MINUTES OF THE 92nd MEETING OF THE EXPERT ADVISORY GROUP ON AIDS 17 October 2012

Chair: Professor Brian Gazzard

Secretariat: Dr Linda Lazarus (HPA)
Dr Alison Brown (HPA)

Members:
Dr Chris Conlon
Mr David Crundwell
Dr Matthew Donati
Ms Ceri Evans
Dr John Green (pm only)
Dr Jeremy Hawker
Ms Ruth Lowbury
Ms Beatrice Osoro
Sir Nick Partridge
Prof Deenan Pillay
Dr Anton Pozniak (am only)
Dr Alison Rimmer
Dr Susan Sellers
Dr Ewen Stewart

Observers:
Mrs Moji Ajeneye (MHRA)
Dr Su Brailsford (NHS BT/HPA)
Dr Naresh Chada (DHSSPS Northern Ireland)
Professor Noel Gill (HPA)
Lt Col Peter Hennessy (MoD)
Mrs Julie Nugent (DH)
Ms Kay Orton (DH)
Dr Nicola Steedman (Scottish Government)

Invited:
Dr Éamonn O'Moore (DH/HPA)
Dr Alan Tang (BASHH)
Dr Rowena Jecock (DH)

Apologies:
Dr Helen McIlveen
Dr Keith Radcliffe

Apologies:
Dr Valerie Delpech (HPA)
Mrs Tracey Gauci (Welsh Assembly)
Mr Gerry Robb (DH)

Agenda item 1 Welcome, introductions, apologies and announcements

1. The Chair welcomed everyone to the meeting and announced that this was the last meeting for three long-serving EAGA members – Dr Jeremy Hawker, Sir Nick Partridge and Dr Alison Rimmer. It had not been possible to extend their terms of appointment any further. The Chair offered them each the opportunity to reflect upon their time on EAGA and would return to invite their thoughts at the end of the meeting. It was also noted that Gerry Robb had been temporarily assigned to the immunisation team in the Department but was expected to return in the New Year; Julie Nugent was covering for him.

2. Members were reminded that discussions at EAGA were confidential. Papers, unless in the public domain, were also to be treated as confidential. No interests were declared.

Agenda item 2 Minutes of the last meeting (22 February 2012)

3. The minutes were agreed as an accurate record without amendment.

Agenda item 3 Matters arising

Agenda item 3.1 *Report from the Secretariat* *Paper EAGA(92)1*

4. Two of the sections in the report from the Secretariat were discussed. Firstly, the change in EAGA's status to a Departmental Expert Committee (DEC) was due to take effect on 1 November 2012. All the members plus observers from the Devolved Administrations' Health Departments had received written notification of this from DH. It was important to

briefly discuss the implications and to ensure the observers from the other government departments and agencies were aware of the change.

5. No differences were anticipated with respect to the independence of the committee and the advice it provided. The Chair and Members would continue to be appointed based on individual expertise but these would cease to be public appointments. The Secretariat would be provided by Public Health England from 1 April 2013. As with any change, there were both potential opportunities, for example to have a broader remit, and possible threats. DH was not averse to receiving advice on a wider range of issues (see agenda item 6 for some possible examples), but EAGA needed to be careful not duplicate the work of the Sexual Health Forum, which was an informal stakeholder group advising the DH.

6. The second subject discussed concerned recruitment of new members. For the public health specialist role, working with local authorities (LAs) was viewed as a critical attribute. For the occupational health role, current working knowledge of occupational health within the NHS was important. For the HIV voluntary sector members, there were several important attributes including the need to attend regularly, to be articulate and able to represent the views both of people living with HIV and those wishing to remain HIV negative from the most affected populations. Applicants for any of the posts would be encouraged to be open about their HIV status.

Agenda item 3.2 *Selection of a new Vice Chair of EAGA* *Paper EAGA(92)2*

7. Nominations for the position of Vice Chair were invited from the membership. These were to be forwarded to the Secretariat within a week of the meeting. [Mr David Crundwell was subsequently elected by the membership to be the new Vice Chair.]

