Standards 1a and 1b

Organisation name (if you are responding as an individual, please leave blank)			
Name of commentator			Ben Cromarty
Role of commentator			
6	1a	14	We should add first reception to immigration removal centres to the list
7	1b	18	It says: “the chance of a person living with HIV who has an undetectable viral load transmitting their virus is negligible” Using “negligible” is less preferred…the U=U website suggests “Sometimes the risk is described as "negligible" which means: so small as to not be worth considering; insignificant. Therefore, HIV experts and health educators have described the transmission risk in public health communications in clear and unambiguous ways such as: effectively no risk; untransmittable; no longer infectious; zero risk; no infection risk; do not transmit; cannot transmit” It would be better to use these approaches rather than “negligible”, as is done in the Quality Statement…this is much clearer!

Organisation name (if you are responding as an individual, please leave blank)			
Name of commentator			Hilary Curtis
Role of commentator			BHIVA Clinical Audit Co-ordinator
3	1a AN D G	16	Some outcomes suggest 98% targets. I’d suggest using 97% instead as the target for any outcome where we’re aiming for 100% compliance (which isn’t measurable). The reason for choosing 97% is because this allows for audit of 40 cases with one failure (eg due to poor recording). To measure 98% requires audit of more than 50 cases, which can be problematic.

4	1a	16	"In areas where the prevalence of diagnosed HIV infection is 2:1000 or greater, the proportion of new registrants in general practice with a documented offer of an HIV test, either at new patient check or first clinical consultation, who also have a documented HIV test result in their clinical record (target: 98%)." 97/ 98% uptake of a blood test by GP registrants, many of whom will rightly perceive themselves at very low risk, seems an impossible and unrealistic target. Suggest target for offer only – monitor uptake but without target.
5	1a	16	"In areas where the prevalence of diagnosed HIV infection is 2:1000 or greater, the proportion of those admitted to secondary care with a documented offer of an HIV test during their admission who have a documented HIV test result in their clinical record (target: 98%)." Even though nearly everyone admitted to secondary care has bloods taken, I still think 97/98% is an unrealistically high target for uptake.
6	1a	16	"Proportion of services using the required HIV assays with a process for quality control." "Required" seems an odd word. Suggest "recommended" instead.

Organisation name			
Name of commentator			Dr Anthony France
Role of commentator			Retired consultant physician – HIV & Respiratory Medicine I set up the HIV/AIDS service in Dundee in 1989 and ran it until I retired from HIV work in 2012. I do not see HIV patients now. I have no conflict of interest.
2	1a	14	Have you asked GPs if they have the resource to test all new registrants ?
3	1a	15	Look back exercises can be divisive. Your document has not addressed the difference between sensitivity and specificity of the HIV indicator conditions. Oral candidiasis is very common in patients who have dentures and in those who use inhaled

			steroids. I think you will be surprised by how low the specificity is when you look at indicator conditions. You run the risk here of alienating your general medical colleagues.

Organisation name (if you are responding as an individual, please leave blank)			
Name of commentator			Kaveh Manavi
Role of commentator			Consultant physician in HIV
1	1b	18	' HIV services should be able to demonstrate that they have care pathways for partners of people living with HIV to access PreP as appropriate.' I dont think this is an achievable outcome as PREP is not widely available in the UK. How are we supposed to develop a care pathway to a service that currently does not exist?
2	1b	19	indications for offer of PREP: there is a BASHH/ BHIVA guidelines on this issue. I think the document should make a reference to that document rather than to spell out the indications.
3	1b	19	' Documented evidence that people living with HIV with sustained viral suppression (at least 6 months) and high adherence to ART have been advised that there is effectively no risk of sexually transmitting the virus to an HIV-negative partner (target: 98%).' I am not sure about ' effectively no risk'. Many of partners of HIV infected patients request the numerical risk of HIV transmission. According to HPTN 052 the risk is 7%. To some people this is not a negligible risk.

