care pathways should be in place for those who test positive.
- Definitions
  - A definition of testing is needed to clarify if venous sampling or point of care testing should be used.

5.3 Draft statement 3

Adults and young people diagnosed with an indicator condition are offered an HIV test.

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- Statement
  - There was general support for this statement.
  - Testing for other blood borne viruses such as hepatitis C and syphilis testing should be included for those with an STI indicator condition.
- Measures
  - It may be difficult to measure the number of people diagnosed with an indicator condition in primary care.
- Audience descriptors
  - It is important to include GUM/sexual health services and hospital outpatient settings where indicator conditions are likely to be seen (such as colposcopy, anal dysplasia clinics, and lymphadenopathy assessment clinics).
  - It is important to ensure that GPs and clinicians who do not routinely offer HIV testing are aware of indicator conditions and are offered support to implement testing, such as training.
  - Some specific suggestions were made to encourage testing:
    - Technology could be used to automatically prompt when HIV testing is required, for example, via laboratory reports and GP systems.
    - Opt-out testing
    - Anonymised testing in primary care as some people avoid testing in primary care due to concerns about confidentiality.
  - Care pathways should be in place for those who test positive.

Consultation question 4

We have identified indicator conditions that could be a priority for local measurement from the longer list of indicator conditions identified by HIV in Europe. Will it be practical to implement this?

Stakeholders made the following comments in relation to consultation question 4:

- Agreement that the prioritised list of indicator conditions is reasonable, although there were some concerns that it may still be too long to be practical to implement.
- Improvements were identified as follows:
  - Simplify list to include all cases of lymphoma and pneumonia
  - Focus on main conditions which are commonly missed such as pneumocystis pneumonia, shingles, oral candidiasis and weight loss.
- Confusion about whether some conditions are restricted to areas with a high HIV prevalence (HIV prevalence of >0.1%).

5.4 Draft statement 4

Adults and young people in at-risk groups in areas of high and extremely high HIV prevalence can find information about HIV testing services, including self-sampling.

Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

- Statement
  - The statement is important to ensure that local areas have a strategic approach to providing information but it may be difficult to measure.
  - Access to information should be universal and therefore the statement should not be limited to high prevalence areas. People at risk in low prevalence areas may be particularly vulnerable to late diagnosis.
  - 'Can find information' should be replaced with 'are provided with information'.
  - Include wider information about blood borne virus testing services.
- Measures
  - Structure measure should be more specific about where information should be made available.
  - Resource implications for carrying out local surveys although it may be possible to get sexual health outreach workers to collect this information.
- Audience descriptors
  - Important to emphasise that funding to provide self-sampling kits is available.
- Definitions
  - 'Including those who participate in high-risk sexual practices such as 'chemsex' is unnecessary and potentially confusing.
  - Trans men who have sex with men should be included.

5.5 Draft statement 5

Adults and young people in at-risk groups who test negative for HIV are advised to repeat the test at least annually.

Consultation comments

Stakeholders made the following comments in relation to draft statement 5:

- Statement
  - ‘At least annually’ is not specific enough and too long an interval for at risk groups.
  - The population should be based on risk behaviour rather than risk group.
  - Should include testing for hepatitis C for those who test negative for HIV and advice on annual repeat testing for hepatitis C for those who remain at risk.
- Measures
  - At risk groups may not be adequately recorded outside sexual health services and therefore steps will need to be taken to improve this.
  - It will be difficult to collect data on whether people have been advised to repeat testing.
  - The denominator for outcome measure a) should be people who have used the service previously.
- Audience descriptors
  - Advice on retesting should be accompanied with information and advice on safe sex, behaviour change and prevention advice.
- Definitions
  - Should include trans men who have sex with men.
  - People tested for chlamydia in primary care should be excluded as they may be tested because their symptoms could be explained by chlamydia even though their risk is low.

5.6 Draft statement 6

People identified as at risk of HIV from contact with an adult or young person newly diagnosed with HIV are offered an HIV test.

Consultation comments

Stakeholders made the following comments in relation to draft statement 6:

- Statement
  - The current wording may lead to misconceptions about potential routes of transmission for HIV. Alternative wording suggested '*People newly diagnosed with HIV have the opportunity to identify people known to them who may have been exposed and those people are contacted and offered an HIV test'*.
  - Should be clearer that testing children of HIV infected women is included.
- Measures
  - Clarify if the denominator for the process measure should be 'identifiable contacts'.
- Rationale
  - The wording should clarify potential transmission routes rather than just including these in the definition.
- Audience descriptors
  - Consider a specific descriptor for GP setting that emphasises the need to make a referral and check that the person attends (electronic systems could notify re. non-attendance).

Consultation question 5

The 3-month timescale included in the process measure is derived from the British HIV Association HIV partner notification standards for sexual health services and is included to aid measurability. Is this timescale an appropriate focus for quality improvement in all settings responsible for contacting people who may be at risk following a diagnosis of HIV?

Stakeholders made the following comments in relation to consultation question 5:

- The majority of stakeholders agreed that this timescale is appropriate and could be implemented.
- The 3 month timescale should be a maximum.
- The timescale could be challenging for patients who are struggling with the diagnosis or who are very sick and therefore it would be worth collecting the data over a longer period.

Appendix 1: Quality standard consultation comments table – registered stakeholders

ID	Stakeholder	Statement number	Comments[1]
	Association of Directors of Public Health	General	Overall, we agree with the thinking in this guidance, but practically it would involve a lot of collaborative commissioning and agreement.
1	British Association for Sexual Health and HIV (BASHH)	General	Many thanks for the opportunity to review this. We have collated comments from members of the BASHH HIV Special Interest Group (SIG) regarding each statement as below and hope these will address some of the questions posed. We have a general concern as to what is to be regarded as 'extremely high prevalence', and would like reassurance that this will not deter from attempts to provide more universal testing at the 2:1000 level. Defining the cut off for HIV screening to above 2 per 1000 strikes may be counterproductive. This approach would miss on reduction of late HIV diagnosis in areas with lower prevalence of HIV. For example in the West Midlands, Staffordshire has a prevalence of 0.72 per 1000 adults, and yet a rate of 47% for late HIV diagnosis. Many of our colleagues may not be able to convince GP/A&E colleagues to increase HIV testing if following the proposed NICE guidelines. The quality standard may also consider requiring senior health professionals in GUM and HIV to promote education and awareness actively through teaching programmes, grand rounds, mortality reviews and so on, and to have a written local strategy for this. We hope these comments will be of use and would be happy to consider any further queries if they should arise. Yours sincerely Dr Tristan Barber Chair, on behalf of the BASHH HIV SIG
2	British HIV Association	General	We believe that the term 'offer' in each of these statements (1-3 & 6) is not sufficiently prescriptive. Arguments for adopting a more prescriptive term than 'offering' HIV testing are: 1. HIV is a serious infectious disease with high mortality if diagnosed late. 2. Diagnosing HIV earlier is beneficial to society since it reduces transmission of infections.