Agenda item 3.3 *EAGA Workplan 2012/13: to agree and review progress*
Paper EAGA(92)3

8. Most of the items on the draft 2012/13 workplan had either been completed, were scheduled for future discussion or were standing items. Other items still needed confirmation and might therefore need to be carried over to the 2013/14 workplan. Monitoring and evaluation of HIV Prevention England (the new national HIV prevention programme) had been commissioned by Terrence Higgins Trust (THT) from Sigma Research, based at the London School of Hygiene and Tropical Medicine. This was a legitimate topic of future interest for EAGA but not for the current workplan. (Agreed workplan at Annex 1).

Agenda item 4 **HIV in prisoners and immigration detainees**
Agenda item 4.1 *BASHH survey of prison HIV health care*

9. Dr Alan Tang, as the lead for BASHH on HIV and STIs in prisons, presented some preliminary results from a recent BASHH survey of HIV healthcare in prisons (including young offenders' institutions) and immigration removal centres (IRCs). The survey was publicised through the BASHH newsletter, BHIVA e-mail network and BASHH branches. A number of the survey questions specifically sought evidence on how NAT/DH's best practice framework was being used in prisons[1].

[1] NAT/DH. Tackling blood-borne viruses in prisons: a framework for best practice in the UK. Updated May 2011.

10. Most of the HIV-related workload was concentrated in prisons and IRCs in London and Surrey. Data were received from 61 prisons and IRCs indicating that they provided measurable levels of HIV healthcare; a further 25 respondents provided no HIV healthcare. Services provided were a mix of 'in reach' outpatient services (i.e. on-site clinics) and 'out reach'. In 2010, 73% of respondents saw fewer than 10 HIV-positive patients. In-depth interviews were planned with those service providers with the largest caseloads. Some of the problems identified by the survey included: (i) lack of written policy for managing HIV-positive inmates; (ii) poor availability of PEP starter packs and (iii) lack of written policies on PEP use after needlestick injury.

11. Dr Tang acknowledged BHIVA's help in encouraging their members to complete the survey and HPA's ongoing help with data analysis and support with implementing the survey.

Agenda item 4.2 *Policy perspective and NAT survey of Immigration Removal Centres (IRCs)*

12. Dr Éamonn O'Moore, Consultant in Public Health and Senior Policy Advisor on Offender Health working across the Department of Health and Ministry of Justice, provided an update from the policy perspective. The provision of healthcare in prisons had improved substantially since 2006 when commissioning responsibility passed from the Home Office to the NHS. Concerns remained about the quality of care provided in IRCs, which was currently commissioned from a mix of providers including the NHS and UK Border Agency (UKBA), and delivered by a mixed economy of GP consortia and private providers. From April 2013, the NHS Commissioning Board (NCB) will assume commissioning responsibility for healthcare in all English prisons and other prescribed places of detention, including IRCs.

13. Working in partnership with Offender Health and UKBA, the National AIDS Trust (NAT) is currently conducting a repeat survey on HIV care in IRCs. An earlier survey had identified gaps in service provision and standards, which had informed the 2009 NAT/BHIVA document "Detention, Removal and People Living with HIV: Advice for healthcare and voluntary sector professionals". Survey questions covered patient demographics, access to antiretrovirals while in detention and planning for removal/deportation. The findings will inform an update to the best practice advice and provide important evidence for the NCB when considering commissioning specifications for care for people living with HIV in IRCs.

14. The two presentations were discussed together and a number of observations were noted.

- NHS providers needed to show greater flexibility when treating patients in detention, particularly around late arrivals/missed appointments, as these were often beyond the patient's control.
- Lack of information (e.g. due to failure of medical record handover) should never be used as an excuse not to treat, especially where this could result in treatment interruption.
- SystmOne, the integrated IT system operating across the prison estate in England & Wales (but not Scotland or Northern Ireland) had improved the sharing of records between prisons (infected individuals less likely to 'disappear'), but there remained an issue about transferring health records on return of prisoners and detainees to the community/NHS care.

