Government Response to the House of Lords Report of Session 2010-12: No vaccine, no cure: HIV and AIDS in the United Kingdom

Presented to Parliament
by the Secretary of State for Health
by Command of Her Majesty

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Government Response to the House of Lords Select Committee Report on HIV and AIDS in the United Kingdom

Foreword

The Government would like to thank the House of Lords Select Committee for their Report on HIV and AIDS in the United Kingdom. We agree with many of its findings and recommendations.

Twenty-five years have passed since the start of the Government's early responses to HIV and AIDS which took place at a time when little was known about the HIV virus and how it would evolve. There is no doubt that the Government's response at that time ensured the UK has remained a relatively low prevalence country for HIV, particularly compared to some of our European neighbours. This is most noticeable in the very low UK rates of HIV in injecting drug users thanks to the early introduction of needle exchange and harm minimisation programmes.

Twenty-five years ago, there was no effective treatment and infection with HIV was considered life-limiting. Today the position is very different, thanks mainly to the development of effective treatment but also to the talent and commitment of all healthcare professionals involved in providing high quality NHS HIV treatment and care services. Diagnosed early the majority of people with HIV can expect a near normal life expectancy. However, there is no cure or indication of an early vaccine, and treatment is life-long, complex and expensive.

There must be no doubt that effective HIV prevention by all remains at the heart of responses to tackling the spread of HIV. HIV prevention is not without its challenges. HIV still repeatedly attracts stigma which can have a negative impact on people's health and quality of life. Sexual risk behaviours are very hard to change. Nonetheless, the high cost of treating a person with HIV makes effective prevention a compelling investment. The Health Protection Agency have estimated that preventing the estimated 3,800 HIV infections acquired in the UK in 2010 would have saved over £32 million annually or £1.2 billion over a lifetime in costs.

The Government's priority for public health set out in the *Healthy Lives, Healthy People: Our strategy for public health England* Public Health White Paper and proposed modernisation of the NHS offers an important opportunity to improve outcomes for HIV and reinvigorate prevention. The House of Lords HIV Report will also be a valuable resource to help

inform the Department of Health's new Sexual Health Policy Framework planned for 2012.

Introduction

The Government should recognise the scale of the HIV and AIDS challenge in the United Kingdom. Not enough is being done to respond to a steadily growing risk to public health. There are potentially huge cost implications in both the short- and long-term in failing to deal effectively with the epidemic. At a time when public health in the United Kingdom is subject to major reform, the Government should ensure that HIV and AIDS is a key public health priority. (para 34)

The Government recognises the continuing risk HIV presents to public health. The White Paper *Healthy Lives, Healthy People* sets out the Government's strategy for reform of public health in England and this includes HIV and sexual health. We accept that more could and should be done, and recognise the scale of the challenge. The Department of Health has continued to provide dedicated funding for HIV charities for national prevention programmes since 1996. The Department of Health's new Sexual Health Policy Framework will provide an opportunity for the Government to assess where further work is needed to ensure a strong and sustained response to tackling HIV.

HIV vaccine research

Funding bodies, both public and private, should continue to support HIV vaccine research as part of their research strategies. Cooperation with international partners must be central to this work. At the same time, the Government should consult with the pharmaceutical sector to determine whether improvements can be made to existing models of working and regulatory processes to better involve them in efforts to develop a HIV vaccine. (para 43).

Although the successful development of a vaccine is crucial in the longer-term, the response to HIV and AIDS in the United Kingdom must be based on the assumption that none will exist for at least a decade. (para 44)

The Government welcomes the Committee's recognition of the vital contribution being made by ongoing UK publicly funded HIV vaccine research, including research involving international collaborations.

Globally, progress has been slow in the last five years, but more recently there have been developments in basic science with the identification of broadly neutralising antibodies and their potential modes of action. The Medicines and Healthcare Products Regulatory Authority supports pharmaceutical companies during the development of new products by providing scientific and regulatory advice. This service is provided in meetings and in written responses to questions to help companies interpret the guidelines and design appropriate clinical trials for their products.

Prevention

Further Government support for prevention is required. Prevention should be at the forefront of the response to HIV. This must be reflected in the Government's replacement of the 2001 sexual health strategy. More resources must be provided at national and local levels. The Government should monitor and audit the use of resources so provided, to ensure they are used for the purpose of preventing new HIV infections. (para 55)

The Government agrees with the Committee's focus on the importance of prevention. Prevention will be a key part of the Government's new Sexual Health Policy Framework. As the Committee's Report makes clear, investment in prevention offers significant savings in the short and long-term.

We are currently considering how prevention work might be taken forward in the future, in the light of decisions about funding priorities in 2012/13. At local level, it is for local primary care trusts and from 2013 local authorities, to decide their level of investment in HIV prevention, taking into account HIV prevalence and their wider public health needs.

We have highlighted the costs of treating HIV, and the long-term savings which could be made through investment in HIV prevention. The current levels of investment in national HIV prevention programmes are insufficient to provide the level of intervention required. (para 62)

The Department of Health's investment in HIV prevention programmes does not reflect total expenditure on HIV prevention. The NHS also funds HIV prevention activities taking account of local HIV prevalence and other priorities. Disaggregating how much is spent locally

specifically on HIV prevention from wider STI prevention programmes is not possible.