[1]PLEASE NOTE: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees.

ID	Stakeholder	Statement number	Comments[1]
			3. The term ‘offer’ is more consistent with the ‘AIDS exceptionalism’ era when testing for HIV was perceived to be different to other routine tests and required pre-test counselling. Current attempts to normalise HIV testing through ‘opt-out’ and other testing strategies are hampered by the use of terms such as ‘offering’ tests. 4. The term ’offer’ suggests uncertainty or ambivalence on the part of the clinician as to the medical benefit of having an HIV test, which should clearly not be the case given the extensive evidence available. In fact one could argue that HIV testing has a greater clinical and cost-effectiveness benefit, and less risk attached, than many tests we currently recommend (rather than ‘offer’) to patients. Whilst it might be reasonable to recommend a test to patients without indictor conditions or other risk factors (e.g. screening in areas of high/very high prevalence) there should be no doubt that testing is an absolute necessity for patients with indictor conditions or risk factors. 5. Most other NICE quality standards do not use the term ‘offer’, or suggest clinicians do anything but strongly recommend or complete an important course of action, when referring to key diagnostic tests e.g. ‘People presenting in primary care with symptoms that suggest oesophageal or stomach cancer have an urgent direct access upper gastrointestinal endoscopy.’ [QS124]; ‘People with suspected deep vein thrombosis have all diagnostic investigations completed within 24 hours of first clinical suspicion.’ [QS29]; ‘Adults with spinal pain suggestive of spinal metastases, have an MRI of the whole spine and any necessary treatment plan agreed within 1 week of the suspected diagnosis.’[QS56]; ‘People who are referred to a tuberculosis (TB) service, who meet specific criteria, have rapid diagnostic nucleic acid amplification tests (NAATs). [QS141]’; Adults presenting in primary care with symptoms that suggest colorectal cancer, have a test for blood in their faeces.’ [QS124] Suggested replacement terms (alternatives to ‘offer’): 1. Have an HIV test… 2. Are tested for HIV 3. Are recommended to have an HIV test…. (less ideal than above term, but could be used where test is suggested for patients more as a screening test, e.g. new registrants at GP surgeries or attenders at A&E departments in areas of high HIV prevalence) We believe that using either of the three above terms (rather than ‘offer’) will make these quality standards more consistent with other NICE quality standards, provide greater impetus to clinicians to test patients in each of these situations and consequently improve compliance with these quality measures.
3	British HIV Association	General	We believe that it should be made explicit in these standards that for the vast majority of HIV tests, opt-out tests are provided and that pre-test counselling is no longer needed for most patients. Unfortunately, particularly in some lower-prevalence areas, many clinicians are still not aware of this.

ID	Stakeholder	Statement number	Comments[1]
4	Department of Health	General	Thank you for the opportunity to comment on the draft for the above quality standard. I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.
5	MSD UK Ltd	General	MSD thanks NICE for the invitation to comment and believes this quality standard will support progress towards the diagnosis element of the UNAIDS 90:90:90 targets. We also hope that this quality standard will further support timely access to care and treatment following testing and subsequent diagnosis.
6	RCGP	General	• These are excellent QS but there is a cost with increased testing. I hope that near patient testing kits will be available soon. (JA) • This quality standard needs reworking based on this feedback (IR)- see comment by DJ. I realise that it is all part of a process to normalise testing for HIV, and I understand the reasons for wanting to do so. But while the medical sector has come to see this as a routine activity, the same is very unlikely to be true for patients; my recent experience is that the offer of a test remains something that has to be carefully discussed with patients in order to ensure that they are giving genuine consent. The difficulty of building the testing into routine blood testing in this way is that the process of decision making will be skimped, and true consent not given. (DJ) • The standard seems to me for the most part, too, an example where very narrow specialist focus has sought to subordinate every other aspect of health care to HIV. The idea that patients attending either an A&E department or GP surgeries with their own agenda, fears and preoccupations, should then have to enter into the difficult territory of discussing and HIV test, simply on the grounds of where they live is unacceptable, (DJ)
7	Royal College of Physicians	General	The RCP is grateful for the opportunity to respond to the above consultation. We would like to endorse the responses submitted by the British HIV Association and British Association for Sexual Health and HIV.
8	Royal Free London NHS Foundation Trust	General	We endorse the views of BASSH in their response to this consultation.
	Association of Directors of Public Health	Question 1	Yes.
9	British HIV Association	Question 1	Yes – these standards broadly address the key areas, although one could argue that as well as hospitals and General Practices, GUM/Sexual Health Services should also specifically be mentioned as important sites of testing, especially in relation to Standards 3, 4 and 5.
10	The Royal College of Midwives	Question 1	Royal College of Midwives (RCM) believes the developed draft quality standards reflect the key areas for quality improvement and increase the awareness of offering HIV testing for general population when in face-to-face contact with health care providers. It is difficult balance of resources to define high risk prevalence areas/at risk population

ID	Stakeholder	Statement number	Comments[1]
			groups versus universal screening. It maybe that awareness to offer the test will eventually increase self-referral for the test outside those specified defined population groups and increase the demand for resources.
11	The Royal College of Nursing	Question 1	The RCN supports improving access to HIV testing that the quality standard sets out. Alongside processes to help make testing for HIV part of normal screening which we would welcome, appropriate training for all staff involved is essential.
12	Renaissance at Drugline Lancashire	Question 1	The draft quality standard does accurately reflect the key areas for quality improvement. Increasing targeted advertisement of HIV testing services and testing the efficacy of the same is key to increasing testing amongst those people who might not necessarily engage with testing services. Ensuring contacts of people who test HIV positive are also tested regularly is also key to ensuring early diagnosis and treatment.
	Association of Directors of Public Health	Question 2	Yes and no. QS 1- 3 agreed as very good standards to have in place. However, this assumes CCGs and NHSE will commission these services from Acute Hospitals and GP's. If funds were available (from several authorities seeing reductions) this assumes you could gain commitment for the standards/services from all the differing stakeholders and Clinicians.
13	British HIV Association	Question 2	In general systems may be in place in some areas, however probably not all. In General Practice (Statements 2,5), we understand that electronic patient records (EPR) would require there to be 'templates' created to measure how many patients are offered tests when registering. Moreover with current EPRs or Order-Comm systems it would be difficult to measure how many patients undergoing blood tests who had not been tested in the past year were tested, without substantial modifications to these systems or manual extraction of data. It is likely that most hospitals would be able to collect data on testing for the Statement 1, but may find it difficult to measure whether tests had been offered (without the 'templates in EPRs mentioned earlier). The only other method for measuring this outcome in hospitals would be case notes review, which would be time and resource-consuming.
14	The Royal College of Nursing	Question 2	There are concerns about the feasibility of offering routine testing in all settings. There also needs to be careful consideration of follow up and support available.
15	Public Health England	General	- Some of the metrics suggest that local service protocol or specification will include sufficient level of detail to demonstrate that testing is offered - Might be worth including statements about needing processes to record that test has been offered / information given etc. – and that whatever method is used is searchable? - Are there some common codes etc that people could use in their local audits that could be included in an appendix?
	Association of Directors of Public Health	Question 3	As above.
16	British HIV Association	Question 3	This question is slightly ambiguous. If it is asking whether the statements would be achievable given current resources, and without additional resources (e.g. QOF or locally-enhanced service for GPs), assessing most of the measures which are harder to measure would not easily be achieved. Periodic audits of small samples of patients

