MINUTES OF THE 94th MEETING OF THE EXPERT ADVISORY GROUP ON AIDS 19 June 2013

Chair: Professor Brian Gazzard

Secretariat: Dr Linda Lazarus (PHE)

Members:
Prof Jackie Cassell
Mr David Crundwell
Dr Matthew Donati
Dr Annemiek De Ruiter (co-opted)
Ms Ceri Evans
Dr John Green
Ms Deborah Jack
Prof Dame Anne Johnson
Ms Ruth Lowbury
Dr Helen McIlveen
Ms Beatrice Osoro
Prof Andrew Phillips (co-opted)
Prof Deenan Pillay
Dr Anton Pozniak (pm only)
Dr Keith Radcliffe
Dr Ewen Stewart
Mr Paul Ward

Observers:
Mrs Moji Ajeneye (MHRA)
Dr Su Brailsford (UK Blood Services/PHE)
Dr Alison Brown (PHE)
Mrs Marsha David (DH)
Dr Valerie Delpech (PHE)
Lt Col Ngozi Dufty (MoD)
Professor Noel Gill (PHE)
Ms Kay Orton (DH)

Apologies:
Dr Naresh Chada (DHSSPS Northern Ireland)
Dr Chris Conlon
Dr Andrew Riley (WAG)
Dr Alison Rimmer (co-opted)
Dr Nicola Steedman (Scottish Government)

Invited:
Dr Felicity Harvey (DH) from 2.20pm
Dr Hilary Curtis (BHIVA) for item 10
Ms Shahin Parmar (on secondment to DH from Luton Council - observing)

Agenda item 1 Welcome, introductions, apologies and announcements

1. The Chair welcomed everyone, in particular the first time attenders and those who had not attended recently, as follows: Professor Jackie Cassell, the new EAGA representative for Public Health; Professor Andrew Phillips, co-opted member providing cohort study and modelling expertise; Dr Annemiek DeRuiter, co-opted member providing expertise on HIV in pregnancy; Dr Ngozi Dufty, the new MoD observer from the Military Advice Service for Sexual Health and HIV, based at Birmingham Heartlands Hospital; and Mrs Marsha David, who has taken over the DH Sponsorship role from Gerry Robb, as Gerry has now moved permanently to a new role in DH.

2. The Chair announced that Dr Felicity Harvey would be joining the meeting for one or two items in the afternoon, rather than the whole meeting, due to other commitments. He congratulated Professor Johnson on being made a Dame Commander of the Order of the British Empire in the recent Queen's Birthday Honours List, for services to the study of infectious diseases.

Agenda item 2 Minutes of the last meeting (27 February 2013)

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

Agenda item 3 **Matters arising**

Agenda item 3.1 *Report from the Secretariat* *Paper EAGA(94)1*

4. There were no matters arising from the minutes that were not included on the agenda. The Secretariat drew attention to part B of the report concerning annual appraisals for members that would be conducted over the summer. The Chair offered assurances that this would not simply reflect contributions at meetings, but also members' roles in feeding back to their constituencies on developments/discussions held at EAGA.

Agenda item 3.2 *Feedback from NICE Topic Selection Workshop on 25 April 2013*

5. As a registered NICE stakeholder, EAGA had been invited to send two representatives to the topic selection workshop on HIV. The Chair and Dr Radcliffe attended on behalf of EAGA. A similar exercise on sexual health had been conducted the same afternoon. All major stakeholders had been represented and were tasked with identifying the single most important issue to address – *the* public health priority. Officials would then brief Ministers, who would decide whether the topic should be referred to NICE as a priority for guideline development.

6. There was a wide-ranging discussion with many ideas proposed (including primary and secondary prevention, testing and implementation, PrEP, partner notification and behaviour change) but no decision was taken on the top priority. It was noted that a partial update to the Behaviour Change guidance (PH6) was scheduled for December 2013 and that the preparation of guidelines on the effectiveness of educational interventions in schools had been discontinued.