Local prevention programmes, and the voluntary sector bodies that deliver them, have played an important role in tackling HIV. Local authorities, health services and other funders should avoid undermining local HIV prevention work when taking budget decisions. The ongoing trend of pressure on local prevention services also underlines the importance of enhanced Government funding for national HIV prevention programmes. (para 68)

The Government agrees that voluntary sector and community-based organisations have made a major contribution to tackling HIV. Their links, knowledge and understanding of the communities most affected by HIV means that prevention messages are relevant and acceptable to the communities targeted.

Healthy Lives, Healthy People: Update and way forward, explained that the fundamental plank of the Government's reform strategy is providing public health with dedicated resources. This will allow us to promote a strategic approach to spend on prevention, recognising that public health is a long-term investment, and that effective spend on prevention will release savings which can then be used elsewhere in the NHS and cross-government more widely. In the tough financial climate of today, this is a critical commitment to the value of prevention.

The setting up of Public Health England and the proposed new commissioning arrangements will ensure that public health and prevention is seen as a crucially important part of the health improvement process. This is as important for sexual health and HIV as it is for other areas of public health.

We accept that levels of new HIV infection would have been higher without the national prevention programmes, and we support those delivering this work. We feel, however, that more needs to be done to reduce dangerous and risky behaviour that is leading to HIV infection. In part, more funding is needed but, in addition, a broader range of evidence-based approaches are required. (para 78)

Reducing risk-taking behaviour is not an issue unique to sexual health and is one of the reasons why the Government is reforming public health.

The Government agrees that more needs to be done by all to address behaviour that increases the risk of HIV infection. For example, the growth of the internet for dating and arranging sex, the growing sexualisation of society, increasing levels of sexual activity and partner change amongst young people, the use of performance enhancing sex drugs amongst older people as well as other risk taking behaviours have all increased opportunities for HIV transmission. We agree a broad range of evidence-based approaches are required for HIV prevention. The Department of Health will consider this further, including the international evidence, as part of the development of the new Sexual Health Policy Framework.

Both targeted and national HIV prevention campaigns have an important role to play. Given the concentration of HIV infection in two specific groups, we recommend continued targeted HIV prevention campaigning focused on these communities. This should be coordinated at the national level. (para 84)

A range of intensive interventions—including group and individual counselling work—should be delivered for those who are most at risk of either contracting or passing on HIV. This should be set against a backdrop of national campaigns and awareness-raising which is properly evaluated and refined for effectiveness. (para 97)

The Government agrees with the Committee on the role of targeted HIV prevention programmes for those groups at increased risk of HIV. In the UK this remains men who have sex with men (MSM) and sub-Saharan African communities. The national HIV prevention programmes use a range of interventions agreed in-line with the evidence base. As highlighted, the Department of Health's current HIV prevention contracts end in March 2012 and we are currently considering options for taking this work forward.

Whilst we do not doubt the integrity of current evaluation processes, we recommend that the practice of HIV prevention providers commissioning their own evaluation of campaigns be ended. The Department of Health should commission evaluation, ensuring separation from delivery of prevention activity. We also recommend that, once instituted, such independent evaluation activities are used to inform, refine and reinforce subsequent prevention campaigns, providing an evidence-led approach to influencing behaviour. (para 93)

The Department of Health agrees that we should review the current practice where the two national contractors (Terrence Higgins Trust and African Health Policy Network) commission the evaluation of the national programmes as an integral part of the programmes. This does however offer value for money. However, we note the concerns raised by the Committee which we will take into account in taking the national programmes forward from 2012.

HIV awareness should be incorporated into wider national sexual health campaigns, both to promote public health and to prevent stigmatisation of groups at highest risk of infection. We recommend that there should be a presumption in favour of including HIV prevention in all sexual health campaigns commissioned by the Department of Health. (para 72)

We recommend that the Department of Health undertake a new national HIV prevention campaign aimed at the general public. This will ensure that HIV prevention messages are accessible to all of the population. (para 85)

We recommend that those delivering HIV prevention campaigns, whether nationally or locally, should utilise the full range of available media, including internet, social networking and mobile phone applications. We note that national sexual health campaigns, such as *Sex: Worth Talking About*, have been sufficiently resourced to purchase advertising time with national broadcasters. We recommend that messages around HIV are included in these campaigns in future, ensuring the greatest possible exposure for HIV prevention messages. (para 89)

Discrimination against those affected by HIV is based, at best, on ignorance and, at worst, on prejudice, and we unreservedly condemn it. This underlines the need for a general public awareness campaign on HIV. (para 100)

The Government accepts the evidence base that shows that men who have sex with men and people from African communities must remain the main focus of national HIV prevention programmes. We do not support the Committee's recommendations on the need for a national campaign aimed at the general public as there is little evidence that this would be effective. The Government agrees there is a need for information on HIV prevention for the wider population as part of the prevention of other more prevalent sexually transmitted infections. Other partners have a

role to play here too. The Government welcomes the contribution of other agencies in raising awareness, for example the *HIV Aware* website produced by the National AIDS Trust with support from Durex.