- Responding to a question about whether HIV transmission in prisons had been investigated, EAGA was informed that transmission events were rare and difficult to capture (would require testing negative on reception with a subsequent positive test). Hepatitis B transmission was more common, through tattooing practices, although still very rare. While behaviours that give rise to infection, such as sharing injecting equipment, in all probability occur in prisons, the average jail term of 3-6 months means infections are more likely to be detected after release.
- A standard for condom provision in prisons had been introduced via the Prison Health Performance and Quality Indicators[2] and Governors were held accountable. This had resulted in a significant improvement in access. Condoms still had to be requested by prisoners from a member of the healthcare team, but this lack of free access provided an opportunity for discussion of risk behaviours. The Observer from the Scottish Government noted that the uptake of condoms in Scottish prisons was poor and there was significant stigma attached to being found in possession of a condom.
- Blood-borne virus (BBV) screening was included as part of health screening on reception. This was a two-stage process: first, a review of risk factors around drug use and mental health and the offer of first-dose hepatitis B vaccine; second, testing for BBVs if identified as at risk. Data for 2011-12 showed that, overall, 6.2% (9,970/161,125) of new receptions to English prisons received a hepatitis C test compared to 7,200 tests for the whole of 2010-11, but this was only a fraction of the prison population (standing prison population is approx. 85,000).

Agenda item 5 DH policy update

15. Sexual health policy document: Publication of this document, the successor to the National Strategy for Sexual Health and HIV (2001), had been delayed, partly due to the need to clarify the impact of the new commissioning arrangements for sexual health services, and to take account of the possible publication of other sexual health documents.

16. The document aimed to demonstrate how sexual health is integral to public health, why it needs improving and setting this in the context of the broader determinants of health. The intended audience was much broader than for the Strategy, including commissioners, LAs, NHS Commissioning Board (NCB) as well as clinicians.

17. The policy team was optimistic that the new minister for public health would agree to publish the policy document. The same draft as submitted to the minister would be shared with EAGA members in confidence for comment. Members were urged to respond quickly and robustly, focussing particularly on the HIV aspects. The Sexual Health Forum had had the opportunity in September to comment on an earlier draft and their comments were in the process of being incorporated. There would be no further consultation following publication, as all key stakeholders had been consulted during the drafting process.

18. HIV testing kits and services regulations 1992: DH was still committed to repealing these Regulations as they lacked relevance to current medical practice, but there was a formal process to be followed, including a period of public consultation. Capacity issues within the policy team had delayed preparation and publication of the necessary documentation. Both NAT and THT had provided useful supporting data and technical input was also required

[2] Department of Health. Prison Health Performance and Quality Indicators 2012. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_133379

from the Medicines and Healthcare products Regulatory Agency (MHRA) who have an interest as the UK's regulatory body for medical devices (which includes HIV testing kits).

19. NHS (Venereal Diseases) Regulations 1974 and the NHS Trusts and PCTs (Sexually Transmitted Diseases) Directions 2000: DH had taken soundings on the implications of repealing these regulations and directions. There were different issues for HIV as a long-term condition, which would necessitate the sharing of information, versus patients making one-off visits to GUM for whom anonymity might be critical. It was important to safeguard confidence in services. There was also a lack of guidance on GUM providing feedback to GPs on patients they referred to sexual health services. The act of referral implied the patient had consented to their GP knowing they had a sexual health concern, but there was some anecdotal evidence that some GUM clinics did not provide GPs with feedback. This was inconsistent with championing an increased role for GPs in sexual health matters. There was also a need for clear governance arrangements on information sharing with local government, independent and third sector providers that would safeguard patient confidentiality.

20. Re-tendering for national HIV prevention programme contract: The new 3-year contracts for national HIV prevention work and specialist sexual health information had been awarded to THT and fpa, respectively. This was announced in a press release in July 2012.

21. HIV treatment for overseas visitors in England: The charging regulations had been amended to allow HIV treatment for overseas visitors in England, regardless of residency status, consistent with other STI treatment. Associated guidance had been published by the Department of Health on 28 September 2012 and circulated to EAGA members for information.

Agenda item 6 Health System Reform and feedback from HIV Clinical Reference Group

22. Responsibility for HIV prevention was passing to LAs from April 2013 with the exception of the national programme (HIV Prevention England) delivered by THT, the management of which would pass to Public Health England (PHE) from 2013. In contrast, HIV treatment and care services would be nationally commissioned. The existing BHIVA Standards of Care for People Living with HIV and those soon to be launched (29 November 2012) may prove too expensive to adopt in their entirety. The biggest cost pressure on the treatment and care budget remains antiretroviral drugs. The NCB would need to take a view on whether patient-centred care demanded a certain level of expertise (as measured by proportion of time devoted to HIV care) to be commissioned to provide care on an ongoing basis. HPA data on the effect of HIV centre size on care quality outcomes demonstrated that: (i) smaller sites were better at integrating patients into care promptly; (ii) centre size made no different to virological outcomes (i.e. proportion with undetectable viral load).