7. Where PHE fitted in to the DH-NICE axis was unclear to external observers, and there needed to be a clear division of labour between PHE and NICE given the new role for PHE in providing evidence-based public health advice. It was also noted that different analytical methods were applied by NICE in the preparation of public health guidance compared with clinical guidance. Another important difference was that public health guidance was not mandatory for Local Authority commissioners to follow, giving it a different status to NICE clinical guidance.

Agenda item 3.3 *Review of the discussion around service reconfiguration for specialist HIV inpatient care*

8. The Chair reported that the special session held by EAGA at its last meeting on HIV service reconfiguration had been widely discussed, including at the HIV Clinical Reference Group (CRG). The fact that the output had been informal (meeting minutes) had made it more flexible and provided an influential outline to guide discussions around critical mass, future training of doctors and provision of inpatient care.

Agenda item 4 **HIV Clinical Reference Group (see IP11) – latest developments**

9. The model of 'lead providers' of HIV treatment and care services, where a single provider assumes responsibility for commissioning an integrated pathway of services on behalf of the national commissioner (NHS England), was gaining momentum and decisions were expected by autumn 2013. The level of autonomy granted to lead providers was currently unclear. From a commissioners' perspective, it made sense to deal with one provider. Workforce surveys were being conducted to determine staff cost per patient seen and, not

surprisingly, smaller units were more expensive due to marginal costs. Given the similarity in quality indicators across London, units with higher patient throughput would be able to provide high quality care at lower overall cost. However, staff costs were only one component of an economic analysis. Payment by results, in its entirety (i.e. not just the GUM and HIV parts), was to be reviewed by Monitor.

10. Concerns were raised that quality standards could decline if smaller units were closed, forcing patients to travel further to receive care, potentially leading to greater loss to follow up. HPA had analysed data on distance travelled for HIV care in 2007[1]. While 80% of patients lived within 5km of an HIV service, a quarter of patients travelled to a non-local service, with those in the highest socio-economic group being more likely to travel to non-local services. It would be useful to repeat the analysis as changes to services were implemented. Different areas were likely to experience other problems, such as an impact on use of general practice, highlighting that HIV service redesign could not be considered a secondary care issue in isolation.

11. In conclusion, there was high-level awareness of the possibility of fragmentation of services. DH had conducted a survey of tendering intentions for sexual health services provided in GUM clinics and been reassured by the responses received about the impact on co-located HIV services (reported back to EAGA92). The survey letter had also served to encourage commissioners to think holistically and recognised that changes to service configurations might be necessary (to eliminate sub-standard care), but where this resulted in patients having to travel further, it should be to receive better care.

12. Also to be resolved was social support and community service provision for people living with HIV. Commissioning this activity was currently falling between Local Authorities and NHS England and was therefore vulnerable. Ways of addressing this should be considered, including NHS England giving lead NHS providers some discretion to procure specific social care and information services, where these were not being provided from other sources to the requisite volume and quality.

Agenda item 5 Update on the state of the market for point-of-care HIV tests: suitability for home testing

13. EAGA had commissioned an update on what point-of-care tests (POCT) for HIV were available, how reliable they were and what would be recommended for use if home testing was legalised. Members reported back on two home-sampling services: Dean Street at Home (a collaboration between Chelsea & Westminster Health Charity, Gaydar and Dr Thom) and THT's HIV postal test in collaboration with PHE. Uptake and positivity rates had been high, but sustaining funding for these services was a major issue. Postal costs were significant and added to the cost per test relative to tests performed in clinics, although savings could be realised in clinic staff time. It was suggested that the Freetest.me chlamydia testing service, paid for by NHS local services, could be adapted for home HIV sampling. Other important considerations included how much people were willing to pay for HIV home testing (there were precedents from other areas such as pregnancy and cholesterol test kits) and how to ensure clinical governance, quality and linkage to care. Home sampling clearly offered advantages over home testing in these latter respects and could be linked to post-test counselling provision.