Faith leaders and communities and peer support networks

Given the significant influence of faith leaders in some communities, we recommend that the Government, local authorities and health commissioners build upon work already taking place with all faith groups to enlist their support for the effective and truthful communication of HIV prevention messages. (para 111)

We recommend that the Department of Health ensures continued funding and support for work, building upon that currently delivered by the African Health Policy Network, which aims to develop the knowledge of faith leaders about HIV. Such work is vital in supporting a wider range of interventions which aim to address, prevent and treat HIV within all communities. (para 112)

The Government agrees with the Committee's recommendation about the valuable contribution faith leaders and faith groups can make to HIV prevention and care services. The national HIV prevention programme for African communities funded by the Department of Health has contributed to the toolkits for Christian and Muslim faith leaders and communities produced by the African Health Policy Network (AHPN). The Department of Health is working with the AHPN to consider how they might develop this work further as part of the national programme.

People living with HIV need to be empowered to become advocates for understanding of the condition, in order to help to address stigma. We understand the importance of peer support networks and voluntary organisations in supporting this work, and recommend that local authorities and other public sector funders acknowledge the importance of this work in their future funding decisions. (para 115)

The Government supports this recommendation.

Progress achieved over recent decades mean that there are now many facets to HIV prevention. We recommend that the full range of available interventions be used to prevent new HIV infections. We call this approach combination prevention. (para 118)

The Government agrees with the Committee.

Needle exchange programmes

We support the continued provision of needle exchange programmes. The Government should use their influence, both through partnerships such as UNAIDS and their bilateral relationships, to make clear the benefits of needle exchange facilities, and encourage countries whose epidemics are driven by injecting drug use to institute or expand such programmes. (para 125)

The Government agrees with the Committee that provision of such programmes is essential to tackle the alarming rise in HIV transmission by injecting drug use in various parts of the world. *Towards zero infections: the UK's position paper on HIV in the developing world,* published in May 2011, sets out the UK's international support for the provision of comprehensive harm reduction services to prevent HIV infections amongst injecting drug users. Comprehensive harm reduction services include needle exchange programmes.

HIV and schools

Ensuring that as many young people as possible can access good quality sex and relationships education (SRE) is crucial. We recommend that the Government's internal review of PSHE considers the issue of access to SRE as a central theme. Teaching on the biological and social aspects of HIV and AIDS should be integrated into SRE. (para 139)

Whilst acknowledging that the review is yet to complete its work, we recommend that the provision of SRE should be a mandatory requirement within the National Curriculum, to enable access for all. Such education should begin within all schools from Key Stage 1, though this teaching must be age-appropriate. (para 140)

There is an important role to be played by external providers, but we recommend that SRE should be primarily delivered by teachers, who must be trained to deliver this teaching. This training must focus on all aspects of HIV and AIDS, to ensure that teachers are confident on the subject. (para 141)

We agree that good sex and relationship education (SRE) helps young

people learn to respect themselves and others and move with confidence from childhood through adolescence into adulthood.

The Office for Standards in Education report on personal, social, health and economic education (PSHE), published in July 2010, explored some of the key issues in PSHE and found that although teaching and learning about sex and relationships were good in the majority of the secondary schools visited, they were no more than satisfactory in a third of the schools. In the primary schools visited, sex and relationships was reported as one of the weaker elements of PSHE.

DFE launched a review of PSHE on 21 July. The review aims to identify the core body of knowledge that pupils need and ways to improve the quality of teaching. The review asks how the statutory guidance on sex education could be simplified, especially in relation to strengthening the priority to teaching about relationships. The reviews of the National Curriculum and of PSHE by the Department for Education will take account of the Committee's recommendation.

Preventing mother to child HIV transmission

Procedures developed to limit the transmission of HIV from mother-to-child have been an outstanding success. We recommend that the Department of Health and commissioners ensure that such services continue to be provided as required. For the same reason, we also recommend that local authorities provide free infant formula milk to HIV-positive mothers who have no recourse to public funds. (para 146)

The Government agrees with the Committee that offering and recommending an HIV test to all pregnant women has been very successful in reducing HIV transmission antenatally to a very low level. Antenatal HIV testing is part of the Infectious Diseases in Pregnancy screening programme managed by the UK National Screening Committee and there are no plans to change this.

Local NHS Trusts are responsible for determining which services to provide in line with the needs of the local population and in view of this Local Authorities will need to decide locally, if free infant formula milk should be provided to HIV-positive mothers. In their position statement on Infant Feeding in the UK, the British HIV Association and the Children's HIV Association provide advice on access to financial assistance where this may be a barrier to avoiding breastfeeding. This includes a case study of a scheme providing free formula milk with no

recourse to public funds, funded by a Primary Care Trust on behalf of three London Boroughs.

Research

Given the significant cost savings that can be accrued from successful HIV prevention work, the Department of Health should prioritise HIV prevention research. We recommend that the Department establish an advisory committee, to give leadership and coordination to biomedical, social and behavioural prevention research. (para 94)

Treatment has an increasingly important role to play in preventing HIV infection. We note research demonstrating the potential for earlier antiretroviral treatment as a preventive measure. We recommend that the Department of Health, National Institute for Health Research, Medical Research Council and other research funders provide support in order to examine the utility of such approaches in the United Kingdom. In addition, the Department of Health should keep policy in this area under review as further research continues to emerge. (para 150)

We recommend that the Department of Health, National Institute for Health Research, Medical Research Council and other research funders support programmes of work which examine the utility of pre-exposure prophylaxis. This research should take place in both in the United Kingdom and in international settings. We recommend that the availability of post-exposure prophylaxis should continue to be determined by clinicians within GUM clinics. (para 155)

Research should be funded, either by the Government, National Institute for Health Research, Medical Research Council or other research funders, to examine whether service networks would allow for highly specialist care to be delivered more effectively in fewer centres. (para 296)

The Department of Health's National Institute for Health Research (NIHR) funds a wide range of research on HIV prevention, diagnosis and treatment across its programmes and research infrastructure funding streams.