ID	Stakeholder	Statement number	Comments[1]
			could be undertaken by many hospitals, GP surgeries or Sexual Health clinics for some of the measures which are easier to assess. However, we believe that measuring all these measures will require substantial additional resources. It should be mentioned that there is potential for some of these measures to be incorporated into HARS or other PHE datasets, with appropriate additional resources. In addition, mention issues such as GUMCAD reporting accuracy and whether some of the V3 items are included in the measures outlined here.
17	The Royal College of Nursing	Question 3	How this would be funded and more widely supported by the system is a concern particularly given the complexity of sexual health commissioning currently.
18	The Royal College of Nursing	Question 6	*Case studies* These would help.
19	British Association for Sexual Health and HIV (BASHH)	Statement 1	Whilst being happy with the general concept, we felt this statement to be vague, and we would welcome more concrete recommendations about specific places in hospital to recommend testing (e.g. medical admissions units, certain haematology/outpatient clinics etc). Some felt that this should be strengthened to include all outpatient settings. The evidence is clear that many patients have had contact with other healthcare professionals before their eventual HIV diagnosis. ENT, haematology, and dermatology colleagues are particularly good at HIV testing and many of our new diagnoses come from these, or similar, settings. As is always the problem with this strategy it relies on confidence of the healthcare worker to broach the subject, ownership from the relevant ward/assessment unit and a failsafe mechanism to disseminate results if a patient is discharged prior to the result. It is worth noting that on page 5 of the Quality Standard it states 'to aid measurability emergency services may wish to exclude people who attend but are then discharged or referred to another service'. This categorisation includes almost all patients attending A&E and is worth revising.
20	NAT (National AIDS Trust)]	Statement 1	Process measure - NAT is not convinced that the denominator chosen in the process measures (a) and (b) (pp.4 and 5) are the most helpful to support implementation of this standard. Where HIV testing has been successfully demonstrated in emergency care (e.g. Going Viral at Royal London), a significant proportion of positive results were in patients previously diagnosed with HIV. We are concerned that the denominators beginning 'the number of adults and young people who have not previously been diagnosed with HIV admitted to hospital or attending an emergency department…' are not practical as they rely on consistent disclosure of known HIV status, which could pose a barrier to routine offer of a test in an emergency care setting. It may be a more realistic option to monitor the proportion of

ID	Stakeholder	Statement number	Comments[1]
			people admitted who receive an HIV test and for the denominator to be the number admitted to hospital or attending accident and emergency departments. A measure could also be added for the number of those offered a test as well as those who receive the test to identify issues with take up of patients. This would also be comparable to the measures used for statement 3, where the denominator is the number of people registering with a GP and offered a test.
21	NAT (National AIDS Trust)	Statement 1	What the quality statements mean for different audiences (p6) - Local authorities should be included as a commissioner and should be listed first in the illustrative parentheses, before 'clinical commissioning groups'. Local authorities are responsible for public health, including sexual health services, HIV prevention and HIV testing unless clinically indicated. Many local authorities commission HIV testing within primary and secondary care settings, in addition to their mandated sexual health responsibilities, and often work with commissioners and practitioners in CCGs and NHS Trusts to implement testing services. NICE guidelines have supported this activity and explicit mention of local authorities here is important to ensure this continues.
22	Public Health England	Statement 1	Data sources: The NICE consultation for HIV testing quality standard has sentinel surveillance down as the data source for the 3 indicators. 1. Identifying the number of persons not previously diagnosed admitted to hospital or attending A&E who received a test in extremely high prevalence areas 2. Identifying the number of persons not previously diagnosed admitted to hospital or attending A&E who received a test in high prevalence areas 3. Identifying the number of persons who have not had an HIV test in the past 12 months and having blood taken at a GP surgery who received an HIV test Sentinel surveillance of blood borne virus testing is not a robust or appropriate means of monitoring how well trusts are adhering to testing NICE quality standards. This should be undertaken using locally collected data. Hospitals should have all the relevant information they need to evaluate the guidelines if they link lab testing data to attendee data. The sentinel surveillance of blood borne viruses is a surveillance tool which can give estimates of testing and coverage. It has not been set up as an auditing tool, and its output would not be 100% correct because of inherent limitations. Specific issues include: 1. The numerator should "the number in the denominator", this is not a straight forward task of sentinel being used to estimate coverage this is more a matching and auditing process.

ID	Stakeholder	Statement number	Comments[1]
			2. Sentinel surveillance does not cover the whole of England 3. As sentinel surveillance does not have 100% coverage, it would not be possible to identify those previously undiagnosed, or those who have not had a test within the past 12 months as the test could have been conducted outside of the included areas. 4. As sentinel surveillance only started capturing HIV testing in the more recent years, it will be difficult to identify whether a person was previously diagnosed. 5. Capacity to undertake a large auditing process. 6. The gold standard should be the hospitals' data Using the sentinel surveillance in this way would require bespoke processing and analysis of sentinel surveillance data, and the feasibility of doing this has not been examined.
23	Public Health England	Statement 1	Statement - is testing recommended for all elective admissions as well as emergency ones? Might be worth spelling out - not sure why people who are discharged or referred to other services are excluded? What the QS Different audiences - At bottom of p6, the use of 'very high-risk' are (rather than high prevalence) – change of terminology
24	RCGP	Statement 1	• In statement 1 (part a on p4, part b on p5), the standard says that patients should be offered, but the numerator is those who have received a test. Is this just a typographical error or is it assumed (wrongly in my view) that all those offered an HIV test will accept it. Curiously, this error is corrected under statement 2 on p8 & 9, but then reappears under statement 3 on p12 (DJ)
25	RCGP	Statement 1	"Adults and young people admitted to hospital or who attend an emergency department are offered an HIV test in areas of extremely high HIV prevalence or in areas of high HIV prevalence if they have a blood test." • Q1: Yes, full support. • Q2: Hard to measure that an offer was made. Easier to measure tests done if venous sampling used
26	Royal Liverpool Hospital	Statement 1	The perceived need to ask the patient for permission remains a barrier for testing in areas such as emergency dept/admission. Genuine opt-out with signs on walls etc should become standard. Thus anyone who consents to bloods being taken will be tested for HIV without the clinician needing to mention HIV specifically. Until this true opt-out concept is adopted there will never be high testing rates. I'm not sure if it falls within the scope of a NICE quality statement but another barrier for HIV testing is funding. A recognition of this would be important. A recommendation of joint working with Local Authority (who traditionally commission HIV testing) and CCGs who are responsible for inpatient care (and will ultimately fund issues around late diagnosis). Eg Local Authorities investing in HIV testing will save CCG's money.