[1] Huntington S, Chadborn T, Rice BD, Brown AE and Delpech VC. Travel for HIV care in England: a choice or a necessity? HIV Med 2011; 12: 361-6.

14. The MHRA Observer presented an overview of the regulation of HIV test kits and the relevant EU legislation (In vitro diagnostic medical devices directive). In addition to the stringent performance characteristics that apply to all HIV test kits (for POC or laboratory use), those designed for home use must have instructions for use (IFU) written in plain language for the lay user, enabling them to correctly interpret the result and minimise the risk of user error. In the case of an HIV self-test kit, clear information about the need for confirmatory testing and UK-specific directions to sources of medical support would be critical.

15. The current position regarding use of HIV POCT for self-testing in the UK was reviewed. It was not possible to prevent the purchase, and thus use, of self-testing kits from the internet from suppliers outside the UK. CE-marking of tests provided assurance of the quality of the tests and the accuracy of the results obtained, but there were many tests on the market without appropriate validation.

16. Some limitations were explored. Performance statistics were generally based on use by technically qualified personnel, were still subject to inter-user variation, and might not be reproducible in the home-use environment. Fourth-generation (4G) antibody-antigen combination assays were recommended for laboratory use because of their ability to reduce the diagnostic window period (i.e. detect acute infections), but 4G POCT in field tests showed poor detection of antigen, reducing sensitivity to detect acute infection. In a head-to-head comparison of OraQuick (3G test) on blood versus saliva (the latter probably being preferred for self-testing), sensitivity to detect HIV infection was 2% lower with saliva, increasing the likelihood of a false-negative result. FDA reported a 55-day window period for this test and highlighted the importance of the wording of the IFU for understanding and interpreting the test result. Interpretation was also affected by engagement with doing the test, with those already diagnosed positive having poorer interpretation scores. However, the FDA considered potential public health benefits of making the kit available for self-testing outweighed possible disadvantages of variable performance.

17. Advances allowing electronic testing linked to mobile phone technology were likely to overcome some of the concerns associated with current devices (based on lateral flow immunoassays). For example, user error in reading the test result would be eliminated (device gives text read-out rather than visual read-out of test result) and the test platform would enable collection of data for surveillance and facilitate linkage to clinical care.

18. EAGA concluded that POCT self-tests could have a part to play in reducing the number of undiagnosed infections in the population, assuming the majority have established infection. For a high incidence population such as MSM, the current tests risked missing seroconverting cases, and might give false reassurance resulting in risky behaviours (e.g. if used for making instant decisions around whether it was safe to engage in unprotected sex). Data on whether people diagnosed at home proceeded to access care were scarce, but knowledge of positive status alone could result in public health benefits from reductions in risky behaviour. HIV testing in isolation from clinical advice also missed opportunities for reducing risk through behaviour change and engagement with health advisors. A study of French MSM found only 3.5% of those aware of the availability of online self-test kits had accessed one (as in the UK, sale of such kits is unauthorised in France)[2]. However, the characteristics of the men purchasing self-testing kits indicated they could be appealing to harder-to-reach groups who were less likely to attend standard testing services.

[2] Greacen T et al. Access to and use of unauthorised online HIV self-tests by internet-using French-speaking men who have sex with men. Sex Transm Infect 2012;88:368-74.

19. EAGA suggested that research was needed to explore questions such as: who would use home sampling versus self-testing kits; how much would they pay; and would new testing options reach populations that would not otherwise test (i.e. non-clinic attenders)? Modelling could help address some questions around the public health benefits and the risks of using poor quality tests.

20. There were several drivers behind seeking to repeal the testing kits regulations, including the House of Lords report from 2011 and a wider Government goal to reduce the number of regulations. There were a number of issues to be addressed around producing UK-specific patient information with good signposting to care and how the voluntary sector could mitigate potential risks. In addition to individuals being able to purchase a self-test kit, there might be possibilities also for Local Authorities to commission and fund self-testing (as a cost-effective intervention for certain populations).