Organisation name (if you are responding as an individual, please leave blank)			
Name of commentator			Roy Trevelion
Role of commentator			UK-CAB BHIVA Rep, i-Base staff
3	1B	17	Quote “Particularly notable in recent years is the use of ARVs by HIV-negative and -positive individuals to reduce HIV acquisition and transmission in the form of pre-exposure prophylaxis (PrEP) and treatment as prevention (TasP), respectively. It is clear that people living with HIV, with a sustained, undetectable viral load in their blood cannot transmit HIV to their sexual partners. All patients should be made aware of this, which is itself a powerful tool in HIV prevention.” I suggest changing the last sentence to: All patients should be made aware of U=U (Undetectable = Untransmittable), which is itself a powerful tool in HIV prevention.

Organisation name (if you are responding as an individual, please leave blank)			LASS
Name of commentator			Service Delivery
Role of commentator			Staff Team
1	1a	15	Where there is established need to give a test, test should be given if they are initially unwilling to leave detailed personal information. However, before the test clients should be made aware that detailed information will be taken and shared with the HIV clinic in case of reactive results.
2		17	Might be helpful to add (U=U) Undetectable is equal to Untransmissible

Organisation name (if you are responding as an individual, please leave blank)	Scottish Drugs Forum

Name of commentator			Austin Smith
Role of commentator			Policy and Practice Officer
3	1a	13	This entire chapter on prevention almost exclusively presumes sexual transmission and offers nothing in terms of prevention of transmission by any other route. It shows no insight or sensitivity to the needs of those at risk of infection by any other route than sexual transmission. This reflects a cultural and systemic issue within the HIV field which is unhelpful and ultimately leads to deaths – most obviously in the ongoing uncontained HIV outbreak among people who inject drugs in Glasgow which perhaps involves hundreds of people (118 new cases diagnosed). The outbreak in Glasgow shows what could happen in any community of people who inject drugs in the UK and serves as a warning of the dangers of perpetuating a culture and a system which discriminates against this group.
4	1a	14	We recommend that a routine offer of HIV testing should be made by competent health care professionals to all attendees in all the following settings and clinical scenarios • Injecting Equipment Providers (IEP)– (i.e. needle exchange services) Opiate Replacement Treatment (ORT) provision
5	1a	14 - 16	There are 7 references to "In areas where the prevalence of diagnosed HIV infection is 2:1000 or greater" in this section. In the last reported Needle Exchange Surveillance Initiative (NESI 2015/16) – HIV prevalence was recorded at 2.5% in people who inject drugs in Glasgow – and we at the Scottish drugs forum anticipate this to be considerably higher in the NESI report where fieldwork is currently being undertaken. The fact that you exclude this population from any real or meaningful "Quality Statements" or "Measurable and auditable outcomes" throughout this document is a significant and damaging omission , We are hopeful that BHIVA will ensure that this population has the support of the HIV field to prevent further transmission and deaths.
6	1a	15	We recommend annual testing to people in groups or communities with a high rate of HIV, and more frequently if they are at ongoing high risk of exposure. For example: men who have sex with men should have HIV and other sexually transmitted infection tests at least annually, and every 3 months if they are having condomless anal sex with new or casual partners. .

			...people who inject drugs should have HIV tests at least annually, and every 3 months if they are actively sharing injecting equipment.
7	1a	15	All HIV services should undertake a review of all patients diagnosed late (CD4 count <350 cells/mm3) or very late (CD4 count <200 cells/mm3 or AIDS), with 'look back' of previous engagement with health care services. This critical case review should be line with the forthcoming national standardised process for reviewing late diagnoses which is currently in development. This 'look back' should look at engagement with drug treatment and support (and 'recovery') services and other opportunities for testing and support including periods in prison.
8	1a	16	**Measurable and auditable outcomes section should include** The proportion of people newly attending at (or re-presenting at) drug treatment services with a documented offer of an HIV test in their clinical record (target: 98%). The proportion of people in drug treatment services who are offered a test with a documented offer of an HIV test on a three-monthly basis in their clinical record (target: 98%).
9	1b	17	**1b. Prevention** It is extraordinary that this section does not mention the provision of sterile injecting equipment. A full and comprehensive IEP service should be available across the UK and should be flexible to meet the changing needs of people who inject drugs. It would be helpful in achieving this aim if the standards made mention of this. The ongoing uncontained outbreak of HIV amongst people who inject drugs in Glasgow should serve as a model of what could happen elsewhere. Low levels of testing, poor HIV awareness amongst people at risk and the services they use and injecting equipment provision focussed on Hep C and bacterial infection prevention all contributed to this. (Some people accepted that they and people they shared injecting equipment with were likely to be Hep C positive and so sharing was regarded as of ' low risk')