ID	Stakeholder	Statement number	Comments[1]
	Southwark Council	Statement 1	We are supportive of this and our acute trusts have already implemented this. There are local systems and structures in place to collect this data and locally we have found looking at this data useful. We have found a higher than expected number of people who were aware of their HIV status but not engaging in care through A&E testing.
27	The Hepatitis C Trust	Statement 1	With an estimated 25% of all European HIV patients also infected with hepatitis C (known as 'coinfection'), it is essential that people considered at risk of contracting HIV are also tested for hepatitis C. Adults and young people admitted to hospital or who attend an emergency department should also be offered a hepatitis C test in areas of high or extremely high prevalence for HIV. People who are at risk of contracting HIV are also often at risk of contracting hepatitis C. Key at-risk groups for contracting both viruses include injecting drug users and men who have sex with men (MSM). The 'Going Viral' project, which took place in the emergency departments of nine hospitals in October 2014, involved patients who were having a blood test as part of their routine care being offered a blood-borne virus (BBV) test covering hepatitis B, hepatitis C and HIV. In total, 2,118 people were tested for BBVs over the course of seven days across the nine participating hospitals. Of these, 71 tests were positive (3.4% of those tested), with 32 tests (45.1%) being new diagnoses. Of those who tested positive for a BBV, 39 were hepatitis C infections, 17 were HIV infections, and 15 were hepatitis B infections. With more than twice the number of hepatitis C infections having been diagnosed then HIV infections, testing for just HIV would have missed the chance to diagnose a significant number of hepatitis C patients. Hepatitis C prevalence figures for those tested were 4.5 times higher than the reported prevalence for the UK as a while, underlining the effectiveness of targeting BBV testing in an emergency department setting.
28	The Royal College of Nursing	Statement 1	*Testing in acute settings* The feasibility of offering testing and the follow up for those tested needs careful consideration. Appropriate care pathways need to be in place for anyone newly diagnosed to local HIV treatment services.
	Association of Directors of Public Health	Statement 2	Operationalising and funding a population approach to HIV testing through GP practices would be challenging. It would be useful to see further evidence of successful implementation in the UK including funding models. Clarity is needed about commissioning /funding responsibilities for the population approaches proposed to HIV testing in hospitals and primary care. This needs legal consideration. It could be interpreted that a population-screening approach in primary care or hospitals is LA responsibility. With the financial pressures in Local Authority, if this were to fall to LAs, it would not be affordable.
29	British Association for Sexual Health and HIV (BASHH)	Statement 2	This statement is likely to be one that has the potential to have the biggest impact on community testing. However, it is noted that some of our General Practice colleagues will need a lot of support before implementing routine screening for new patients and patients having a routine/annual blood test.

ID	Stakeholder	Statement number	Comments[1]
			A study from East London, RHIVA-2, which looked at readiness criteria for GP practices to start testing, showed that many weren't ready, and the patients prefer the sexual health clinic setting. Genitourinary Medicine (GUM) clinics and primary care are going to need to collaborate to provide practical training as a "real world" barrier to implementation of this guidance would be if primary care feel an awkwardness to take on routine HIV screening due a lack of confidence in this area with concerns about financial implications.
30	NAT (National AIDS Trust)	Statement 2	Measures - (c)(pp.9) provides information on the take up of the offer of an HIV test, as measured in (b). A measure of take up at registration should also be considered, additional to (a) which looks at measurement of how many new registrants are offered an HIV test.
31	NAT (National AIDS Trust)	Statement 2	What the quality statements mean for different audiences (p10) - Local authorities should be included as a commissioner and should be listed first in the illustrative parentheses, before 'clinical commissioning groups'. Local authorities are responsible for public health, including sexual health services, HIV prevention and HIV testing unless clinically indicated. Many local authorities commission HIV testing within primary and secondary care settings, in addition to their mandated sexual health responsibilities, and often work with commissioners and practitioners in CCGs and NHS Trusts to implement testing services. NICE guidelines have supported this activity and explicit mention of local authorities here is important to ensure this continues.
32	Public Health England	Statement 2	Data sources: The NICE consultation for HIV testing quality standard has sentinel surveillance down as the data source for the 3 indicators. 1. Identifying the number of persons not previously diagnosed admitted to hospital or attending A&E who received a test in extremely high prevalence areas 2. Identifying the number of persons not previously diagnosed admitted to hospital or attending A&E who received a test in high prevalence areas 3. Identifying the number of persons who have not had an HIV test in the past 12 months and having blood taken at a GP surgery who received an HIV test Sentinel surveillance of blood borne virus testing is not a robust or appropriate means of monitoring how well trusts are adhering to testing NICE quality standards. This should be undertaken using locally collected data. Hospitals should have all the relevant information they need to evaluate the guidelines if they link lab testing data to attendee data.

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			The sentinel surveillance of blood borne viruses is a surveillance tool which can give estimates of testing and coverage. It has not been set up as an auditing tool, and its output would not be 100% correct because of inherent limitations. Specific issues include: 1. The numerator should "the number in the denominator", this is not a straight forward task of sentinel being used to estimate coverage this is more a matching and auditing process. 2. Sentinel surveillance does not cover the whole of England 3. As sentinel surveillance does not have 100% coverage, it would not be possible to identify those previously undiagnosed, or those who have not had a test within the past 12 months as the test could have been conducted outside of the included areas. 4. As sentinel surveillance only started capturing HIV testing in the more recent years, it will be difficult to identify whether a person was previously diagnosed. 5. Capacity to undertake a large auditing process. 6. The gold standard should be the hospitals' data Using the sentinel surveillance in this way would require bespoke processing and analysis of sentinel surveillance data, and the feasibility of doing this has not been examined.
33	Public Health England	Statement 2	Quality measures - Data source section – will depend on how easily extractable this info is.
34	RCGP	Statement 2	"Adults and young people in areas of high or extremely high HIV prevalence are offered an HIV test by their GP when registering or when having a blood test if they have not had an HIV test in the last 12 months." • This statement contains two proposals with different implications: a) at registration b) when blood being taken for another reason. • (A) At registration o QI: S2a is likely to reflect a recognised key area for quality improvement. However i) has cost benefit of such an intervention been done from the RHIVA trial? ii) would it still be beneficial given the fall in undiagnosed prevalence? o iii) should venous sampling (integrated with the offer of other relevant tests) be used, rather than rapid tests? o Q2: The only feasible data source for S2a given (laboratory practice HIV testing rates) will not distinguish 2a testing from other practice HIV testing (e.g. 2b,3, 5 and 6). Measures of offers of tests will not be feasible / practicable, even if specified in a service protocol.

