# EXPERT ADVISORY GROUP ON AIDS
Providing expert scientific advice on HIV

# ANNUAL REPORT 2012

## Introduction

1. This report from the Expert Advisory Group on AIDS (EAGA) covers the period 1 January 2012 to 31 December 2012.

## Role of EAGA

2. The Expert Advisory Group on AIDS (EAGA) was established in 1985 with the following terms of reference:

   "To provide advice on such matters relating to HIV/AIDS as may be referred to it by the Chief Medical Officers of the Health Departments of the United Kingdom".

3. EAGA's status as an advisory non-departmental public body (non-statutory) ended on 31 October 2012. With effect from 1 November 2012, as part of the implementation of the Government's Public Bodies Reforms, EAGA was reclassified as a Departmental Expert Committee. The implications for the operational independence of the committee and appointment of new members were discussed at EAGA's 92nd meeting. The terms of reference remained unchanged.

## EAGA Membership

4. EAGA membership comprises experts in a range of relevant medical and scientific specialties and disciplines (e.g. epidemiology, genitourinary medicine, general practice, infectious diseases, perinatal HIV, occupational medicine, public health and virology) and also includes members from the HIV voluntary and community sectors. A list of members who served during 2012 is attached at **Annex A**.

5. Three members of EAGA were re-appointed during 2012 for a second term and three long-serving members of EAGA completed their terms of appointment on 31 October 2012. The Chair and all members were issued with new appointment letters, commensurate with the new status of EAGA as an expert committee.

## EAGA Observers

6. The Government Departments and Agencies listed below have Observer status at EAGA.

   - Department of Health
   - Department of Health, Social Services and Public Safety, Northern Ireland
   - Health Protection Agency

- Medicines and Healthcare Products Regulatory Agency
- Ministry of Defence
- Scottish Government
- Welsh Assembly Government
- UK Blood Services

## Code of practice and register of members' interests

7. EAGA works to a code of practice based on the Government Office for Science's Code of Practice for Scientific Advisory Committees (2011). The code covers issues such as the seven principles of public life set out by the Committee on Standards in Public Life, the role of the chair and members, the handling of EAGA papers and declarations of members' interests. The register of members' interests is attached at **Annex B**.

## Epidemiology of HIV/AIDS

8. EAGA receives regular updates on the UK's HIV epidemic from the Health Protection Agency (HPA) and its collaborators (e.g. Health Protection Scotland). Regularly updated and detailed information from surveillance systems is published on the HPA's website: http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HIVAndSTIs/SurveillanceSystemsHIVAndSTIs/

9. The key findings from HIV surveillance in 2011[1] were presented to EAGA at their 92nd meeting, as follows:

   - An estimated 96,000 people were living with HIV in the UK by the end of 2011 (24% undiagnosed), an increase from 91,500 in 2010, equating to an overall prevalence of 1.5 per 1,000 population with the highest rates reported among men who have sex with men (MSM) (47 per 1,000) and the black African community (37 per 1,000).
   - In 2011, 6,280 people were newly diagnosed with HIV in the UK, similar to the level seen in 2010. New diagnoses among MSM have been increasing since 2007, with 3,010 reports in 2011, exceeding the number in heterosexuals for the first time since 1999. This is attributed to the combined effects of a reduction in the number of diagnoses reported among those born outside of the UK (changes in migration patterns) and ongoing transmission among MSM.
   - Over half of the 2,990 heterosexual men and women diagnosed in 2011 probably acquired their HIV infection in the UK, compared to 27% in 2002.
   - There has been a slow but significant decline in the proportion of people diagnosed late (CD4 cell count $<350$ cells/$mm^3$) over the past decade, particularly among MSM. Nevertheless, the overall proportion of late diagnoses remained high in 2011 (47%). People diagnosed late have a tenfold increased risk of dying within a year of diagnosis.
   - 73,660 people living with a diagnosed HIV infection received care in 2011. The most deprived areas in the UK also have the highest HIV prevalence; this