The NIHR welcomes funding applications for research into any aspect of human health, including early HIV treatment, pre-exposure prophylaxis and other preventive measures. These applications are subject to peer

review and judged in open competition, with awards being made on the basis of the scientific quality of the proposals made. Suggestions for evidence needs in HIV prevention can be fed in to NIHR prioritisation processes. Details of the priority-setting and governance arrangements for each programme are available on the NIHR website.

The Department does not accept the need to establish an advisory committee specifically for HIV prevention research. Evidence on managed service networks includes research funded by the NIHR Service Delivery and Organisation Programme.

Offender health services

We recommend that the Government pursue its plans to commission offender health services centrally, which would lead to better equity and continuity of care for prisoners. (para 169)

The Government propose that the new NHS Commissioning Board (NHSCB) will take over the commissioning role of PCTs by April 2013 and this will allow some of these issues to be addressed at a national level. Clinical Commissioning Groups will be required to address the needs of offenders, including providing services for blood borne viruses (BBVs) that are accessible and appropriate to needs. The Department of Health through its Offender Health team will provide support and advice to GP commissioners and the NHSCB with its work with Public Health England.

Data on HIV in prisons must be improved. The Health Protection Agency should utilise surveillance data newly available to provide a robust estimate of the prevalence and profile of HIV within the prison population. At the same time, a review exercise into offender health services in public prisons is underway. The Government should supplement this with a review of the extent and nature of HIV prevention, testing and treatment services within public prisons, to determine the levels of provision across the country. (para 170)

The Department of Health has worked with the Health Protection Agency to improve disease surveillance in prisons and provide prison-specific data on STIs including HIV. The Department and HPA are aiming to disaggregate data on prison diagnoses next year.

The Department of Health has worked with a range of partners, including the National AIDS Trust (NAT), to develop policies, programmes and

implement practices that reduce the risk of the transmission of BBVs within the prison estate. This will remain under review.

We recommend that best practice for managing HIV in prisons is made clearer. The Government should commission NICE to produce guidance for the management of offender health, which should include specific protocols for HIV prevention, testing and treatment. (para 171)

The National Clinical Director for Health and Criminal Justice (Professor Louis Appleby) is currently discussing with NICE to agree future NICE guidance for offender health services. Specific protocols for HIV prevention, testing and treatment will be requested, subject to normal procedures for topic selection at the NICE Public Health Committee.

In the meantime, the Government should draw up a guidance note to prison governors to outline best practice for managing HIV in prisons. This must stress the need for high-quality, continuous treatment and care; robust testing policies, including routine opt-out testing on entry into prison; and the provision of condoms in a confidential manner. Governors should implement these policies within their prisons as soon as possible. (para 172)

There is already extant guidance (PSO 3845) for the management of blood borne and related communicable diseases such as HIV, which indicates that prison authorities owe a duty of care towards all prisoners, to protect them from any harm that can reasonably be foreseen.

The Department of Health has worked with the HPA to develop a new resource *Prevention of infection and communicable disease control in prisons and places of detention: A Manual for Healthcare Workers* which was published in August 2011. This comprehensive and detailed resource provides prison healthcare staff and others with guidance and advice on how to prevent and control a broad range of infections of relevance to people in prison.

Sexual activity between prisoners carries with it known public health risks. All prisons in England and Wales currently provide condoms to prisoners but only on application. Availability of condoms in prisons is measured as a metric within the Prison Health Quality and Performance Indicators annually. Prisons perform well in the metric on sexual health which includes provision of condoms among other indicators. In 2010,

over 90% prisons rated either 'Green' or 'Amber' for sexual health performance indicator metrics.

We do not routinely screen people in prison for HIV. Instead we have an 'active case finding programme' which encourages both prisoners and staff to consider whether their behaviour, current or previous, may have put them at risk of infection with HIV and provides them with an opportunity for testing by prison-based health services. This includes primary care as well as sexual health services provided in the prison. We encourage the offer of HIV and Blood Borne Viruses testing to prisoners by prison-based health services but we respect the rights of prisoners to accept or refuse testing if they so chose. This reflects normal practice in the wider community.