ID	Stakeholder	Statement number	Comments[1]
			○ Q3 this intervention cannot be implemented without additional resource for a) training and staff time b) rapid test kits (if to be used). Need clarity on who would be responsible in a locality for ordering and quality assurance for testing kits. If venous sample to be used, then different budget holder will be impacted (pathology contracts). Would be potentially much more efficient to implement HIV testing in a way that integrates statement 2a, 2b and 3 (See proposal below to combine Statements 2a, 2b, 3, and 5 for the GP setting). • (B) When blood being taken for another reason ○ Q1: Does not accurately reflect recognised key areas for quality improvement, simply because we do not know the positivity rate for additional venous testing in this context / cannot estimate cost. Could be piloted. ○ Much of the blood testing in general practice is routine annual monitoring of asymptomatic people over 50y of age with diabetes and hypertension - and as such very different from the acute medical setting where people are symptomatic and more unwell. ○ Doing ANNUAL HIV testing in the huge proportion of this group will be a waste of resource. ○ Difficult to support this statement unless evidence for positivity in these groups is presented. • The 'offer' of a test, alone, will lead to 'yes' in many not at risk and 'no' in many at risk (aware or, more commonly, unaware of risk). Provisos could be related to ○ testing for people being investigated for symptoms of uncertain cause (deliberately vaguer than QS 3, linking with blood testing provides different trigger) ○ heterosexual men (as late diagnosis a higher risk), but ?better to restrict to those of origin in high prevalence area? (hard to implement) ○ if untested and from a high prevalence country (add in viral hepatitis to get value for money and effort, as far higher rates undiagnosed and destigmatises HIV) – easier to implement ○ whether they have had any risk since last test. • Beware perverse effects: our labs / pathology contracts may be sunk by HIV tests added on to HbA1c and UE monitoring – with extremely low positivity rates; particularly if annual. • Have laboratory leads been consulted? What are the predicted costs for pathology contracts? • Happy to present data on positivity rates in general practice using rapid risk assessment, but not directly relevant to this exact statement (PM)

ID	Stakeholder	Statement number	Comments[1]
			• Q2: The only feasible data source given (laboratory practice HIV testing rates) will not distinguish 2b testing from other practice HIV testing (e.g. 2a, 3, 5 and 6, so see Proposal, below). Measures offers of tests will not be feasible, even if specified in a service protocol. • Q3: Unlikely – unknown • It has to be pointed out that implementing this quality standard correctly will require practices working in high prevalence areas to record carefully the offer of an HIV test when declined. As far as I know there are no codes for this so that auditing it will be time consuming, and I would expect this to be required in practices that are already under-resourced. (DJ) • 2b: Assume that an adult in a high prevalence area had been offered an HIV test, accepted it and had been found to be HIV negative. Again assuming this person was not in any other high risk group. Indeed let us imagine this is a heterosexual woman in a stable marriage of 25 years or more. Is the suggestion that she should be offered another test after 12 months a serious one? The implication is that the risky behaviour is living at the wrong address. (DJ)
35	RCGP	Statement 2	Proposal: • More realistic to combine measures and use total practice HIV testing rates per 1000 registered population as the measure. There is some basis or evidence for what rate of HIV testing might be expected from work in Islington and Haringey, including one publication. This would conflate all practice HIV testing, but that is the result anyway if the only practicable measure is numbers of HIV tests conducted at the laboratory – therefore: • Statement 2a, 2b, 3, 4 and 5 (for the GP setting) combine to: • HIV testing in GP practices: • Adults and young people in areas of high or extremely high HIV prevalence are offered an HIV test in a range of circumstances including: at registration; as part of sexual health and contraception care; when diagnosed with an HIV indicator condition or relevant symptoms; when offered other blood tests or if they are identified as at risk (through risk group and/or risk behaviour). Repeat tests should be offered annually to those at ongoing risk, or sooner in the light of recent risk. • Q1: An integrated approach would be highly relevant for the general practice setting. • Q2: Measurement: a single measure - laboratory practice HIV testing rates / 1000 registered population. Guidance or even a target should be developed, based on what is known (including unpublished data, PMM). NB it is very difficult for a practice to artificially increase HIV testing in a way that is not clinically useful (unless there is perhaps cynical over-reliance on adding them to HbA1c tests annually in the over 60s!). • Laboratories may need resource to compile practice HIV testing numbers.

ID	Stakeholder	Statement number	Comments[1]
			• Positive rates/numbers (collected from lab) in general practice are unlikely to achieve statistical significance even at Local Authority level even where around 1% of all GP 'clinical use' tests are positive, therefore we cannot recommend using these as a measure, although worth monitoring and reviewing over time. • Q3: (for this proposed statement) means that implementation across 2a, 2b, 3, 4 and 5 is integrated, which is more feasible. NB some existing interventions have been demonstrated as ineffective, so choose from those that are effective (RHIVA, SHIP).
36	Royal Liverpool Hospital	Statement 2	As per comment 1. Clinicians not routinely offering HIV testing eg in sexual health are generally not comfortable offering HIV testing and thus true opt-out should be recommended. Again recognition of funding streams and who is expected to fund testing should be made clear.
	Southwark Council	Statement 2	It has been difficult to implement HIV testing on registration at GPs because practices have had an online registration or have not done any clinical review upon registration and those that do report poor attendance. We have done training with GPs to include HIV in routine blood testing where the patient has not had an HIV test in the previous year. We are looking at how we can incorporate HIV into other near patient testing in primary care and are also looking at the role of pharmacies.
37	The Hepatitis C Trust	Statement 2	Adults and young people in areas of high or extremely high HIV prevalence should also be offered a hepatitis C test by their GP when registering or when having a blood test, given the common at-risk groups for the two viruses (namely injecting drug users and MSM). Testing people for hepatitis C when they are already having a blood test is cost-effective, with very little additional cost involved due to blood already being taken. Indeed, given the significant costs involved with treating hepatitis C, this could not only be cost-effective but cost-saving.
38	The Royal College of Nursing	Statement 2	*Primary care testing* Routine testing in primary care would be welcome however as above there needs to be consideration of how this is funded, what services are available for those being tested. Appropriate care pathways need to be in place for anyone newly diagnosed to local HIV treatment services.
39	ViiV Healthcare	Statement 2 – Question 1	*Question 1: Does this draft quality standard accurately reflect the key areas for quality improvement?* Yes. Furthermore, this quality standard is particularly helpful in normalising the offer of an HIV test within primary care.
40	British Medical Association	Statement 2 – Question 3	This proposed quality statement refers to a screening procedure to be undertaken at registration with a GP or during other phlebotomy procedures. Screening procedures are excluded from essential services within the General Medical Services Contract, and as such this is not a suitable measure of quality unless the activity is commissioned by CCGs.