10	1b	18	We recommend that people living with HIV should be made aware of the range of interventions which have been shown to reduce risk of onward HIV transmission, including the risks and benefits. **Also ..** We recommend that people at high risk of HIV (e.g. people who inject drugs) should be made aware of the range of interventions which have been shown to reduce risk of onward HIV transmission, including the risks and benefits.
11	1b	18	We recommend that people living with HIV should be made aware of the evidence that treatment with ARVs substantially lowers the risk of transmission and once viral load is sustained at undetectable, there is effectively no risk of sexually transmitting the virus to an HIV-negative partner **Also ..** **In the outbreak of HIV among people who inject drugs in Glasgow people affected and people at high risk have expressed fatalistic understandings of the risk they are at – that they will die anyway and so treatment is pointless or that drugs will kill them anyway and so HIV is only a theoretical risk to their lives.** We recommend that people at risk of HIV should be made aware of the evidence that treatment with ARVs substantially lowers the risk of transmission and allows a people to live a full life.
12	1b	19	PrEP should be available to people at risk of being infected with HIV through injecting drug use
13	1b	19	We recommend that people who have recently shared injecting equipment should receive a prompt offer of post-exposure prophylaxis (PEP) and that this facility should be advertised to people at risk through injecting drugs.

Organisation name (if you are responding as an individual, please leave blank)			Sophia Forum
Name of commentator			Sophie Strachan
Role of commentator			Co Chair
1	1a	13	Please refer to Inside gender identity report – care needs for transgender people in the criminal justice system
2	1b	19	Please make equal reference to all those who can access prep , women are not mentioned (only as others) please amend this as you facilitate a message of exclusion by not appropriately naming those eligible
6		16	References NICE 2017 guideline physical health of people in prison / Quality standards https://www.nice.org.uk/guidance/qs156/chapter/Quality-statement-3-Blood-borne-viruses-and-sexually-transmitted-infections https://www.nice.org.uk/guidance/qs156/chapter/Quality-statement-1-Medicines-reconciliation
8	1b	18	you mention only heterosexual and male same sex, you are limiting who this paragraph speaks to. We appreciate that reference may be linked to the studies and if that is the case you still need to insert another line that reaches other people LBTI

Organisation name (if you are responding as an individual, please leave blank)			Centre for Primary Care and Mental Health, Queen Mary University of London
Name of commentator			Dr Werner Leber
Role of commentator			NIHR CLAHRC Clinical Lecturer in Primary Care
1	1a	15	98% target for test offer and uptake in general practice is unrealistic. In RHIVA2 (Leber et al, 2015) we saw 11% uptake; and Elmahdi et al 2015 described 29.5% coverage. Elmahdi R, Gerver SM, Gomez Guillen G, Fidler S, Cooke G, Ward H. Low

			levels of HIV test coverage in clinical settings in the U.K.: a systematic review of adherence to 2008 guidelines. Sex Transm Infect. 2014 Mar;90(2):119-24. doi:10.1136/sextrans-2013-051312.
2	1a	16	Please add reference of RHIVA2 study demonstrating cost-effectiveness of HIV testing in general practice. Baggaley RF, Irvine MA, Leber W, Cambiano V, Figueroa J, McMullen H, Anderson J, Santos AC, Terris-Prestholt F, Miners A, Hollingsworth TD, Griffiths CJ. Cost-effectiveness of screening for HIV in primary care: a health economics modelling analysis. Lancet HIV. 2017 Oct;4(10):e465-e474. doi:10.1016/S2352-3018(17)30123-6
3	1a	16	You may wish to add our audit on late diagnosis in primary care to this section: Wellesley R, Whittle A, Figueroa J, Anderson J, Castles R, Boomla K, Griffiths C, Leber W. Does general practice deliver safe primary care to people living with HIV? A case-notes review. Br J Gen Pract. 2015 Oct;65(639):e655-61. doi:10.3399/bjgp15X686905.
7	1a		Also section 3a. An audit of delayed diagnosis could also be a great training opportunity for GP staff to learn about the importance of providing patient support at the time of diagnosis and prompt linkage with the clinic. Interviews with some of the patients diagnosed during RHIVA2 also highlighted lack of support/lack of professionalism when receiving a reactive POC test result (unpublished data still, unfortunately). GPs really seem to struggle with this and more training is needed. I also wonder whether the 2 week entry target is too wide and should be reduced even further? Should patients be given a referral form to attend the clinic at their most early convenience? Also, what is your policy on clinical lead for newly diagnosed patients with comorbidity? Should their initial care be at the clinic rather than the GP and if yes, when should they transition over?

