Health and Sports Committee

Evidence session on sexual health, blood borne viruses and HIV.
NHS Lothian Response. 9th January 2018.

1. To what extent do you believe the Scottish Government's Sexual Health and Blood Borne Virus Updated Framework and the approach by Integration Authorities and NHS Boards is preventative?

Within the Framework there is a good focus on preventive measures, even within the more ‘clinical’ outcomes. This is partly because the Framework takes a long view. There is also recognition that for some of the outcomes (Outcome 5 in particular) this can be difficult to articulate and measure, and the Scottish Government has done some good work around trying to resolve this.

However, on the ground, the preventive approach can be a difficult one to sustain in the face of huge issues like budget cuts and the need for diverse services delivered through multiple agencies to provide patient centred care.

These challenges can result in the approach being more about mitigation than prevention.

For example,

Many of the individuals that stand to benefit from the SHBBV Framework are socially excluded on the basis of gender, drug use, sexuality, homelessness, migrant status, sex work, incarceration and poverty. Many of these people have multiple overlapping risk factors and extremely high levels of morbidity and mortality. A recent paper in the Lancet looked at morbidity and mortality rates in England and Wales (Robert Aldridge et al) and found that socially excluded populations have a mortality rate 8 times higher than average for men and 12 times higher for women; versus 2.8 times and 2.1 times respectively for people in most deprived versus least deprived areas.

Many of the interventions recommended by or linked to the Framework, are locally tailored to these population groups: e.g. community case management for substance misuse and BBV infection; pharmacological interventions like PrEP, HCV antivirals, opioid substitution therapy and DirectlyObserved Therapy for TB and HIV; harm reduction as part of routine services for populations at risk (including outreach and criminal justice settings); sexual health services for young people, trans people, sex workers and prisoners; screening for latent TB infection in homeless people. To an extent, interventions are multi component and based on local intelligence, there is service user involvement and providers are trained (e.g. trans healthcare, quality, wound care).

However, although evidenced based and effective, most of these interventions only mitigate the impact of the upstream causes of exclusion and multi morbidity. More work is required to address the causes; which include poverty, poor housing, poor education, under employment and difficult early years of life.

NHS Lothian Directorate of Public Health and Health Policy has established a group working on ‘inclusion health’ - an approach that aims to address extreme health and social inequities and aims to strengthen the links locally between the ‘proximate’ interventions above and the social determinants such as housing, employment and early years.
2. Is the approach adequate or is more action needed?

As an approach, the Framework gives a clear signal about the values and ethos in Scotland towards sexual health and BBVs which is very positive. But this doesn’t always translate into actions. More policy direction from the top could be useful to help address the difficult elements of the outcomes, and the determinants of health such as poverty, homelessness, employment and incarceration. This is especially key for people at risk from multiple overlapping risk factors. Clinical and social services for groups such as drug users, people in the criminal justice system, sex workers, transgender people, men who have sex with men and the homeless need to have stronger links with each other and mutual accountability for outcomes; and this also applies to service providers who require training in management of (and services/opportunities available for) people with multiple exclusions.

Prevention depends a lot on health promotion work with the communities most at risk. Strong partnership with the third sector organisations is crucial to this and in NHS Lothian third sector partners such as Waverley Care, Change Grow Live, Turning Point and many others are invaluable. However, there is a lot of work that needs to be done to promote involvement of beneficiaries at all levels of the service. This is important to help ensure that the way services are offered suit those that need them, and to help promote retention within services. Again this is a particular challenge for the people with multiple overlapping risks factors.

It would be helpful to have a clear steer from Scottish Government regarding issues that sometimes stand in the way of joint working between NHS and third sector organisations, for example information sharing and information governance.

The SHBBV Framework acknowledges, as cross cutting issues, the importance of the determinants of health and the role that health and social care integration has for effective prevention and care. But it would be beneficial for this perspective and approach to be more central to the prevention strategy, and in local implementation.

Effective prevention as ever will require national and local policies that create opportunities for all through reduced poverty, productive childhood experiences, better education and improved social cohesion.

**HIV**

Prevention is effectively actioned (Outcome 1) through the provision of HIV Treatment as prevention and PrEP. However more emphasis could be put on primary prevention e.g. education about safer sex. This is particularly important in the context of falling use of freely provided condoms.

The most significant gap in addressing HIV infections and achieving the 90:90:90 target is the failure to achieve the required levels of HIV testing. This is challenging in a low-to-intermediate prevalence population. A nationally co-ordinated effort to promote diagnostic testing to prevent late HIV diagnosis is required. A Short Life Working Group on HIV testing in Scotland is about to complete a report and a new UK National Guideline on HIV Testing is nearing completion. It will require significant focussed effort to put the recommendations of these documents into practice.