Agenda item 6 Public health value of the HIV and AIDS Reporting System (HARS): strategic issues

21. Introduction of the new dataset for HIV and AIDS Reporting (HARS) had been slower than anticipated but 10 (of 210) eligible sites in England were reporting, with a further 40 signed up to begin. The goal was for all sites to provide quarterly data on 60 variables (half required for Payment by Results) by April 2014.

22. The public health utility of the new dataset included better insights into the UK epidemic, integrated longitudinal CD4 count data to facilitate back-calculation of incidence, late diagnosis data for monitoring the public health outcomes indicator and improved linkage with TB and HIV drug resistance databases. It was a very rich source of high-quality data, with the quality guaranteed by the direct link to commissioning activities. HARS would support different types of analyses, such as using patient complexity as a new variable. The HIV dashboard for the CRG (monitoring standards of care) would also be dependent on HARS. However, resources for developing some of these new outputs had yet to be secured.

23. A planned use of HARS was to monitor the treatment cascade to ensure that changes in service configuration did not have an adverse impact; linkage to care would be a crucial marker. An ‘add on’ to HARS being piloted in 2013 was ‘Positive Voices’ – a national survey of people with HIV accessing care – to provide added value on co-morbidities, behaviours and attitudes and patient-reported outcome/experience measures (PROMs/PREMs). For example, this could enable assessment of the impact of smoking on life expectancy in HIV-infected individuals.

24. On the research agenda, there would be interest in linking HARS to primary care data and GUMCAD and triangulating data sources to examine whether service provision for HIV-infected individuals was extending into primary care. It was important to establish robust funding for processing HARS data, whether that came from NHS England or PHE. The majority of clinical sites already had the software installed and had been advised that payment for services was dependent on submitting HARS data. The HIV dashboard would serve to audit certain of the care quality indicators nationally.

Agenda item 7 Expanded HIV testing in England: results of 2012 audit (SP1)

25. A survey of progress with expanding HIV testing had been conducted among sexual health commissioners in high HIV prevalence areas (undiagnosed prevalence >2/1000). The survey pre-dated the new commissioning arrangements. The results showed some efforts to expand into community settings and general practice, but on a modest scale. Unless mainstreamed into general medical care outside GUM and infectious diseases specialties, expanded HIV testing could become a casualty of transition. HIV exceptionalism remained an issue, particularly among some general practitioners who were fearful of testing; normalisation was still a distant goal. Register-based screening, linking to HIV indicator conditions, could present opportunities for testing. In Brighton, over half of new HIV diagnoses in 2012 were made outside GUM, demonstrating that it was possible to embed testing in non-hospital settings[3]. This reflected sustained initiatives over many years and could prove difficult to replicate in other areas.

Agenda item 8 HIV transmission/progression model: what are the key public health questions to address? (SP6)

26. A model charting progress of the HIV epidemic among MSM in the UK from 1980-2010 had been presented to EAGA previously (EAGA91)[4]. It enabled the impact of variables such as HIV testing uptake, condom usage and taking of antiretroviral (ART) drugs to be examined. However, no distinction was made between receptive and insertive sex acts, nor allowance made for the number of sex acts. Some limitations of the model included the exclusion of data on heterosexuals, preventing questions around universal HIV testing and cross-over between populations at risk (e.g. bisexual men bridging between MSM and heterosexuals) from being addressed. The main conclusions from the model were: current levels of condom use were having a strong limiting effect on the epidemic in MSM; higher testing rates would reduce HIV incidence; the extent of this reduction depended on the proportion who reduced condomless sex upon receiving a positive diagnosis; and use of ART had reduced incidence and would have greater impact if initiated earlier (i.e. at diagnosis).