Testing

Earlier diagnosis ensures that those infected receive timely treatment, saving money on the treatment costs of more advanced infections and preventing onward transmission of the virus. This is cost-effective in the long-term. We therefore recommend that the Government endorse both the 2008 professional testing guidelines and the 2011 NICE testing guidelines. The policies recommended within those documents, and the recommendations made in the interim *Time to Test* report by the Health Protection Agency, should be implemented. (para 191)

In particular, HIV testing should be routinely offered and recommended on an opt-out basis, to newly registering patients in general practice, and to general and acute medical admissions. This should begin with high-prevalence areas (where prevalence is greater than 2 cases per 1,000 people). HIV testing should also be made routine and opt-out in relevant specialties where conditions are associated with increased rates of HIV infection, such as TB and hepatitis. Finally, testing should be expanded into the community. Local testing strategies must be put in place to facilitate this. (para 192)

These testing policies should be supported with financial and human resources from commissioning bodies. HIV testing should feature prominently in local needs assessments and testing strategies in high-prevalence areas. The Government must ensure that the performance of commissioners and clinicians is monitored through

regularly commissioned audits now, and the late diagnosis indicator in its Public Health Outcomes Framework in future. (para 193)

The Government agrees with the Committee about the importance of early diagnosis so that people can access treatment and prevent onward transmission. The Government welcome both the NICE Recommended HIV Testing Guidelines for MSM and Black African Communities and the 2008 British HIV Association (BHIVA) HIV Testing Guidelines. The testing pilot projects funded by the Department of Health in 2009/10 supported implementation and review of the BHIVA HIV Testing Guidelines. In September 2011 the Health Protection Agency published its final *Time to Test* report reviewing the findings from the pilot projects and other work. The Department will consider the *Time to Test* report and findings in developing the new Sexual Health Policy Framework. The Department will also ask the UK National Screening Committee to consider all the evidence, including the BHIVA Guidelines, and provide its views on increasing routine HIV testing in high prevalence areas.

We agree that increasing HIV testing should be part of local HIV prevention testing strategies especially in areas of high prevalence. The Department is aware that some Primary Care Trusts are already funding new HIV testing initiatives in primary and secondary care in line with the NICE and BHIVA Guidelines. However, more work is needed to capture the data on this through the current HIV monitoring and surveillance programme managed by the Health Protection Agency.

The Public Health Outcomes Framework includes a proposal for an indicator on late HIV diagnosis. Decisions on the final set of indicators will take place later this year.

HIV testing outside of GUM and antenatal clinics must become more widespread. Professionals, most notably general practitioners, must become more confident and competent in offering and administering tests. Training and education are important tools to use to achieve this; they should form an important part of local testing strategies. Such training must incorporate efforts to address HIV-related stigma, and develop understanding of the needs of people living with HIV. (para 204)

Practitioners must be more confident in identifying those at risk of HIV and those with symptoms of infection. Undergraduate training and ongoing professional development for medical practitioners should stress the importance of these skills. This is particularly so for

specialists dealing with hepatitis and tuberculosis, where co-infection with HIV is more common. (para 205)

It is imperative that medical practitioners have the knowledge and skills to manage HIV. Undergraduate teaching and ongoing professional development should, therefore, incorporate sufficient specialist training relating to HIV and AIDS. (para 286)

The Government agrees training and education for healthcare professionals is important. Offering an HIV test should be within the competence of all doctors and nurses. This is especially relevant where a person is presenting with symptoms which could be an indication of HIV infection, or live in a high prevalence area or they are from one of the groups at increased risk of HIV. Findings from the pilot projects funded by the Department of Health on new approaches to testing, in primary, secondary and community settings reported that HIV testing was acceptable to all patients and healthcare professionals while recognising they may need training and support to raise the subject of HIV in their consultation with patients.

The content and standard of healthcare and undergraduate training is the responsibility of the independent regulatory bodies. The Department of Health is funding the Medical Foundation for AIDS and Sexual Health (MedFASH) to develop an HIV resource for primary care staff to support them in offering HIV testing. This will complement training resources produced by MedFASH and funded by the Department of Health, for use by staff in hospital departments.

Encouraging people to test, through the provision of education, training and support, can have significant benefits for the public. We support the development of local testing strategies, recommended within NICE testing guidelines. Equipping people with the knowledge and desire to get tested should form an integral part of those strategies. (para 213)

The Government agrees with this recommendation.

The ban on HIV home testing kits, as laid out in the HIV Testing Kits and Services Regulations 1992, is unsustainable and should be repealed. A plan should be drawn up, in consultation with clinicians, patients, voluntary organisations and professional associations, to license kits for sale with appropriate quality control procedures in place. The licensing regime must make sure that the tests are

accurate, and that the process gives comprehensive advice on how to access clinical and support services in order that those who test positive get the care that they need. (para 214)

The Government supports this recommendation and the Department of Health is reviewing the policy which bans the sale of home testing kits.

Treatment and care

HIV treatment and care services should be commissioned at a national level, given their high cost and the variation in HIV prevalence nationwide. To ensure commissioning is responsive to differing patterns of need across the country, regional treatment and prevention service networks, appropriately supported and resourced by the Government, should be established. (para 223)

The Government agrees that some services should be commissioned at a national level. In the consultation on *Healthy Lives, Healthy People* we proposed that the NHS Commissioning Board (NHS CB) would commission HIV treatment and care. As part of the transition to the NHS CB the Department of Health has set up a Clinical Advisory Group (CAG) to consider the most appropriate level for the services listed in the Specialised Services National Definitions Set (including HIV) to be commissioned. The CAG is considering HIV alongside other specialised services for inclusion in the list of services to be commissioned by the NHS CB. The CAG will present its recommendation to Ministers later this year.