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[1] From *HIV in the United Kingdom: 2012 Report*. Available from: http://www.hpa.org.uk/Publications/InfectiousDiseases/HIVAndSTIs/1211HIVintheUK2012/

health inequality is particularly evident in London, where diagnosed HIV prevalence is as high as 8 per 1,000 in the most deprived areas and less than 1.5 per 1,000 in the least deprived areas.
- 88% of people for whom treatment was indicated were receiving antiretroviral therapy (ART) in 2011. Understanding why some eligible patients were not on treatment was important to maximise the public health benefit of treatment.
- The introduction of routine HIV testing in antenatal settings has resulted in overall mother-to-child transmission rates of around 2% (<1% for infants born to women diagnosed before delivery). In the Genito-Urinary Medicine (GUM) setting, 70% of all attendees received an HIV test in 2011, with the highest coverage among MSM (83%). However, almost two-thirds of MSM newly diagnosed as HIV-infected in GUM had not attended that clinic for testing in the previous three years, which strongly suggests there is room for improvement in the frequency of testing by those at highest risk.
- Progress with expansion of routine HIV testing to general medical admissions and the general practice setting has been slow.

**Main items of business**

10. EAGA met on two occasions during the period of this report - on 22 February 2012 (91st meeting) and 17 October 2012 (92nd meeting). The substantive items discussed and their outcomes are summarised below. EAGA's annual Work Plan can be found at **Annex C**.

**91st meeting, February 2012**

- **Reconstructing the HIV epidemic among men who have sex with men:** Using a modelling approach, the epidemic of HIV infection among MSM in the UK, starting from 1980, was reconstructed. The key influences on the model included the number of new and long-term condomless sex partners, the rate of HIV transmission at a given viral load, and the rate of HIV progression with and without treatment. Having constructed a model that accurately reflected the past, it can be used to predict the impact of different interventions (e.g. higher rates of HIV testing, starting antiretroviral treatment earlier, pre-exposure prophylaxis) on the future course of the epidemic. Insights derived from the model included that, without condom use, there would have been a much greater rise in HIV incidence than was observed and that the condom effect on incidence was greater than that of antiretroviral treatment.

- **Impact of the health reforms on HIV prevention, testing, treatment and care:** EAGA was briefed on a number of important initiatives: (i) the establishment by the NHS Commissioning Board (rebranded NHS England) of a limited number of Strategic Clinical Networks (SCNs) working across boundaries of commissioning and provision. HIV services were not being considered as one of the initial tranche of SCNs[2]. (ii) An HIV National Clinical Reference Group (CRG) had been set up as part of transitioning arrangements for specialised commissioning. It was developing service specifications for HIV services. (iii) The British HIV Association (BHIVA) was leading on an update to quality standards for the care

[2] http://www.england.nhs.uk/2012/07/26/strat-clin-networks/

of people living with HIV[3], in partnership with stakeholders, built around the indicators in the Public Health and NHS Outcomes Frameworks. The CRG's service specifications and BHIVA care standards would be closely aligned.

- **Position statement on the use of antiretroviral therapy to reduce HIV transmission:** In response to a request from the National AIDS Trust for an authoritative statement on the preventive benefit of ART, EAGA had developed a draft statement and then invited BHIVA to share their thinking and work on a joint response. There was consensus about the convincing evidence of transmission risk reduction for heterosexuals and acknowledgement of the more limited data concerning transmission risk reduction for MSM. The published statement[4] sought to promote the positive impact of ART for prevention. It also linked the benefits for individual and public health to the absence of other sexually transmitted infections (STIs) and having a stable undetectable viral load. The two-part statement was intended to meet both the needs of a general audience, including health promoters and people affected by HIV, as well as the expert audience, by providing the underpinning evidence and explaining its limitations.

- **Access to and retention in HIV care:** The UK's record on access to and retention in care is very good. However, defaulting from care has serious consequences for individual and public health prompting EAGA to review the latest data.

  Access to HIV care is one of a suite of care quality indicators currently monitored in the UK. Evidence of prompt transfer into care comes from the finding that 88% of HIV-infected adults had their CD4 count recorded within one month of diagnosis in 2011. Latest data on loss to follow-up (LTFU) found that 94% of patients seen for care in England, Wales and Northern Ireland in 2009 were seen again in 2010, with 90% on average in continuous care. Factors associated with defaulting from care included female gender, younger age, black African ethnicity, recent diagnosis and not receiving ART. It was noted that HIV patients were granted a much greater degree of autonomy than patients with other serious long-term conditions, for whom non-attendance would usually be reported to the patient's GP. There were important clinical questions to address around the impact on patient outcomes of intermittent attendance or transfer of care. A number of suggestions were made for minimising LTFU, including using a patient tracing service to identify patients who have changed care provider and automating appointment reminders.