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			The document does refer to a duty on commissioners to ensure training and resources are available to support general practices, and we welcome this, but this needs to be universally available before this quality standard is acceptable. We cannot support measures of quality being imposed on general practices which relate to activities which are outside contractual duties and have not been separately commissioned. We cannot support measures of quality which relate to screening procedures unless those procedures have been authorised by the UK National Screening Committee.
41	ViiV Healthcare	Statement 2 – Question 3	*Question 3: Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment* Despite the clear benefits from a health outcome and cost-effectiveness perspective, perceived cost of the test might present a challenge to the successful implementation of this standard in primary care. In addition, lack of understanding of the local HIV prevalence presents a barrier to the successful implementation of this quality standard. There is a need for a clear communication to GPs regarding their local HIV prevalence together with the benefits of this testing approach including the cost of the HIV test, the minimal resource impact and cost effectiveness.
42	ViiV Healthcare	Statement 2 – Question 6	Our experience of working closely with GPs provides practical examples of how implementation might be supported. With the support of a GP Taskforce, ViiV Healthcare has developed both a national campaign (changethefaceofHIV.co.uk) to engage GPs in the need for expanded HIV testing and we are supporting a number of local initiatives within CCGs in extremely high prevalence areas to increase testing in line with the NICE HIV testing guideline. The national campaign was launched in September 2016 and the first CCG pilot will commence 1st May 2017. These initiatives will be evaluated but we do not have any measurement to date to enable us to complete a local case study at the current time. Current resources (including RCGP accredited training materials) to address the barriers to expanded HIV testing in primary care are available at changethefaceofHIV.co.uk and further resources are in development.
	Association of Directors of Public Health	Statement 3	Many clinicians outside of GUM, whether in GP practices or hospital settings who do not routinely offer HIV testing are uncomfortable doing this – this is important barrier. It would be useful to consider opt-out systems.
	Association of Directors of Public Health	Statement 3	Resources would involve conducting a local study into HIV and late HIV diagnosis to pinpoint locally where the gaps are. One local authority recently completed a 'look back' study into late HIV diagnosis which concluded that 75% of late diagnosis had missed opportunities ranging from 1-6 times leading to up to 24 months delay of diagnosis and treatment. The resources therefore are far reaching. To ensure QS 3 is achieved would require ensuring all clinicians: primary and acute sectors were aware of the indicators that can be presented, particularly so, as being seen more widely within the very 'unlikely' cases.
43	British Association for Sexual Health and HIV (BASHH)	Statement 3	GPs reportedly struggle with 'indicator conditions' checklists and indicator conditions can be confusing.

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			The draft recommends testing everyone with any form of “malignant” lymphoma for HIV in areas with HIV prevalence of above 0.1%, but then (correctly) identifies non-Hodgkin lymphoma as an AIDS defining illness, which obviously warrants HIV testing regardless of background HIV prevalence. The same confusion exists for pneumonia, recommending testing for any community acquired pneumonia (that can technically exclude streptococcal pneumonia), and then recommend it for anyone who has had two or more episodes of any form of pneumonia in 12 months. A simplified and consistent recommendation for testing in cases of all lymphoma and pneumonia, for example, might be more readily adhered to. GPs may find a blanket policy of testing easier, whether restricted to ‘high prevalence areas’, or not.
44	British Association for Sexual Health and HIV (BASHH)	Statement 3	There was general support for this refined list, and it was felt that this makes it easier to see at a glance when testing is recommended. It also provides a clearer rationale, such as recommending testing in leukocytopenia/thrombocytopenia rather than the historical 'blood dyscrasias'. It is felt that this list means that Statement 1 should be strengthened to include hospital outpatient settings where indicator conditions are likely to be seen (e.g. colposcopy, anal dysplasia clinics, lymphadenopathy assessment clinics). Specifically mentioning these settings may incentivise them to start testing. For all GP testing scenarios it is felt we should encourage pathways and mechanisms to provide referral and support rapidly to people who are diagnosed. BHIVA care standards give a maximum 2-week allowance between diagnosis and assessment but in the modern context that is considered too long. Consideration should be given to providing anonymised testing for people who are tested in primary care as (anecdotally) many patients cite confidentiality as a reason why they would not get tested in primary care. A further addition to Standard 3 could be to introduce such a system for all conditions where laboratory testing supports the diagnosis/prompts re testing. This has minimal resource implications. The aim would be to introduce mandatory messages on lab reports to prompt HIV testing, and this has been used well already in some settings.
45	Public Health England	Statement 3	Definition of terms used in this QS - I think the list of indicator conditions may still be too long for primary care
46	RCGP	Statement 3	“Adults and young people diagnosed with an indicator condition are offered an HIV test.” • Q1: Yes, full support. • Q2: Difficult to measure denominator– not least as coding is being changed from Read coding to Snomed; Read coding is a very primary care derived system, we don’t know if Snomed will capture HIV-associated symptoms and conditions. Expert views would be welcome. NB even with Read coding it is difficult to reliably capture all HIV-associated symptoms and conditions.