Organisation name (if you are responding as an individual, please leave blank)			African Health Policy Network
Name of commentator			Deryck Browne
Role of commentator			Chief Exec
1		13	Effective HV testing strategies should be tailored to local populations and maximise the opportunity for testing in both clinical and non-clinical settings. Community testing initiatives have been found particularly effective among men who have sex with men (MSM) and **black African** populations.

Organisation name (if you are responding as an individual, please leave blank)			CHIVA
Name of commentator			Dr Bala Subramaniam
Role of commentator			Executive member, CHIVA
2	1	14	Quality statements: 4th bullet point. Typo- should be opt out testing in wider medical settings

Organisation name (if you are responding as an individual, please leave blank)			Terrence Higgins Trust
Name of commentator			Alex Sparrowhawk
Role of commentator			Membership and Involvement Officer
3	1	G	There is a lack of consistency in the audience of the standards between the testing and prevention sections. The testing section is aimed at people who do not know their HIV status or do not have HIV and the prevention section is aimed at people living with HIV, and worryingly implies responsibility of transmission is down to this group alone. We would recommend that the prevention section is re-written to be inclusive of broader HIV prevention strategies aimed at both people living with ***and*** at risk of HIV
4	1a.	G	Self-sampling and self-testing methods deserve as much prominence in the guidelines as point of care testing. At a time where many services are utilising online HIV self-sampling and, increasingly, HIV self-testing in addition to face-to-face appointments services it is important to include some information and recommendations about these HIV testing strategies and it is a significant omission to leave out this information.
5	1b.	G	There is no mention of national or local HIV prevention campaigns within this section, either in England or the devolved nations.

Organisation name (if you are responding as an individual, please leave blank)			British Psychological Society (BPS)
Name of commentator			Sarah Rutter & Tomás Campbell
Role of commentator			Chair & Treasurer of the BPS Faculty of HIV & Sexual Health
2	1a	13	Having a mental health problem (often undiagnosed) increases vulnerability to acquiring HIV infection (WHO, 2008). HIV prevention messages should also include information that issues relating to mood, anxiety, and/or PTSD may facilitate behaviours that increase vulnerability (e.g. increased alcohol and substance misuse, increased rates of risky sex, difficulties managing relationships, increased distress) (Michlig et al, 2018). The Society believes that this should be echoed by adding 'mental health services' in the third quality statement on page 14: "All those who present to medical and mental health services with identifiable risk factors (behavioural and geographical) should be offered an HIV test in accordance with national guidance".

Organisation name (if you are responding as an individual, please leave blank)			Scottish HIV Clinical Leads group
Name of commentator			Dr Nick Kennedy
Role of commentator			Consultant Physician. Former Clinical Advisor on HIV to Healthcare Improvement Scotland (HIS); former Co-chair of HIV Clinical Leads group
7	1a	14	*'In areas where the prevalence of diagnosed HIV infection is 2:1000 or greater, all men and women having a blood test at their general practice should be offered a HIV test if they have not had a HIV test within the last year'.* We feel this is overkill and unrealistic. Expecting GPs to offer annual HIV testing to a whole practice in areas of higher prevalence 'just isn't going to happen'. Testing at registration and with further testing if identified risk and/or indicator condition would be more realistic.