Existing procurement arrangements, where antiretroviral drugs are locally procured, mean that drug prices vary across the country. This should be changed. Antiretroviral drug treatments should be procured on a national scale. This offers the potential for significant savings by making use of the purchasing power and economy of scale of the National Health Service, as well as standardising prices nationwide. (para 229)

The costs of HIV treatment are best managed by purchasing well-tolerated, easily adhered to drug regimens. This reduces the likelihood of incurring the much higher costs of inpatient care which result from poor adherence to treatment. Under national commissioning structures, commissioners must procure drugs that allow clinicians the flexibility to prescribe regimes that best serve this long-term view. (para 230)

London which is the region in England with the largest spend on antiretrovirals has been successful in attracting the most competitive prices as a result of successful collaboration between commissioners and clinicians as part of the procurement process and by the introduction of price/volume opportunities. In other regional procurements this has been less successful.

The Department of Health recognise that clinical collaboration is a key factor in leverage of price and experience from procurements on a local and a regional basis will be used in evaluating the ability to take this forward on a multi regional and national basis. This will also be appropriate when developing procurement plans for purchasing well-tolerated, easily adhered drug regimens.

Whilst controlling the cost to the NHS of antiretroviral drugs and other HIV treatments is important, care must be taken not to undermine clinical autonomy in this area so that clinicians can continue to take their patients' individual circumstances into account when making prescribing decisions.

Continued monitoring of viral resistance to drug treatments, currently carried out through the UK HIV Drug Resistance Database, is essential. (para 231)

The Government agrees that this novel and valuable data source should be continued.

We recognise the concerns arising from the proposed split in commissioning responsibility for HIV prevention, treatment and social care services. We recommend that the Department of Health place a duty upon those commissioning HIV services to support the integration of all HIV services in their commissioning decisions. (para 236)

We recognise the importance of prevention efforts in relation to other STIs, and the role that they can play in preventing the spread of HIV. The integration of STI and HIV treatment services, therefore, is essential for prevention efforts. We share the concerns of those who suggest that the proposed NHS reforms may increase the fragmentation of services. We recommend that the Department of Health place a duty to promote service integration upon those commissioning sexual health and HIV services. (para 237)

The Government does not agree with the concerns raised by the Committee. *Healthy Lives, Healthy People: Update and way forward*, indicated the Government's proposals for improving public health services. The Government believes it remains appropriate for the NHS to commission HIV treatment alongside its responsibilities for commissioning treatment for other infectious diseases, but we have given a clear commitment to ensure that prevention work does not become isolated from treatment services

We agree with the Committee that it is essential for commissioners to promote integrated provision of services, where possible - and that is why the Health and Social Care Bill includes clear requirements for the NHS Commissioning Board, clinical commissioning groups and Health and Wellbeing Boards to promote integration. These duties will apply to all health services, so there is no need to have separate duties applying to integration of specific services such as sexual health and HIV

HIV treatment and care standards have an important role to play in guiding commissioners and clinicians in a complex area. We recommend that the Government commission NICE to develop treatment and care standards for HIV and AIDS. These should be developed in association with people living with and affected by HIV, along with service providers, drawing upon existing treatment guidelines. (para 247)

Treatment and care standards must take into account psychological and mental health needs, and social care needs more broadly. They should also reflect the value of interventions from healthcare professionals, such as advice on reducing risk behaviours, in preventing onward transmission of the virus. This should happen immediately, as the required expertise is already in place. (para 248)

Commissioners should support managed service networks where they already exist. This should involve the provision of appropriate financial resources and the use of commissioning frameworks. Commissioners elsewhere should consider whether sufficient capacity is in place to move towards a networked model of care. NICE should consider, as part of its remit in developing treatment and care standards for HIV, the role of service networks as a means of efficient and integrated care provision for HIV and AIDS. (para 295)

We agree that we should consider the value that NICE could add in developing standards for HIV. The British HIV Association has produced clinical guidelines for HIV treatment since before NICE was established in 1999. These guidelines are widely accepted by clinicians and commissioners as describing best practice in the management of HIV.

NICE quality standards are currently produced for NHS services and NICE is carrying out an engagement exercise on a draft library of NHS Quality Standards on behalf of the National Quality Board. HIV treatment is not included in the draft library and a quality standard focussed exclusively on NHS treatment services may be of limited value. However, the provisions set out in the Health and Social Care Bill allow for the development of quality standards for social care and public health in England, thereby opening up the possibility of quality standards, commissioned jointly by the NHS Commissioning Board and Secretary of State, that support fully integrated care pathways. The Quality Standards core library will be kept under review to ensure that it reflects priorities, and includes cross-cutting topics where appropriate.

Charging people for their HIV treatment and care is wrong for public health, practical and ethical reasons. We recommend that HIV should be added to the list of conditions in the National Health Service (Charges to Overseas Visitors) Regulations 1989, for which treatment is provided free of charge to all of those accessing care, regardless of residency status. (para 257)

The Department of Health is reviewing the current policy which excludes some people from free HIV treatment.