27. Funding had been received to undertake cost-effectiveness analyses of starting ART at diagnosis – CAPRA NIHR Programme Grant and further funding was being sought to address a range of public health questions using the model, including optimal testing frequencies, impact of PrEP, enhanced PEP provision, enhanced partner notification, condom promotion and the effect of reducing other STIs. Further data were needed on the role of casual partners, in particular in relation to those 'recently' infected, and results were anticipated from the START (Strategic Timing of Anti-Retroviral Treatment) trial and the PARTNER (Partners of people on ART: a New Evaluation of the Risks) study, examining the effect of undetectable viral load on HIV transmission through anal sex in serodiscordant MSM couples.

28. A question that the earlier discussion had highlighted was about the impact of HIV self-testing and/or home sampling on incidence and the potential savings in clinical staff time from these alternative testing strategies. A starting point would be to estimate the

[3] Mahendran P et al. *Policies to increase HIV testing result in reduced late presentation and increased diagnosis in non-genitourinary medicine settings.* BASHH Spring Conference 2013, Bristol, abstract O12.
[4] Phillips AN et al. Increased HIV incidence in men who have sex with men despite high levels of ART-induced viral suppression: analysis of an extensively documented epidemic. PLOS ONE 2013; 8:e55312. http://dx.plos.org/10.1371/journal.pone.0055312

proportion of undiagnosed individuals that needed to be diagnosed this way to have an impact, which in turn would be influenced by who used self/home sampling tests and the balance between chronically and acutely infected individuals.

29. Understanding these variables was important for commissioners when deciding how best to invest in HIV prevention services. The model suggested that much higher rates of testing combined with early ART initiation would have a substantial impact on transmission, but that the benefits would be undermined if condomless sex increased in the MSM population due to reduced concern about HIV acquisition, begging the question as to the best combination of biomedical interventions and risk reduction /behavioural interventions to commission.

30. Other key questions:
    - can a level be defined for a reduction in late HIV diagnosis (monitored through the public health outcomes indicator) that equates to a good impact on HIV incidence?
    - how much is it worth spending to achieve a 1%, 5% etc reduction in condomless sex (in terms of infections avoided)?
    - if current levels of HIV partner notification activity were doubled, what difference would it make to HIV transmission? [More data were needed on the benefits of partner notification, in order to overcome perceptions that it was a punitive aspect of HIV care.]
    - what proportion of undiagnosed individuals would it take to sustain the epidemic, assuming a certain proportion will never test until they become sick?

31. Finally, it was noted that prevention messages needed to become more sophisticated, incorporating factors such as the risk of having sex with someone who is unaware that they have HIV. There was potential risk of mixed messages - on the one hand stating that HIV-infected individuals can expect a near-normal life expectancy, but on the other emphasising the importance of avoiding infection in the first place.

Agenda item 9 A Framework for Sexual Health Improvement in England (SP2)

32. This was discussed under Agenda item 11.

Agenda item 10 BHIVA clinical audit of non-retention in care: presentation of results

33. Dr Hilary Curtis presented the results of the BHIVA audit on non-retention in care, conducted in collaboration with HPA. There were a number of reasons why it was important to monitor the number of HIV-infected individuals moving out of care each year: (i) intermittent care undermines cost-effectiveness - patients who default from care account for a disproportionate burden of care costs (e.g. around 50% of HIV inpatients at a large centre were previously diagnosed but not in care); (ii) to understand the underlying risks for non-retention in care and thus mitigate against them; and (iii) to protect public health, as patients in care were less likely to transmit HIV to others.

34. The audit focussed on patients seen for care or newly diagnosed in 2010 but not reported in SOPHID (for patients in England, Wales and Northern Ireland) as having received care in 2011 and not known to have died. Scottish patients were similarly identified. Case-note reviews were conducted for all patients meeting these criteria, 2255 in total. Compared with

the HIV-infected cohort overall, audited patients were more likely to be of Black African ethnicity and to be born outside the UK.

35. The case-note review identified that 26.2% of the patients not retained in care in 2011 had probably left the country, 3.2% had died and the status of 25.6% was unknown. However, a large proportion, 42.7%, was probably in the UK, of whom 22.6% were believed to be in care, but not linked in SOPHID. Those not in care were more likely to be younger (age <40), Black African, female, recently diagnosed (in 2009 or 2010) and ART naïve.