- **Pre-exposure prophylaxis (PrEP) initiatives:** EAGA agreed that the HIV prevention potential of PrEP in MSM was a high research priority given the continuing high rates of transmission in this population in the UK. The Health Protection Agency, in partnership with the MRC Clinical Trials Unit, was undertaking a trial to investigate the public health effectiveness of PrEP in preventing HIV transmission among MSM. Enhanced prevention services in GUM were an integral part of the study and had the potential to generate wider benefits by spreading good practice.

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[3] http://www.bhiva.org/standards-of-care-2013.aspx
[4] Fidler S et al. Position statement on the use of antiretroviral therapy to reduce HIV transmission, January 2013: The British HIV Association (BHIVA) and the Expert Advisory Group on AIDS (EAGA). HIV Med 2013; 14:259-62.

**92nd meeting, October 2012**

- **HIV in prisoners and immigration detainees:** Following on from a written briefing on the standards for management of HIV infection in these populations, external experts had been invited to present the policy perspective and some recent survey results. A British Association for Sexual Health and HIV (BASHH) survey of prisons and immigration removal centres (IRCs) found that the HIV-related caseload was concentrated in prisons and IRCs in London and Surrey. Not all centres provided HIV healthcare and different models of service were in operation – both in-reach and out-reach.

  Responsibility for provision of healthcare in prisons had passed from the Home Office to the NHS in 2006 and NHS England would assume commissioning responsibility for healthcare in all English prisons as well as IRCs from April 2013. A repeat survey of HIV care in IRCs was being undertaken to inform updated best practice advice and commissioning specifications.

  Medical record handover on transfer of prisoners between facilities had been improved by the introduction of an integrated IT system across England & Wales, but there remained an issue about transferring health records on return of prisoners and detainees to the community/NHS care. EAGA voiced concerns about the availability of condoms in prisons and blood-borne virus screening among inmates. Arrangements for both had improved, but there was scope for further improvement. HIV transmission events within prisons were believed to be rare although difficult to attribute accurately.

- **HIV treatment for overseas visitors in England:** EAGA had long-argued that the policy of charging overseas visitors for HIV treatment was potentially damaging to public health by discouraging health-seeking behaviour. An amendment to the NHS (Charges to Overseas Visitors) Regulations came into force on 1 October 2012. This means HIV treatment is now provided in the same way as for other STIs for which NHS treatment is free to all.[5]

- **Health system reform:** EAGA had some preliminary discussions about the need for HIV service reconfiguration to reflect numerous changes to the patient population (e.g. in terms of size, age profile, non-medical needs etc) and treatment advances since the current service was designed. A pro-active approach to service re-design was recommended to ensure patients' best interests, and not financial considerations, were central to any decisions.

- **Management of HIV-infected healthcare workers:** Technical queries arising from the responses to the Department of Health (DH) consultation on HIV-infected healthcare workers had been addressed by the Tripartite Working Group (which included several EAGA members). DH referred two outstanding issues to EAGA; these were discussed and advice agreed for incorporation in DH's formal response to the consultation.

[5] Department of Health. HIV treatment for overseas visitors: guidance for the NHS. Published 28 September 2012

For full details of EAGA's discussions, see the agendas and minutes of these meetings, which can be found at: https://www.gov.uk/government/policy-advisory-groups/expert-advisory-group-on-aids#minutes

**Consultations**

11. EAGA submitted a response to the Health and Safety Executive's *Consultation on proposed regulations to implement Council Directive 2010/32/EU on preventing sharps injuries in the hospital and healthcare sector*. EAGA welcomed the proposals for regulation, which were consistent with EAGA's guidance on HIV post-exposure prophylaxis (PEP), and supportive of efforts to reduce the risk of HIV transmission in healthcare settings.

**EAGA Subgroups**

12. A subgroup of EAGA met to discuss the position statement on treatment as prevention. A subsequent meeting was held jointly with representatives nominated by BHIVA.