There are a number of innovative ways of delivering specialist services which should be employed more extensively. These changes benefit patients by delivering treatment more conveniently and closer to home, whilst relieving pressure on specialist clinics and allowing closer working with those in primary care. These include:

- **Home delivery of antiretroviral drugs;**
- **Flexible evening and weekend access to services;**
- **Patient self-management services, including more extensive support materials;**
- **Virtual services such as telephone and email clinics for stable patients; and**
- **Nurse-led clinics. (para 267)**

The Government agrees that there are a number of innovative ways of delivering specialist services. The NHS is increasingly recognising innovative ways to redesign patient care pathways. For example, in the case of homecare delivery of medicines, this can reduce the frequency that patients have to attend outpatient clinics and help them adhere to their treatment.

Primary and community care

Given the increasing proportion of HIV-positive people on stable treatment regimens, commissioners and clinicians (including GPs) should develop, after consultation with patients, guidelines and protocols for the expansion of the above innovations. This can free up human and financial resources for more complex elements of HIV treatment and care. Protocols must, however, provide for specialist consultants to monitor the conditions of all patients at regular intervals. (para 268)

We recommend that the Government work with specialists, GPs and patients to develop a strategy for GPs to take on shared responsibility for the care of HIV-positive patients. This work should include broader consideration of the appropriate boundaries of responsibility between primary care and specialist services. The results should form the basis of longer-term strategies for expanding the role of GPs in the management of HIV-positive patients. (para 277)

The Government agrees with the Committee that HIV is increasingly seen as a long-term condition. We believe the NHS reforms will present opportunities for GPs, HIV charities and other qualified providers to provide part of the HIV treatment pathway, in partnership with specialist HIV treatment providers. We agree with the Committee that this would free up time and resources to enable HIV specialists to focus on the more complex elements of HIV treatment which may increase as people age with HIV.

The modernisation within the NHS provides an opportunity to develop new models for HIV treatment and care services. These will take time to evolve and for the relationships and confidence to develop between patients, specialist and non-specialist clinicians and other providers.

The Department of Health is developing a Payment by Results (PbR) tariff for HIV outpatient treatment and care. This will result in providers being paid for each patient and a focus on improving outcomes. It will

replace other funding methods like block contracts which provide no incentives for organisations to improve patient care. The HIV PbR tariff has been developed using a patient pathway approach with each element of the pathway costed out. The Department of Health has taken this work forward with a National Reference Group comprising HIV specialists and commissioners. If elements of the pathway are provided in future by primary care, HIV charities or other qualified providers, the tariff will enable appropriate reimbursement.

We are considering how Any Qualified Provider might be appropriate for elements of the HIV treatment and care pathway. It will be for commissioners to decide which service areas are suitable for Any Qualified Provider locally. In 2012-13 we are asking commissioners to assess local needs and priorities and select three or more community or mental health services. This might include HIV services if patients have identified this as an area where services could improve through offering more choice of provider.

Confidentiality

Upholding the confidentiality of patients is essential in any medical setting. This is particularly so for a condition as stigmatised as HIV, and in a setting as important as primary care. Confidentiality must be taken seriously, and shown to be taken seriously; general practice staff should make clear to patients the weight they attach to it. This should include clear and easily accessible confidentiality policies, and joint work with specialist HIV clinicians to highlight to patients how important confidentiality is considered within primary care. (para 284)

For better, more integrated HIV treatment and care, general practices and specialist services should work in partnership. We recommend that the Government work with professional associations to commission an audit of information-sharing processes and confidentiality policies in place between practices and HIV specialist clinics, to ensure that good practice is widespread. (para 285)

The Government agrees that protecting confidentiality is important; that is why the Department of Health has published the NHS Confidentiality Code of Practice, examples of good practice through the NHS Information Governance Toolkit (IGT), and requires NHS organisations to demonstrate minimum levels of attainment against the IGT standards through an annual data collection exercise. However, we recognise that

patients with HIV may require additional reassurance on these points. We will ask all Caldicott Guardians (who support patient confidentiality within each NHS organisation) to ensure that staff take appropriate steps to address this issue; we will also work with specialist HIV clinicians to exploit any channels of communication they may have to frontline practitioners.

The Department of Health would welcome the opportunity to work with professional associations to promote good information governance practice between GPs and specialist HIV clinics.

Monitoring and surveillance

The United Kingdom has an excellent system of HIV monitoring and surveillance. Monitoring has been part of the front-line response to HIV, with the HPA providing effective delivery, leadership and coordination in this respect. In undertaking reform, the Government must ensure that the surveillance of HIV infections, at a national level, continues to be appropriately resourced and managed. We recommend that Public Health England should coordinate this work nationally. (para 306)

The Government welcomes the Committee's acknowledgement of the excellent quality of the UK's HIV monitoring and surveillance system. This has been very important in informing national and local HIV responses and identifying areas for improvement, for example reducing late diagnosis of HIV.

The Health Protection Agency (HPA) carries out a broad spectrum of work relating to HIV surveillance. Our public health system reforms in England will preserve the quality and integrity of HPA's HIV surveillance with these functions seamlessly transferring into our new specialist public health body, Public Health England (PHE). This will be established as an executive agency of the Department of Health in April 2013 (subject to completing the normal government approval processes for establishing new bodies and passage of the Health and Social Care Bill through Parliament).