36. An extended case-note review for a subset of the audited patients examined risk factors for non-retention and found poor attendance record and adherence concerns were predictive. A wide range of other factors were cited, with stigma and financial issues ranking highest, but there were no other useful predictors.

37. Of those not in care in 2011, 52% re-attended in 2012; 12% were symptomatic, 9 patients had to be admitted for inpatient care and, as a group, they experienced a higher incidence of serious adverse events.

38. A number of observations concerning action/policy arose from the audit findings. For example, contacting GPs to encourage patient re-attendance was not routine, despite high levels of disclosure of HIV status. Policies for transfer of care to other providers were not standardised. It was unclear why more than 1 in 5 patients were believed to have remained in care in the UK but were not linked in SOPHID. Receiving private medical care was an unlikely explanation for not being reported to SOPHID; the numbers would be very small. However, it was encouraging that the upper estimate of those out of care in 2011 and believed to be living in the UK was as low as 2.6% (456 patients) of the SOPHID 2010 population. This figure compared very favourably with other countries, such as the United States, where fewer than half of individuals diagnosed with HIV were in care. The audit also provided reassurance that HIV care was not attracting significant numbers of health tourists.

39. Discussion turned to the ethics associated with re-engaging patients in care. Did the duty of care override the duty of confidentiality (e.g. using the Personal Demographics Service to trace a 'lost' patient)? Expectations for patients newly diagnosed with HIV were that they would consent to their GP being informed, as well as to sharing of information with other parts of the NHS. There were public health arguments for aggressive follow-up, but these had to be balanced with a patient's right to make an informed decision not to remain in care. Investing in minimising loss to follow-up made financial sense, as 'lost' patients would eventually fall sick and require more costly care. Appropriate action to take in cases where patients had been out of contact with services for over 1 year was something that could be considered at an upcoming BHIVA/NAT roundtable meeting on confidentiality and HIV.

Agenda item 11 DH policy update

40. A Framework for Sexual Health Improvement in England (SP2): The final framework document was published in March 2013. Key stakeholders had been consulted during development; feedback from EAGA had been included as part of that process. All aspects of sexual health improvement and wellbeing were addressed across the life course and in the context of the new commissioning arrangements, together with suggested actions for local areas and key principles for effective commissioning of sexual health services. The

overarching priorities remained the same as before – reducing STIs and unwanted pregnancies in the context of rapid, easy access to services – and there were no targets or new policy statements. The Framework set out the DH's ambitions for good sexual health including the need for an increased focus on prevention of HIV (and STIs), and a culture free from prejudice, to enable people to make informed and responsible choices about relationships and sex. DH would be developing proposals on how best to review progress with implementation of the Framework. DH had received positive feedback on the Framework including on the life-course approach, the comprehensive range of issues addressed and identifying the wider influences on sexual health outcomes.

41. An EAGA member had been asked to comment from a provider's perspective. Everything had been covered and there was nothing to disagree with. However, there was concern about how the ambitions would be implemented in the absence of associated targets and the apparent disconnect with what happens at the Local Authority (LA) level. Would PHE have leverage over autonomous LAs?

42. Repeal of HIV testing kits and services regulations: This work was proceeding and was part of a wider initiative on regulatory control. It was possible that a formal consultation to repeal the regulations might not be required. As discussed under Agenda item 5, it would be critical to ensure the adequacy of patient information supplied with HIV test kits marketed for self-testing in the UK. [CMO announced the removal of the ban on HIV self-testing kits in a press release on 15 August 2013, with effect from April 2014.]