23. The number of centres currently providing specialist HIV care was clearly unsustainable. The system had not adapted to the need to work differently, in recognition that HIV infection was now largely a chronic condition. The number of patients receiving NHS care had expanded significantly since the current service configuration was designed. The need for face-to-face specialist care was now minimal, with delivery of the majority of care possible through a combination of self-care and primary care. The ageing HIV-infected population also meant a rise in co-morbidities, which were more appropriately managed in

primary care. Social care provision and other non-medical elements were major contributors to quality of life. Current data collection, with its focus on CD4 count and viral load, was unable to capture this essential patient outcome measure.

24. A lesson could be learned from oncology. They had taken a pragmatic approach to re-organising services, which had faced considerable opposition initially but had since won acceptance. Guidance would be needed to identify the dedicated components of an HIV service and score units against a set of objective measures. Work on the HIV outpatient pathway indicated that around 80% of HIV patients overall would be categorised as 'stable', with the remainder split equally between 'new' and 'complex' patients. However, medically stable patients could still have a myriad of social and psychological needs. There was a danger that, if service re-design was not tackled proactively, financial considerations could dictate the outcome rather than patients' best interests.

25. The Chair pointed out that achieving consensus among HIV clinicians on amalgamating services might be hampered by their vested interests and he proposed that EAGA, with its multidisciplinary representation, would be well placed to provide such advice. The aim would be to achieve the best deal for patients whilst minimising risks.

26. Other areas on which EAGA could offer advice in future included:
    - Generic prescribing – with more antiretrovirals coming off licence in the near future, there was a need to consider whether switching from the 'ideal' regimen of one pill per day to two (or more) pills (because the co-formulated versions were not yet generic) would have a negative impact on patient outcomes.
    - PrEP – if demonstrated to reduce transmission among MSM in the UK, how should this be funded? LAs would be unlikely to fund it, yet long-term savings to the treatment and care budget were potentially very large.
    - Risks and benefits to patients of service reconfiguration and changes to delivery of care.
    - Maintenance of tertiary GUM as a source of specialist expertise, research and training capacity.

27. The Chair confirmed that the HIV Clinical Reference Group was not addressing maternity care; this was being commissioned locally. The risk of not taking a holistic approach to the medical complications of pregnancy had been flagged with DH. It was also observed that HIV infection was not like other chronic conditions, such as diabetes, because of the public health implications and associated high costs of poor management (i.e. it is not just the individual's health that suffers). Psycho-social support helps mitigate risk behaviour (e.g. poor adherence) and is therefore a critical component of good HIV care.

28. One of the unintended consequences of the change in commissioning arrangements was that some HIV units in low and medium prevalence areas might have to close or merge following transfer of co-located GUM services to other providers, if tendered. DH had written to PCTs and other NHS commissioners to gauge the extent to which tendering of GUM sexual health services was happening and whether HIV services were included or excluded from tenders. Responses to date indicated that exclusion of HIV services was uncommon. The concern was that the process of service reconfiguration needed to be well-managed – patients attending under-performing units may benefit from having their care transferred to better-performing centres. However, HIV physicians needed to be aware and engaged in the process as advocates for their patients.

29. There was scant research data on best models of HIV care. The literature was based on North American studies and these were not particularly recent.[3] It was noted that resource-poor countries had achieved good patient outcomes with far less sophisticated models of care. THT had launched a pilot project of a nurse-led community clinic combined with self-care. During the pilot, 40 people living with HIV in Lambeth would be selected to receive routine HIV monitoring and care within a local GP surgery from HIV clinical nurse specialists and a range of integrated services including counselling, advice and bespoke web-based support for self-care. Results of the pilot would be published in July 2013.

30. Some key principles could probably be agreed from the outset. While the HIV outpatient pathway had defined three patient groups, it did not specify how patients should be managed. For example, complex patients and inpatients needed specialist management. A certain minimum throughput of patients was needed to maintain competencies and train up expertise. Stable patients could perhaps be offered a choice of providers – GPs, community-based service or GUM clinic – with specialist review every 3 years (or more frequent for those aged >50 years) to ensure treatment regimens remained optimal and reflected therapeutic advances.