8	1a	14	Testing – very little reference to IV drug users and recommended testing intervals/testing at IEP sites?
9	1a	14	There is nothing about improving testing in low prevalence areas, which remains is a significant concern in much of Scotland despite the lower absolute numbers. Late presentations are (proportionately) common in low prevalence areas/ low risk groups due to a lack of HIV awareness. Improved education for GPs/ primary care teams and others is needed.
10	1a	15	Providing test results within 48 hours considered to be challenging in some settings (e.g for PWID, where dry blood spot testing is often performed)
11	1a	16	Auditable outcome: target of 98% of new GP registrants and admissions to hospital care offered HIV test. This is a very high target: ?basis for this ?realistic
12	1b	17	The 'Rationale' is for 1b (Prevention) is quite long and not very clear – albeit that this is admittedly a complex area. Overall, there should be more prominence given to TaSP and the importance of treatment adherence for full confidence in TaSP, with perhaps slightly less emphasis on PrEP, in the context of Standards which are aimed at 'people living with HIV'. The (high) efficacy of condoms for HIV (and other STI) prevention should also be emphasised more. PrEP clearly also has a role and needs to be discussed - and reference should be made to the Scottish guidelines on PrEP use.

Organisation name (if you are responding as an individual, please leave blank)			Positive East
Name of commentator			Mark Santos & Steve Worrall
Role of commentator			Director & Deputy Director
3	1	14	Add to the quality statement that 'people should have an understanding of different HIV testing methodologies enabling better access to testing'
4	1	15	Add to quality statement that - Lost to follow-up strategies need to start at this stage and there needs to be a protocol in place that mitigates the risk at the point of diagnosis
5	1	15	measurables – we would suggest a new metric of proportion of newly diagnosed retained in clinical services

6	1b	17	We share the excitement about PrEP but would suggest that the section is more balanced about combination prevention as a whole

Organisation name (if you are responding as an individual, please leave blank)			
Name of commentator			Laura Waters
Role of commentator			Consultant Physician
7	1a	13	The testing section is accurate but I fear this simply duplicates the key elements of the HIV testing guidelines – I think a much shorter section signposting these would be as impactful and more readable. I suggest a shorter summary of what patients should expect, what commissioners should provide and what specialists should push for.
8	1b	17	"the rate of new HIV infections in the UK still remains high" – how high? I think the incidence and putting this in the context of other European countries would be helpful
9	1b	17	I'd argue vaginal microbicides are not available in the same way as other tools mentioned so should be excluded
10	1b	17	Suggest specify tenofovir-DF for PrEP as no evidence for tenofovir-AF
11	1b	17	I fear the paragraph on PrEP availability will be out of date before the standards are finalised – suggest shorten and acknowledge the time-limited nature of this section.
12	1b	17	"in the interim PrEP monitoring is being provided in sexual health clinics." – are the authors confident this is routinely provided/commissioned?
13	1b	18	"Despite limited access, the game-changing potential of PrEP has been borne out in at least five London sexual health clinics which have seen the number of new HIV diagnoses reduce dramatically over 2 years" – can you say this/ In the absence of PrEP coding? I appreciate it's very likely but it's not certain?
14	1b	18	Suggest the recommendation wrt PrEP eligibility signpost to PrEP GL instead

15	1b	18	"Evidence of a patient experience survey to assess satisfaction regarding discussion around HIV transmission and HIV prevention options." I applaud this but, to my knowledge, this is not done routinely so there's an opportunity to standardise the patient experience questions

Organisation name (if you are responding as an individual, please leave blank)			
Name of commentator			Kevin Kelleher
Role of commentator			
			Inclusion and consideration: http://sigmaresearch.org.uk/reports/item/report2013f http://sigmaresearch.org.uk/reports/item/report2009e http://sigmaresearch.org.uk/reports/item/report2007b http://sigmaresearch.org.uk/reports/item/report2006a Others to consider are: http://sigmaresearch.org.uk/reports/tags/tag/All-living-with-HIV
			"Cost-effectiveness of pre-exposure prophylaxis for HIV prevention in men who have sex with men in the UK: a modelling study and health economic evaluation" Valentina Cambiano, Alec Miners, David Dunn, Sheena McCormack, Koh Jun Ong, O Noel Gill, Anthony Nardone, Monica Desai, Nigel Field, Graham Hart, Valerie Delpech, Gus Cairns, Alison Rodger, Andrew Phillips
			"Cost-effectiveness of screening for HIV in primary care: a health economics modelling analysis2 Rebecca F Baggaley, Michael A Irvine*, Werner Leber*, Valentina Cambiano, Jose Figueroa, Heather McMullen, Jane Anderson, Andreia C Santos, Fern Terris-Prestholt, Alec Miners, T Déirdre Hollingsworth†, Chris J Griffiths†