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			• With respect to tests done, the only feasible data source given (laboratory practice HIV testing rates) will not distinguish Statement 3 testing from other practice HIV testing (e.g. 2a,2 b, 5 and 6). Measures of offers of tests will probably not be feasible, even if specified in a service protocol. • Q3 and Q4: Difficult to implement without an effective / evidence based educational intervention. The only training that publishes evidence of impact on this is Sexual Health in Practice (SHIP) which confirms total Haringey 600% increase in HIV testing once 30% of GPs trained with around 1% positive (the 8 year data set confirms increases are sustained over time); there is published evidence of failure by some interventions. Submission will be made to NICE local practice collection. • See proposal below to combine Statements 2a, 2b, 3, 4 and 5 for the GP setting • I would not for one moment argue against the principle of offering HIV testing to patients with indicator conditions. My only problem here is that it would be difficult to implement as it stands. There are ways in which GP computer systems could provide prompts for the commoner conditions, and the onus could be put on laboratories to prompt GPs for the long list of specific infections. The numbers will always be small for any individual practice, so I am not sure of the value (DJ)
47	RCGP	Statement 3	These are excellent reminders of when to consider HIV. We must lose the stigma and reserve about testing. (JA)
48	Royal Free London NHS Foundation Trust	Statement 3	We support the addition of screening for other blood borne viruses (Hep B & C) and syphilis testing, especially for those with an STI as an indicator disease.
	Southwark Council	Statement 3	We are supportive of this standard and have done a lot of work with practices in training around indicator conditions and opt out blood testing for indicator conditions. We have found this easy to implement and see no difficulties in implementing the longer list.
49	The Hepatitis C Trust	Statement 3	Offering HIV tests to adults and young people with an indicator condition is a sensible strategy. With HIV being an indicator condition for hepatitis C (due to common risk factors), testing people for hepatitis C at the same time as for HIV would therefore be a logical extension to Statement 3.
50	The Royal College of Nursing	Statement 3	*Testing for those indicated as at risk and availability of information*. The RCN welcomes making testing part of routine screening in those at risk, where risk factors and other indicators are identified. We also welcome having better routine access to information and support and for self-testing. Alongside self-testing, there needs to be systems for services to offer testing and for picking up those who are vulnerable.
51	British HIV Association	Statement 3 – Question 4	Yes – this is a reasonable list of indicator conditions to flag up and should also include shingles.
	Association of Directors of Public Health	Statement 3 – Question 4	This is perhaps too long to be practical. One local authority saw main conditions which were: PCP, Shingles, oral candidiasis and weight loss. All of which were missed.
52	The Royal College of Midwives	Statement 3 – Question 4	To increase practicability of implementation of testing, when associated with HIV indicator conditions, it would have to be technology IT driven. In majority of these conditions blood tests would be indicated and the technology should flag

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			HIV testing to be offered. However, it may be more practical for specialist areas than for GP or community services and there is already some level of red flag fatigue amongst GPs. Therefore sensible to keep the list somewhat more focussed than the longer Europe HIV indicator conditions.
	Association of Directors of Public Health	Statement 4	Despite the excellent effort to develop quality measures, this statement is undoubtedly the hardest to measure. Saying people "can find information about HIV testing services" and suggesting local areas do surveys and audits doesn't offer any guarantee of access to nor of quality of information. However, perhaps it is enough to have this here to make local areas think about this challenge, and how they might make their efforts more robust.
53	British Association for Sexual Health and HIV (BASHH)	Statement 4	We are concerned about how the data is obtained here and how it may be interpreted. 'Evidence of local processes to ensure that adults and young people in at-risk groups in areas of high and extremely high HIV prevalence can find information about HIV testing services, including self-sampling' is felt to be vague and should be more explicit 'Adults and young people in at-risk groups in areas of high and extremely high HIV prevalence should be provided with information (as opposed to 'can find') about HIV testing services, including self-sampling'. In the 'At-risk groups' definitions we are not sure the add-on sentence of 'including those who participate in high-risk sexual practices such as 'chemsex'' after 'MSM' is necessary. MSM by definition are high risk. There are still a lot of healthcare workers out there who don't know what chemsex is or how to address it, and they may be put off by this. Of note, trans women are addressed, yet trans men who have sex with men appear to be omitted, which is an oversight. These are a particularly high-risk group for HIV acquisition and frequently have limited knowledge of testing (same point could be made for Statement 5).
54	NAT (National AIDS Trust)	Statement 4	Quality statement - We recommend that the aim for people in high risk groups to have access to information about HIV testing services should not be limited to areas of high or extremely high prevalence. People in at-risk groups who reside in areas of lower prevalence may be particularly vulnerable to late diagnosis. Even if a low prevalence area, it should be ensured people who may be at risk have access to information on where they can access testing services. Self-sampling services may be particularly beneficial to these individuals. Between November 2015 and September 2016 around half of those who return self-sampling kits via the PHE national scheme were in low prevalence areas and the reactivity rate was the same as for high prevalence areas. Whilst it is recognised that areas of high and extremely high prevalence may have a need to commission a wider offering of HIV testing services, this statement refers to access to information which should be universal.
55	NAT (National AIDS Trust)	Statement 4	Measures - As above, we recommend that the measures are adapted to take account of all areas, not only those with a high or extremely high prevalence.
56	Public Health England	Statement 4	Quality measures - In 'structure' section – may be helpful to be more specific about where information should be available? Although service protocols may include statements about having information available – this is a different thing to whether people in at risk groups are actually able to find it / info is easily available

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57	RCGP	Statement 4	"Adults and young people in at-risk groups in areas of high and extremely high HIV prevalence can find information about HIV testing services, including self-sampling." • Q1: We can support this, practices could be given patient information to use in their service, but no point in each practice inventing approaches for itself / would need a strategic, locality approach.
50	The Royal College of Nursing	Statement 4	*Testing for those indicated as at risk and availability of information*. The RCN welcomes making testing part of routine screening in those at risk, where risk factors and other indicators are identified. We also welcome having better routine access to information and support and for self-testing. Alongside self-testing, there needs to be systems for services to offer testing and for picking up those who are vulnerable.
	Southwark Council	Statement 4	Yes this is achievable and should promote self sampling services and targeted community outreach services for specific groups. This standard may be difficult to measure, particularly amongst hard to reach groups
58	The Hepatitis C Trust	Statement 4	Information about hepatitis C testing services should also be made available to adults and young people in at-risk groups in areas of high and extremely high HIV prevalence. Awareness of hepatitis C is often low among at-risk groups, such as MSM and certain migrant communities – groups which are also often at risk of contracting HIV. It therefore makes sense to adopt a wider BBV approach to information provision, rather than focusing solely on HIV.
59	The Royal College of Nursing	Statement 4	*Testing for those indicated as at risk and availability of information*. The RCN welcomes making testing part of routine screening in those at risk, where risk factors and other indicators are identified. We also welcome having better routine access to information and support and for self-testing. Alongside self-testing, there needs to be systems for services to offer testing and for picking up those who are vulnerable.
60	Renaissance at Drugline Lancashire	Statement 4	The provision of information about HIV testing services, including self-sampling, would be measurable as we can collate where information has been placed and in what quantities, or which social media / information platforms have been used in what frequency. Funding streams would need to be available for providing large numbers of self-sampling kits once increased awareness of service provision has occurred. There would be time and cost implications of surveying adults and young people to see how many people are aware of the services offered for HIV testing, however some of this could be undertaken by Sexual Health Outreach Workers whilst they are delivering outreach services, the survey would have to be a one or two question survey though based on the amount of time the outreach workers spend with each person.
	Association of Directors of Public Health	Statement 5	The understanding from ADPH members is that the most cost-effective approach to annual testing in primary care is targeting those at increased risk, and it may be more cost-effective to implement a universal approach to annual testing in primary care at higher thresholds than those proposed. It would be useful to see the modelling evidence supporting the thresholds proposed.