31. The Chair proposed that EAGA host a half-day meeting to address the issue of service reconfiguration, inviting selected external participants to present views. Invitees to include:
    - Chair of BHIVA
    - A clinician from a small unit outside London
    - An expert on measuring outcomes
    - Representative from a successful managed clinical network (e.g. cancer) to explain how it works/the benefits
    - Diabetologist
    - Patient advocate

Agenda item 7 Management of HIV-infected healthcare workers: remaining consultation queries (SP 1&2) Paper EAGA(92)4

[Some discussion under this agenda item relating to policy in development has been omitted.]

32. Technical queries arising from the responses to the DH consultation on HIV-infected healthcare workers had been addressed by the Tripartite Working Group (which included several EAGA members) to inform DH's formal response to the consultation feedback. DH referred two outstanding issues to EAGA. These were discussed and advice agreed.

Agenda item 8 Treatment as prevention (TasP): joint position statement with BHIVA – latest draft Paper EAGA(92)5

33. The Secretariat explained that the draft circulated as Paper EAGA(92)5 had not had the latest comments from the Working Group incorporated but was being shared with EAGA to allow them to see how the work had progressed. EAGA would be invited to endorse the document once finalised.

34. The statement on treatment as prevention was in two parts: the first part was intended for a wide audience including health promoters and people affected by HIV; the second part

[3] Handford CD et al. The association of hospital, clinic and provider volume with HIV/AIDS care and mortality: systematic review and meta-analysis. AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV, 2012; 24:267-82. Available from: http://dx.doi.org/10.1080/09540121.2011.608419

provided the detailed rationale for the viral load cut-off and the duration of undetectability, for those who wanted to understand the supporting evidence.

35. The drafting had created potential confusion about the role of condoms and a revision of the highlighted statement was suggested, as follows: "It must be noted that, for the prevention of other STIs, condoms remain the most effective method, irrespective of ART. No one method can completely prevent HIV transmission." This proposed revision would be forwarded to the BHIVA lead.

36. The Chair advised that the International Association of Physicians in AIDS Care (IAPAC) were planning a follow-up meeting in September 2013 to the TasP-PrEP summit held in London in June 2012.

Agenda item 9 Request for confidential advice (SP3-5) Paper EAGA(92)6

[Discussion under this agenda item relates to policy in development and has been omitted.]

Agenda item 10 Annual HIV epidemiology update Paper EAGA(92)7

37. An overview of the 2011 HIV data for the UK was presented. The latest new HIV diagnoses, AIDS and deaths tables were about to be published [click for link]. In summary, the total number of new diagnoses for 2011 was 6630, similar to the level seen in 2010. There were more new diagnoses in MSM than in heterosexuals for the first time since 1999 due to the combined effects of reduced migration from sub-Saharan African countries and increasing numbers of infections among MSM. Around half of new diagnoses were still made late (at a CD4 count <350), although this varied by prevention group, being lowest among MSM at 29%. Those diagnosed late accounted for 90% of the total 500 deaths. Around 70,000 diagnosed individuals received HIV treatment and care in 2011. The overall prevalence estimate for 2011 was in preparation for inclusion in the annual HIV report to be published for World AIDS Day. However, it was projected that 100,000 individuals would be living with HIV by the end of 2012.

38. A back-calculation method based on the natural history of CD4 counts had been used to estimate annual HIV incidence in MSM; the resulting rate was 2000-3000/year over the past decade. A marginal decline in the median time from infection to diagnosis was also observed.

39. Another method had been applied to better understand the force of infection driving the UK's MSM epidemic. Despite the proportion of MSM on treatment having increased annually, around 14,000 (35%) in 2010 were potentially 'infectious', having a viral load of >1500 copies/ml. The majority of infectious MSM were undiagnosed, with only around 5% on treatment being in this category (typically those who only started treatment recently). Starting treatment earlier, i.e. for those with CD4 counts in the 350-500 range, would have a relatively modest impact on infectivity (35% reducing to 29%), whereas combining this with halving the undiagnosed fraction would leave an estimated 21% infectious. For this population, treatment as prevention alone was not predicted to have a major impact on transmission.