PHE will work closely and in partnership with NHS health care providers and local authorities to allow for the effective planning and delivery of treatment services and to support national and local prevention initiatives. PHE will continue to provide HIV monitoring and surveillance, thereby supporting NHS and local commissioners and the voluntary sector to

work in concert to support people living with HIV and those at risk from infection. It will do so by providing timely and world-class information, intelligence, data and expert advice. Our health and social care reform and the establishment of PHE will provide a real opportunity for national leadership of public health initiatives such as those on HIV.

Public health reforms

It is essential that Health and Wellbeing Boards are able to draw upon the insights of those commissioning HIV treatment. We therefore recommend that, in areas of high HIV prevalence, the national NHS Commissioning Board be required to provide appropriate representation on local Health and Wellbeing Boards. (para 315)

The Health and Social Care Bill already makes provision for the NHS Commissioning Board to be required to have a representative when asked by the health and wellbeing board. It will also be required to send a representative to participate in the health and wellbeing board's preparation of the Joint Strategic Needs Assessment (JSNA) and joint health and wellbeing strategy (JHWS). The NHS Commissioning Board will have clear duties to promote integration and to have regard to the JSNA and JHWS in exercising their own commissioning functions. These provisions should enable health and wellbeing boards and those commissioning HIV treatment to collaborate in the way this recommendation intends.

The local presence that the Board will have is yet to be decided. The abolition of PCTs creates an opportunity to find the best solution for different services and this is something the shadow board will be working with the NHS and other stakeholders on over the coming year.

Health and Wellbeing Boards will be required to coordinate a wide range of public health interventions, many of which affect large numbers of people. It is possible that areas such as HIV, and sexual health more generally, may struggle to compete for attention. We therefore recommend that, in areas of high HIV prevalence, Health and Wellbeing Boards should be required to undertake an annual review of the management, coordination and integration of HIV and sexual health services. (para 316)

Health and wellbeing boards will provide a forum to bring together the NHS, councils and local communities in each local area to develop a

shared understanding of local needs (through the JSNA) and a shared strategy for how the NHS and councils will address those needs (the joint health and wellbeing strategy) to inform both the NHS and councils' commissioning plans. This will help ensure that the needs of people living with HIV or at risk from HIV are understood and that local commissioning plans, and in turn local provision, are meeting those needs appropriately.

Local HealthWatch will also have a key role in ensuring the needs of the most vulnerable are heard and addressed. It will be up to each local health and wellbeing board to take account of vulnerable groups in the most appropriate way.

We expect health and wellbeing boards will need to engage with a variety of players to ensure the right expertise and voices including those of less well-heard groups are inputted into both the JSNA and joint health and wellbeing strategy.

Health and Wellbeing Boards will be particularly important for conditions such as HIV, where they provide the opportunity to coordinate disparate service commissioners and providers. We recommend that commissioners be placed under a duty to secure the approval of Health and Wellbeing Boards before finalising their commissioning plans. We also call upon the Government to make clear the funding routes and mechanisms which will ensure that Health and Wellbeing Boards can deliver their programme of work. (para 317)

The Government's response to the NHS Future Forum underlined that the health and wellbeing board should be involved during the development of clinical commissioning group's commissioning plans. Though they will not have a veto health and wellbeing boards will have a clear right to refer plans back to the clinical commissioning group or to the NHS Commissioning Board for further consideration if they do not think they are in line with the joint health and wellbeing strategy. The joint health and wellbeing strategy and its link to commissioning plans will form the basic link for the health and wellbeing board to promote joint commissioning and integrated provision between health, public health and social care.

Health and wellbeing boards are not just about assessments and strategies. Health and wellbeing boards will have a stronger role in promoting joined up commissioning and, through that, integrated

provision between health, public health and social care. While they will not hold funds in their own right, they can be the vehicle for "lead commissioning" for particular services, for example social care for people with long-term conditions – with pooled budgets and lead commissioning arrangements where the relevant functions are delegated to them by the local authority or to the local authority by NHS commissioners.

We recommend that Directors of Public Health should be registered with an appropriate professional body. In addition, local authorities should be required to appoint Directors of Public Health to corporate management positions. More generally, we recommend that the Department of Health should give greater formal definition to the revised role and status of Directors of Public Health. (para 323)

Public health professionals play a critical role in ensuring effective arrangements for improving health and protecting the public from harm. In the recent public health policy paper *Healthy Lives, Healthy People: update and way forward*, we have asked for further evidence as to how extending statutory professional regulation or registration would provide significant public protection over and above the currently proposed arrangements for ensuring high quality appointments to Director of Public Health (DPH) posts. We are now considering this evidence and will bring forward proposals in due course. As set out in *Healthy Lives, Healthy People: update and way forward* we would expect the DPH to be of Chief Officer status with direct accountability to the Chief Executive for the delivery of local authority public health functions.

The Public Health Outcomes Framework indicator on late HIV diagnosis will be vital in ensuring that HIV testing is prioritised by local authorities in the new structure. We recommend that it be included in the final adopted set of indicators by the Department of Health, and that it be included in the health premium calculation for all local authority areas. (para 327)

The Government have yet to make decisions on which indicators should be included in the health premium. We expect the health premium indicators to be a small subset of the indicators in the Public Health Outcomes Framework, but we will have to consider other factors, such as the influence local authorities have to improve the indicator and the availability of sufficiently robust data for each local authority. The indicator on late HIV diagnosis will be considered in this context, alongside other candidates for inclusions.

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