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**Prepared by EAGA Secretariat: April 2013**

Annex A

## MEMBERSHIP OF THE EXPERT ADVISORY GROUP ON AIDS IN 2012

| Name | Position | Interest represented | Term of appointment |
|---|---|---|---|
| **Chair** | | | |
| Professor Brian Gazzard | Professor of HIV Medicine/Director of Clinical Research, Chelsea & Westminster Hospital, London | N/A | Appointed 1 July 2005; re-appointed 1 March 2011 |
| **Members** | | | |
| Dr Christopher Conlon | Consultant in Infectious Diseases, John Radcliffe Hospital, Oxford | Infectious disease | Appointed 14 February 2007; re-appointed 14 February 2011 |
| Mr David Crundwell | Corporate Affairs – Thomson Reuters | Lay member | Appointed 1 July 2005; re-appointed 1 July 2011. Elected Vice Chair 7 November 2012. |
| Dr Matthew Donati | Consultant Medical Virologist, Health Protection Agency Regional Laboratory, Bristol | Virology | Appointed 2 February 2009; re-appointed 2 February 2012 |
| Ms Ceri Evans | Senior Sexual Health Adviser, West London Centre for Sexual Health, Charing Cross Hospital | Sexual Health Advice | Appointed 1 April 2006; re-appointed 1 July 2011 |
| Dr John Green | Chief Clinical Psychologist, Central & North West London NHS Foundation Trust and St Mary's Hospital, London | Clinical psychology | Appointed 1 April 2006; re-appointed 1 March 2011 |
| Dr Jeremy Hawker | Regional Epidemiologist, Health Protection Agency | Public health | Term completed 31 October 2012 |
| Ms Ruth Lowbury | Chief Executive, MEDFASH | Voluntary sector | Appointed 1 July 2005; re-appointed 1 July 2011 |

**MEMBERSHIP OF THE EXPERT ADVISORY GROUP ON AIDS IN 2012 (continued)**

| Name | Position | Interest represented | Term of appointment |
|---|---|---|---|
| Dr Helen McIlveen | Clinical Manager Sexual Health and HIV, Northumbria Healthcare Foundation Trust | HIV/GUM nurse consultant | Appointed 2 February 2009; re-appointed 2 February 2012 |
| Ms Beatrice Osoro | Case Worker, Positively UK, London | BME groups affected by HIV | Appointed 2 February 2009; re-appointed 2 February 2012 |
| Sir Nick Partridge | Chief Executive, Terrence Higgins Trust, London | Voluntary sector | Term completed 31 October 2012 |
| Professor Deenan Pillay | Professor of Virology ,University College London | Virology | Appointed 1 July 2005; re-appointed 1 July 2011 |
| Dr Anton Pozniak | Consultant Physician in GUM/HIV, Chelsea & Westminster Hospital, London | HIV medicine | Appointed 1 July 2005; re-appointed 1 July 2011 |
| Dr Keith Radcliffe | Consultant in HIV/GUM, Whittall Street Clinic, Birmingham | HIV/GUM | Appointed 14 February 2007; re-appointed 14 February 2011 |
| Dr Alison Rimmer | Consultant Occupational Physician, Sheffield Occupational Health Service, Northern General Hospital, Sheffield | Occupational medicine | Term completed 31 October 2012 |
| Miss Susan Sellers | Consultant Obstetrician, St Michael's Hospital, Bristol | Perinatal HIV | Appointed 1 April 2006; re-appointed 1 March 2011 |
| Dr Ewen Stewart | General Practitioner, Edinburgh | General practice | Appointed 1 July 2005; re-appointed 1 July 2011 |