40. Accurate estimates of the proportion of HIV infections that are acquired in the UK versus abroad are important for informing HIV prevention activities in this country, especially for black African heterosexuals who have the highest rates of late diagnosis. Among UK-born individuals, 80% probably acquired their infection in the UK. More heterosexual men

(older and of white ethnicity) tended to acquire their infection abroad[4]. Applying an algorithm (based on rates of CD4 decline between infection and diagnosis) to assign probable country of infection for HIV-infected heterosexuals born abroad led to substantially higher estimates of UK-acquired infections – 46% versus 20% based on clinic reports – with an upwards trend over time[5]. Adjustments for age and year of arrival in the UK were incorporated. The possibility of gender differences for those born abroad and infected in the UK had yet to be explored.

41. The treatment cascade was used to illustrate the high quality of care attained in the UK. Based on 2010 figures, 76% of HIV-infected individuals were diagnosed, 82% of them were on treatment and 87% had an undetectable viral load. Areas for improvement included the speed with which newly diagnosed patients were transferred into care (date of first CD4 count used as a proxy), which varied considerably by the setting in which they were diagnosed. Overall, 92% of newly diagnosed patients were transferred within 1 month, but outside GUM (e.g. from GPs, antenatal clinics and inpatients) there appeared to be delays.

42. HPA was collaborating with BHIVA on their audit of loss-to-follow-up (LTFU) by providing clinics with lists of patients who had not been seen for care for >12months and were not known to have died or transferred their care to another site. In addition, an audit of patients who had died was to be conducted across London to support quality of care indicators.

43. HPA was involved in data provision for a number of indicators including those in the HIV Dashboard and the Public Health Outcomes Framework. Submission of timely data to HPA/PHE was to be included in the new BHIVA standards. To support this work a new HIV and AIDS Reporting System (HARS) would be rolled-out to clinics during 2013 (pilots to run from January 2013) to replace existing data returns for new HIV diagnoses and SOPHID, simplifying and streamlining returns for reporters and allowing for a range of new outputs. Records would be attendance-based and would collect new information, such as on co-infections, to inform commissioning.

44. In the ensuing discussion, the following points were made. (i) With respect to treatment as prevention, commissioners would not fund antiretroviral medication for patients with CD4 >350 nor for pre-exposure prophylaxis. This position was unlikely to change until the outcome of the Strategic Timing of AntiRetroviral Treatment (START) trial was known. However, there remained strong arguments for prescribing TasP for some individuals regardless of commissioners' willingness to pay. Maximising the public health benefit of treatment for eligible patients meant looking more closely at those not on treatment, to determine whether this was through choice or because they had not been offered treatment. Modelling indicated that treating those with higher CD4 counts would have a minor impact on infectivity and hence transmission, but there was evidence that diagnosis *per se* was beneficial, even without treatment.

45. (ii) The indication that the number of heterosexuals acquiring HIV infection in the UK had been under-estimated suggested more prevention work was needed to protect this group. The unchanged incidence among MSM was further evidence that prevention needed strengthening. Critical to addressing this was knowing how well the recommended expansion of HIV testing in areas of high HIV prevalence (>2/1000 diagnosed prevalence)

[4] Rice B et al. Safe travels? HIV transmission among Britons travelling abroad. HIV Med 2012; 13:315-7.
[5] Rice B et al. A new method to assign country of HIV infection among heterosexuals born abroad and diagnosed with HIV in the UK. AIDS 2012; 26:1961-6.

was being implemented. Investment in prevention at the local level had declined and local government should be challenged to address this. Integrating behaviour change expertise into clinics would be a key area for development.

46. (iii) 22% of patients accessing HIV care in 2011 were over 50 years old. Patients' expectations of accessing all their medical care from HIV specialist services would have to be revised. General practitioners were more experienced in treating conditions associated with ageing (e.g. cardiovascular risk, bone loss) and shared care was more appropriate for non-HIV-related matters. How HIV care can best be delivered in conjunction with other parts of the healthcare system, such as services for the elderly, was proposed as a topic for future discussion by EAGA.

47. (iv) Commenting on the delays to transfer into care of patients diagnosed outside GUM, members thought these might be artefactual, arising from problems identifying or matching CD4 count samples to patient records. Antenatal care had established standards for time to referral of pregnant women with HIV to the multi-disciplinary team. GPs tended to refer patients very quickly, requesting specialist appointments within 1-2 days. One group whose transfer might be delayed were people who inject drugs because of difficulties contacting them following initial testing. It was recommended that HPA examine these data on access to specialist care more closely.