Organisation name (if you are responding as an individual, please leave blank)			Catholics for AIDS Prevention and Support Positive Catholics
Name of commentator			Jim McManus
Role of commentator			
			Standard 1 a. Testing, diagnosis 1(a) including access to peer support. Might this need qualifying? access to peer support that meets the needs of the person eg specific access to gay mens peer support, young adults, or peer support that takes account of spirituality and religious identity – We know that 'one size fits all' approach in peer support means that some people are effectively excluded if there is not a range of provision where this can be achieved. We see that this aspect of various-appropriate types of peer support is covered under peer support but maybe emphasise consistently?
			1b. Prevention COMMENT: I notice that whilst it is stated that 'HIV prevention should go beyond a focus on only primary prevention for HIV negative people, and also work with people living with HIV as important partners in prevention.' There is little explicit out-working or description about or recommendation of the role of peer support as preventative insofar as the PLWH who is well supported / adjusted is less likely to fail to adhere to medication and also less likely to engage in other sexual/drug use behaviours that risk onward transmission. I think this deserves at least an acknowledgment. Something like: Individual support (eg counselling) and peer support is an important factor in terms of HIV prevention insofar as it assists the person to maintain a healthy lifestyle and adjust to living with HIV responsibly.

Organisation name (if you are responding as an individual, please leave blank)			
Name of commentator			Sophie Strachan
Role of commentator			
			I also wanted to inform you that following the success of the blood borne virus Opt Out Policy implemented in UK prisons this is now going to be rolled out into Immigration removal centres later this year. https://www.nice.org.uk/guidance/qs163/chapter/Quality-statements

Organisation name (if you are responding as an individual, please leave blank)			LGBT Foundation
Name of commentator			Craig Langton
Role of commentator			Services Officer - Sexual Health
1			Overall, I find this a brilliantly worded document that explains many necessary points and highlights amazing ideas in HIV prevention and after diagnosis care with a well promoted community based asset approach.
2	1a	14	Extremely well worded section. 'In addition, the availability and use of community testing should be encouraged and advertised, with appropriate funding from local authorities'. To echo: structural barriers, cultural competency, opening times, fear, stigma etc. When using our findings on our existing community testing clinics, signposting into external services can definitely be improved. For example, if someone chooses not to or isn't available to test, then recommendations and the soonest other options available in that area could be given to the service user. We have learnt that a lot of service users leave a GUM clinic because of walk-in waiting times. We think a gap here is because the service user is usually recommended to return to the same GUM clinic but on another day. They luckily then find our service using their own initiative, but notably when we ask, they disclose GUM clinics didn't provide other options. Home testing kits could also include advertisements for GUM clinics, helplines, local community POCT etc. We really feel the importance of readily available support services during and

			after a test. When staffing issues occur in any setting, whether it's in a GUM or a community based setting, services could work closer with each other to offer pop-up like services.
3	2	21	Really necessary points made and well worded here. We feel community testing can also incorporate holistic approaches to health and wellbeing for example, nutrition classes, meditation, creative workshops, etc.
4	G	G	We've learnt from a recent survey that we carried out over National HIV Test Week 2017, that a lot of people avoid testing from fear of blood. Big scale ongoing campaigns for rapid/ finger prick tests, and increasing POCT access points could help tackle this barrier.
5	G	G	Our Sexual Health Programme team have recently been looking into ways in which to expand our offer in community based testings settings. One of our key focal points was looking at common sexual health issues that LB women and people with vaginas, cervixes and vulvas face, in a trans inclusive way. For us, a key part of this running cervical screenings, and LGBT inclusive pregnancy testing in a POCT setting, and being able to advice people on next steps. In terms of new testing opportunities we are looking to move from the HIV INSTI to the HIV & Syphilis INSTI, as well as potentially including Hepatitic C testing, which MSMs and people living with HIV are at greater risk to infection. This will encourage people living with HIV, to still access POCT services, where additional holistic take aways can be available.