**Annex B**

## EXPERT ADVISORY GROUP ON AIDS (EAGA): REGISTER OF MEMBERS' INTERESTS 2012

| MEMBER | PERSONAL INTERESTS | | NON-PERSONAL INTERESTS | | OTHER INTERESTS | |
|---|---|---|---|---|---|---|
| | Name of organisation | Nature of interest | Name of organisation | Nature of interest | Name of organisation | Nature of interest |
| Professor Brian Gazzard | Bristol-Myers Squibb, Gilead, GlaxoSmithKline, ViiV Healthcare | Consultant (ad hoc) | Bristol-Myers Squibb, Gilead, GlaxoSmithKline, ViiV Healthcare | Research and educational grants | | None |
| Dr Christopher Conlon | | None | Medical Research Council, Wellcome Trust | Research grants | | None |
| Mr David Crundwell | | None | | None | Imperial College Healthcare Charity<br><br>BASHH | Trustee<br><br>Member of the Public & Patient Panel |
| Dr Matthew Donati | | None | | None | | None |
| Ms Ceri Evans | | None | | None | | None |
| Dr John Green | | None | | None | | None |
| Dr Jeremy Hawker | | None | | None | Health Protection Agency<br>UK Faculty of Public Health | Employee<br><br>Trustee and Registrar |
| Ms Ruth Lowbury | | None | Abbott, Gilead, ViiV, Merck Sharp & Dohme | Educational grants and speaker fees | MEDFASH | Chief Executive |
| Dr Helen McIlveen | | None | | None | Blue Sky Trust Newcastle (HIV Third Sector Organisation) | Chairperson |
| Ms Beatrice Osoro | | None | | None | Positively UK | Staff member |
| Sir Nick Partridge | | None | | None | THT | Chief Executive |

**Annex B**

## EXPERT ADVISORY GROUP ON AIDS (EAGA): REGISTER OF MEMBERS' INTERESTS 2012 (continued)

| MEMBER | PERSONAL INTERESTS | | NON-PERSONAL INTERESTS | | OTHER INTERESTS | |
|---|---|---|---|---|---|---|
| | Name of organisation | Nature of interest | Name of organisation | Nature of interest | Name of organisation | Nature of interest |
| Professor Deenan Pillay | | | Gilead, Johnson & Johnson, ViiV Healthcare, Boerhinger Ingelheim, Merck, Bristol-Myers Squibb, Abbott | Sponsorship for CHAIN Workshop in October 2012 | | None |
| Dr Anton Pozniak | Bristol-Myers Squibb, Boehringer Ingelheim, Janssen, Gilead, Roche, ViiV, Merck;<br>LEPRA and St Stephens AIDS Trust | Consultant<br>Board Member (charities) | Bristol-Myers Squibb, Boehringer Ingelheim, Janssen, Gilead, Roche, ViiV, Merck | Consultancy fees paid to Department | | None |
| Dr Keith Radcliffe | | None | | None | BASHH<br>IUSTI | Board Member<br>European Regional Director |
| Dr Alison Rimmer | | None | | None | | None |
| Dr Susan Sellers | Medical Protection Society | Chair of Claims Advisory Group | | None | | None |
| Dr Ewen Stewart | ViiV Healthcare | Sponsored attendance at HIV Dialogues: Managing Change meeting (July 2012) | | None | RCGP Sex, Drugs and BBV Group | Chair |

BASHH - British Association for Sexual Health and HIV; BHIVA - British HIV Association; IUSTI - International Union Against Sexually Transmitted Infections; LEPRA – the British Leprosy Relief Association; MEDFASH – Medical Foundation for HIV & Sexual Health; MRC – Medical Research Council; NAT - National AIDS Trust; THT – Terrence Higgins Trust

**Annex C**

**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 |
| ➢ 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 |
| ➢ PEP<br>• Audit of compliance with HIV PEP guidelines<br>• Discussion of revisions/addendum | Alison Rimmer/Keith Radcliffe | To be completed<br><br>October 2012 |
| ➢ HIV partner notification: review of the evidence base | Keith Radcliffe | February 2013 |
| ➢ HIV treatment and care service reconfiguration | Brian Gazzard | February 2013 |
| ➢ Consideration of agenda (and desired outcomes) for Director General for Public Health's attendance at EAGA | ALL | February 2013 |
| ➢ Delivery of HIV testing, treatment and care and prevention in England – impact of NHS and public health reforms | ALL | Standing agenda item |
| ➢ Horizon scanning for emerging HIV issues | ALL | ongoing |
| ➢ 'Test and treat' and 'treatment as prevention' strategies:<br>o Expansion of HIV testing<br>o Pre-exposure prophylaxis<br>o Discordant couples management<br>o Risk compensation following biomedical interventions (e.g. PrEP, TasP, male circumcision) | Brian Gazzard, Ceri Evans, 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 |