Agenda item 11 PEP guidelines
Agenda item 11.1 Addendum to PEP guidance and PrEP query Paper EAGA(92)7

48. *PEP for students on electives*: EAGA reviewed the queries raised by Dr Swann concerning PEP provision for medical students undertaking elective studies in countries of high HIV prevalence. There were several reasons why EAGA had recommended Truvada/Kaletra in preference to Combivir/Kaletra including: (i) the deliquescence of Combivir (i.e. Truvada was more stable for long-term storage); (ii) the greater likelihood of transmitted resistance to the components of Combivir; (iii) the better side effect profile of Truvada and (iv) the less stringent food requirements for the Truvada/Kaletra regimen.

49. The PEP guidance (paragraph 90) recommended a 7-day starter pack of PEP drugs be made available to students undertaking elective studies. This assumed PEP would not be commonly available in the country visited. However, the starter pack requirement could be tailored to match availability of local supplies. A minimum of 2-days' supply was necessary to cover the most critical period for establishment of infection following exposure.

50. *PrEP for operating teams*: In the expectation that such a question would arise in future, EAGA had been asked for its advice concerning a request from a member or members of a surgical team to receive PrEP to protect them when operating on HIV-infected patients. EAGA rejected the idea, arguing that the risk-benefit balance would not favour use of PrEP under such circumstances. Reducing the patient's viral load with antiretroviral treatment and other precautions (such as double-gloving and using blunt suture needles) would be more appropriate and effective.

Agenda item 11.2 *HSE Consultation on proposed regulations to implement Council Directive 2010/32/EU on preventing sharps injuries in the hospital and healthcare sector: draft response from EAGA* *Paper EAGA(92)8*

51. There were no comments on the draft response (Paper EAGA(92)8). It would be submitted by the Secretariat to the Health and Safety Executive.

Agenda item 12 Any other business

52. The three EAGA members who were leaving the committee after more than 10 years service were invited to share their thoughts on their time on EAGA.

Agenda item 13 Date of the next meeting

53. The next meeting will be on **27 February 2013.**

Annex 1 **EXPERT ADVISORY GROUP ON AIDS**
WORKPLAN 2012-13

Topics	Lead	Timescale
➢ Management of HIV-infected healthcare workers: issues responding to consultation queries	EAGA members of Tripartite Working Gp	Sept/Oct 2012
➢ PEP • Audit of compliance with HIV PEP guidelines • Discussion of revisions/addendum	Alison Rimmer/Keith Radcliffe	tbc October 2012
➢ HIV partner notification: review of the evidence base	Keith Radcliffe	February or June 2013
➢ HIV treatment and care service reconfiguration	Brian Gazzard	February 2013
➢ National Screening Committee scoping study on HIV screening in general practice	Helen Ward	tbc
➢ Delivery of HIV testing, treatment and care and prevention in England – impact of NHS and public health reforms	ALL	Standing agenda item
➢ Sexual health policy framework: opportunity to comment on draft	Kay Orton	October 2012
➢ Prison HIV healthcare: results of BASHH survey	Alan Tang/Eamonn O'Moore	October 2012
➢ Ongoing review of surveillance data	HPA	October 2012
➢ BHIVA Clinical Audit on Loss to Follow-up: presentation of results	Hilary Curtis	Not before June 2013 (timing tbc)
➢ Consideration of agenda (and desired outcomes) for Director General for Public Health's attendance at EAGA	ALL	February 2013
➢ EAGA's remit and purpose in the context of Public Health England and restructured Department of Health	ALL	June 2013
➢ Horizon scanning for emerging HIV issues	ALL	ongoing
➢ 'Test and treat' and 'treatment as prevention' strategies: • Expansion of HIV testing • Pre-exposure prophylaxis • Discordant couples management • Risk compensation following biomedical interventions (e.g. PrEP, TasP, male circumcision)	Brian Gazzard, Ruth Lowbury, Keith Radcliffe, Beatrice Osoro	Ongoing + joint work with BHIVA on position statement on treatment as prevention
➢ Contribute to DH, NICE, BASHH, BHIVA consultations/reviews of guidance	As appropriate	As required