43. NHS (Venereal Diseases) Regulations 1974 and the NHS Trusts and PCTs (Sexually Transmitted Diseases) Directions 2000: As EAGA was previously advised, once the Health and Social Care Act 2012 was fully enacted, these Regulations would cease to apply. More work was under way to address concerns about erosion of confidentiality for patients with STI diagnoses, such as linking to the Caldicott 2 review. The NHS Information Centre would be producing a statutory code of practice on sharing patient identifiable information, including guidance on confidentiality.

44. HIV-infected healthcare worker (HCW) consultation - Government response: The consultation response was ready to publish subject to clearance from the CMO, Chief Dental Officer, Ministers and the Home Affairs Committee (required for any change of Government policy) and agreement of a publication date. Publication was expected in summer 2013, and until then the Department was still at risk of legal challenge from representatives of infected HCWs. There had also been a number of questions raised in parliament, all supportive of a change in policy. Following publication of the Government's response, new guidance for implementing the policy will be issued. [The Government's response to the consultation was published on 14 August 2013.]

45. The guidance would take time to prepare, as the aim was to produce integrated guidance covering all the policies on blood-borne viruses in HCWs and ensuring consistency. It would also be necessary for the national database for monitoring of HIV-infected HCWs on treatment to be operational before the guidance was issued, to meet the expectations of affected HCWs seeking clearance from their Occupational Health Departments. It was also important to ensure the lessons from auditing compliance with guidance for hepatitis B infected HCWs, which demonstrated the need for centralised monitoring, were integral to implementing the new policy.

Agenda item 12 EAGA's remit and purpose in the context of Public Health England and restructured Department of Health Paper EAGA(94)2

46. The Chair summarised the key points from the morning's discussion for the benefit of Dr Harvey, Director General for Public Health at DH, who joined the meeting towards the end of the DH policy update. Dr Harvey commented on some of the structural issues that had been raised e.g. around how NICE, DH and PHE would work together on provision of public health guidance to support local government, ensuring expert scientific input and avoiding duplication. The decisions on work to be commissioned by NICE would continue to be determined by ministerial priorities.

47. On the issue of fragmented commissioning, there was an expectation that services would be jointly commissioned through Health and Wellbeing Boards. Local Authorities were on a steep learning curve as regards their new responsibilities for commissioning clinical services. PHE was currently identifying sexual and reproductive health workforce capacity in its centres. These staff would provide key support to local government.

48. Considering EAGA's remit, the ambition to broaden it to address service management issues was welcomed. For example, EAGA was well-constituted to identify where services were going wrong and providing evidence-based advice to enable them to work better. The change in EAGA's status to a Departmental Expert Committee brought EAGA closer to policy making. EAGA has a role to play in developing policies that are fit for implementation.

49. Dr Harvey concluded by thanking all the members of EAGA for the time they devote to the committee's work, expressing the Department's appreciation and acknowledging the fundamental importance of the scientific advisory committee structure in helping DH take forward a challenging agenda.

Agenda item 13 EAGA Workplan 2013/14: draft for review and agreement Paper EAGA(94)3

50. The workplan would be circulated to members for final comments and sign-off.

Agenda item 14 Feedback from 20th Conference on Retroviruses and Opportunistic Infections, March 2013. Reports of eradication: need for guidance (SP3-5)

51. Discussion of this agenda item was deferred to the next meeting.

Agenda item 15 Any other business

52. Third National Survey of Sexual Attitudes and Lifestyles: Six papers reporting the results of the survey had been submitted to the Lancet for publication on 26 November 2013. A launch event was being planned for that date at University College London. EAGA members were advised to hold the date in anticipation of receiving an invitation to attend.

53. 100,000 genomes project: The Government had earmarked £100 million to fund the sequencing of 100,000 genomes. In the infectious diseases field, HIV, hepatitis C and TB had been prioritised as being the most tractable to integration of sequencing information into clinical and public health practice. The task of operationalizing the project had been delegated to Paul Cosford as Director of Health Protection for PHE. Professor Pillay was leading on the HIV and hepatitis C elements and plans would be well advanced by October.

Agenda item 16 Date of the next meeting

54. The next meeting will be held on **23 October 2013.**