Organisation name (if you are responding as an individual, please leave blank)			ADPH
Name of commentator			Policy Manager - ADPH
Role of commentator			Rachel Cullum
			We would like to see reference to testing frequency by risk category

Organisation name (if you are responding as an individual, please leave blank)			NAT
Name of commentator			Yusef Azad
Role of commentator			Director of Strategy
			In the Rationale section, 2016 data could be provided.
			In the Quality statements, fourth bullet, a typo 'opt-out' for 'opt'. In the seventh bullet, there is reference to 'high-risk groups who do not routinely access NHS services'. Perhaps 'or sexual health clinics' should be added, which are not always NHS services.
			Is it worth cross-referring to the more detailed content on partner notification later in the Standards?

Organisation name (if you are responding as an individual, please leave blank)			PHE
Name of commentator			Valerie Delpech
Role of commentator			Lead for national surveillance of HIV for the UK
			1a. Testing and Diagnosis measureable and auditable outcomes (pg 15) • *Proportion of individuals diagnosed late or very late (CD4 count <200 cells/m3 or AIDS)….those with recent infection presenting with a transient or early low CD4 count should be excluded* The HIV and AIDS Reporting System (HARS) monitors this outcome though the definition used for a very late diagnosis does not specify patients with AIDS (although these mostly present with a CD4 count <200). Additionally those with recent infection and a low CD4 count are not excluded; they are reclassified.

Organisation name (if you are responding as an individual, please leave blank)			BASHH HIV Specialist Interest Group (SIG)
Name of commentator			Tristan Barber
Role of commentator			Chair, BASHH HIV SIG
1	1a	13	'First' reception to prison services – is this enough for this high risk population? As it's a recommendation of an 'offer' shouldn't it be at every reception to prison services (can opt out if recently tested)
2	1a	13	Very little reference to IV drug users and recommended testing intervals/testing at IEP sites/addictions services etc?
3	1b	18	'HIV services should be able to demonstrate that they have care pathways for partners of people living with HIV to access PreP as appropriate.' I don't think this is an achievable outcome as PREP is not widely available in the UK. How are we supposed to develop a care pathway to a service that currently does not exist?
4	1b	19	Indications for offer of PREP: there is a BASHH/ BHIVA guideline on this issue. I think the document should make a reference to that document rather than to spell out the indications.
5	1b	19	'Documented evidence that people living with HIV with sustained viral suppression (at least 6 months) and high adherence to ART have been advised that there is effectively no risk of sexually transmitting the virus to an HIV-negative partner (target: 98%).' I am not sure about 'effectively no risk'. Many of partners of HIV infected patients request the numerical risk of HIV transmission. According to HPTN 052 the risk is 7%. To some people this is not a negligible risk.
24	G	G	Further down page 14 there is an auditable outcome, as follows "Proportion of individuals diagnosed late (CD4 count <350 cells/mm3) or very late (CD4 count <200 cells/mm3 or AIDS). A transient or early low CD4 count is not uncommon in PHI. Therefore, considering CD4 count alone may overestimate the proportion of individuals diagnosed late. Audits of late diagnosis should ideally take into account the clinical stage at diagnosis. Those with recent infection presenting with a transient or early low CD4 count should be excluded." This is such a mixture of outcome and explanation and so on. It needs a much clearer definition. How would they define transient? They say audits of late diagnosis should IDEALLY take into account the clinical stage are diagnosis, but there is no SMART measure here - how would they do that? It is another example of rather vague statements. The term ideally has no place here - it should be specific and reproducible or left out. I would like to see a much clearer requirement to conduct case reviews for late diagnoses and missed opportunities. It is

			there as a requirement but the definitions need expansion to make it actually happen. The feedback to other departments is good too. It would be good to make it a standard requirement that HIV services have an education strategy for their locality to improve knowledge and testing rates.