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61	British Association for Sexual Health and HIV (BASHH)	Statement 5	Please see above comment regarding the inclusion of trans men who have sex with men. We are also concerned about data regarding this standard as risk groups may not be adequately coded for. These groups will rarely be identified outside sexual health services. We should make sure that the standards for sexual history taking reflect all these risk groups, which might need revision of those standards.
63	RCGP	Statement 5	"Adults and young people in at-risk groups who test negative for HIV are advised to repeat the test at least annually." • Annual test only relevant if any further risk (ie risk behaviour trumps risk group for repeat tests); if we don't ask about risk we fail to educate on what risk is (and support avoidance of risk). NATSAL tells us how many people, including young, have not had sex, for example, in the last year. • Use of rapid risk assessment is important here (witness ultra low positivity in even chlamydia testing where wrong people are offered tests / or wrong people agree to test). • See proposal below to combine Statements 2a, 2b, 3, 4 and 5 for the GP setting • The difficulty is in gathering the data. Finding out whether patients have been advised to repeat testing will always be difficult. (DJ) • My other concern with this statement is considering those patients 'who have been tested for a sexually transmitted disease' to be at risk. We test lots of patients for Chlamydia where we think the risk of infection is very low, but where the symptoms might be explained by Chlamydia infection. Given that they tell us that the chance of a sexually transmitted infection is very low, it might be sensible to leave that group out. (DJ)
65	Royal Liverpool Hospital	Statement 5	"Numerator – the number in the denominator whose previous HIV test was in the past 12 months" - does not take into account whether patient has even been to a service to be advised of annual testing. Would suggest those who have previously been to service who return for repeat test within 12/12.
	Southwark Council	Statement 5	Feedback from local clinician's within GUM services have indicated that 'at least annually' is not specific enough and that annually for at risks groups is too long an interval. We would like to see more specific testing interval guidance for at risk groups.
64	The Royal College of Nursing	Statement 5	*Screening and repeat testing for those at risk* The RCN supports offering and encouraging people to be retested on a regular basis. This should be accompanied with information and advice of safe sex, behaviour change and prevention advice.
66	The Hepatitis C Trust	Statement 5	Adults and young people in at-risk groups who test negative for HIV should be offered a test for hepatitis C. Failing to offer testing for hepatitis C alongside testing for HIV risks missed opportunities to diagnose people who are HIV-negative but hepatitis C-positive. Those who test negative for hepatitis C but remain at risk of contracting the virus (e.g. injecting drug users) should be advised to repeat the test at least annually.

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68	British Association for Sexual Health and HIV (BASHH)	Statement 6	Whilst explained later on, the early wording in the 'rationale' for this statement is strange - 'people who have had contact with a person with HIV in a way that is associated with HIV transmission are at high risk of being infected' - and could be more explicit. It was also noted that the statement on testing children of HIV infected women should be made clearer, and that Statement 6 is currently overly vague regarding this important issue. Whilst making no sense to have a different time scale to the BASHH standards, it should be noted that a 3-month window for partner notification might be challenging with patients who are struggling with the diagnosis, or are very sick. It is important this is done to find new cases quickly, but we recommend that it would be worth seeking data collection for a longer period.
62	NAT (National AIDS Trust)	Statement 6	This quality statement refers to 'contacts' which is in line with HIV partner notification for adults: definitions, outcomes and standards, published by BASHH, NAT, SSHA, and BHIVA. However, we have concerns that this language may not be appropriate in the context of the NICE quality statements as it could be misleading and wrongly interpreted by stakeholders with less knowledge of HIV and may feed in to misconceptions about HIV risk through different forms of contact. Whilst the term is further explained in the rationale, and routes of transmission are referred to on pp.26, we still feel the language should be adapted in the standard itself. We recommend the following alternative wording: 'People newly diagnosed with HIV have the opportunity to identify people known to them who may have been exposed and those people are contacted and offered an HIV test.' It would also be useful to have HIV transmission routes upfront in the rationale for the statement on pp.24.
69	RCGP	Statement 6	"People identified as at risk of HIV from contact with an adult or young person newly diagnosed with HIV are offered an HIV test." • Q1: This is good practice and we support it. If newly diagnosed in the GP setting, HIV positive patients should be referred promptly and securely to HIV services, which are expected to manage partner notification. Occasionally, it may be an appropriate option for the GP to notify the partner of someone recently diagnosed with HIV. • Q2: Rare enough to make this measure impracticable for the GP setting - exclude • Q3: Most important message to GPs is to check that referral was made and that patient attended clinic (might be safest if normalised urgent (eg suspected cancer) referral electronic systems were used: "2 week wait" – which has its own checks and balances and GPs are notified of non attendance.
70	Royal Liverpool Hospital	Statement 6	Testing contacts at risk refers to "Denominator – the number of contacts identified as at risk of HIV". Is this identifiable contacts. Ie those for whom names/contact details are available. This is quite a different measure from the number of casual encounters that are not identifiable/contactable as is the case in many situations. If a benchmark/target is going to be set it should be explicit.

ID	Stakeholder	Statement number	Comments[1]
			As for specific question. Three months should be maximum. Would even consider shortening this timeframe but not extending.
71	Renaissance at Drugline Lancashire	Statement 6	Ensuring adults and young people who test positive for HIV have the opportunity to identify any contacts who may be at risk of HIV is possible with the linking in of lay testers with Sexual Health Clinics, who can use the procedures in place to identify contacts once the diagnosis has been confirmed with confirmatory blood tests. Any person who may have been at risk can be notified and signposted to the lay testers for testing, with reminder for re-tests every three months sent via the Sexual Health Clinic. This wouldn't be resource intensive for lay testers, particularly those with a good working relationship with the Sexual Health Clinic.
	Association of Directors of Public Health	Statement 6 – Question 5	Yes. If it is not already within main contracts, then could do a contract variation to reflect this.
72	British HIV Association	Statement 6 – Question 5	Yes this timescale is appropriate
	Southwark Council	Statement 6 – Question 5	Yes we feel this timescale an appropriate focus for quality improvement.
73	The Royal College of Midwives	Statement 6 – Question 5	The RCM would agree with the 3-month timescale derived from the HIV partner notification standards to be applied this will help to streamline with other existing standards and service development. As for outcome it may not be feasible to expect high compliance sensitivity as numerator numbers are dependant on having to have information for the identification in the first place. however the service protocols should be in place.

Registered stakeholders who submitted comments at consultation

- Association of Directors of Public Health
- British Association for Sexual Health and HIV (BASHH)
- British HIV Association
- British Medical Association
- Department of Health
- MSD UK Ltd
- NAT (National AIDS Trust)]

- Public Health England
- RCGP
- Royal College of Physicians
- Royal Free London NHS Foundation Trust
- Royal Liverpool Hospital
- Southwark Council
- The Hepatitis C Trust
- The Royal College of Midwives
- The Royal College of Nursing
- Renaissance at Drugline Lancashire
- ViiV Healthcare