Outcome 2 is variably addressed by boards. There is insufficient routine national monitoring of sexual health performance data according to deprivation. It would be relatively simple to map important outcomes such as HIV testing by SIMD although as noted above this would not provide information on multiply excluded individuals as risk factors are not routinely recorded at present.
**Sexual and Reproductive Health**

It would be worth considering a recommendation for easy access to long acting contraception as some services including Lothian have a 4-6 week wait for an IUD or implant. This would require sufficient capacity to meet demand within a reasonable timeframe and a standard for waiting times (e.g. within two weeks) to avoid the risk of unintended pregnancy, a high DNA rate and long waits.

Groups with multiple vulnerabilities (eg homeless, women who sell sex and inject drugs) require tailored accessible services for STI care and contraception.

Novel approaches are required to provide education with young people, easier access to contraception after abortion and emergency contraception (e.g. from pharmacies), and recent policy on home misoprostol is a welcome intervention to improve access and acceptability of early medical abortion care.

**HCV**

The emphasis on Prevention Networks at local and national level has been welcome, as was the original recommendation in 2008 for a certain proportion of hepatitis C monies made available to Boards to be spent on prevention. However the time has come now for hepatitis C prevention to be fully incorporated into drug strategies and services at a national and local level. This would enable the full hepatitis pathway from treatment, through testing, to treatment to be fully integrated as part of a person’s drug recovery journey.

The national short life working group on testing and access to hepatitis treatment will be useful in determining what works, and will enable Boards to learn from each other’s experience in case finding.

It might be useful to revisit the evidence around testing for hepatitis C antenatally, given the changes regarding hepatitis C treatments.

3. **Are the services and Sexual Health and Blood Borne Virus Updated Framework being measured and evaluated in terms of cost and benefit?**

There is a lot of good practice, measurement and evaluation across Scotland, and much of this has been stimulated by the SHBBV Framework.

There are examples where successful evaluation is or can be carried out: local boards report monitoring data to the Scottish Government and this can be used for evaluation; NHS Lothian have evaluated the abortion service move from the sexual and reproductive health community setting⁴, and there is an ongoing evaluation of postpartum contraception provision from the maternity setting⁵: a harm reduction needs assessment that includes IEP, BBV testing and care, naloxone provision etc in the community, criminal justice and hospital setting has been completed and is promoting a wide range of service developments⁶; an assessment of the needs of older people with HIV is ongoing; the Bridge-It study is evaluating provision of interim progesterone only pill following emergency contraception⁷; a qualitative study is examining the views of health professionals on access to postnatal contraception (PNC) for South Asian women⁸; and an evaluation is underway of the sexual health services for vulnerable women, including sex workers.

Whilst this work is not always specifically about cost/benefit analysis these factors are taken into consideration and inform allocation of resources and modes of service delivery.

However, it can be very difficult to obtain data that gives an overview of services that an individual needs since there are multiple providers, databases and recording practices; and membership of populations and risk factors are not always recorded in all databases. This
can make evaluation of cost and benefit difficult. For example the homeless database in the City of Edinburgh does not routinely record whether a person is a drug user, sex worker or recently liberated prisoner; virology records for HIV testing do not routinely record the risk factor for testing. Further, although arrangements for data sharing are in place, the actual process of doing so between different agencies can be extremely time consuming. It would be helpful to have more national coordination on data collection and use. For example, while the NESI survey is extremely helpful especially taken along with local needs assessment, it would be good to see more accurate reporting from NEO on a national basis and that needs more coordination and funds.

There is no comparative data on inputs and outputs (and therefore efficiency) for sexual health and HIV services across Scotland. In the absence of any commissioning process, this limits the extent to which the effectiveness of different interventions can be measured. It would be relatively simple to measure inputs against performance data.

The development of initiatives such as the IRESH network should also help facilitate an approach to service delivery and interventions which are grounded in research and evidence around quality and impact.

There are areas that may benefit from greater leadership from the top:

1. **Support for a programme of research to formally evaluate, small scale innovations.** Areas for research could include: interventions to modify the determinants of health; models of care for most at risk populations (e.g. vulnerable women, trans people); mainstreaming of ‘specialised’ harm reduction services like IEP; models of user involvement in service development; peer support, especially for people with multiple overlapping risk factors; ways to improve data collection and linkage to support service development. The IRESH network is a very welcome start but it is not clear the extent to which this will support areas such as substance misuse and how to address determinants of health in excluded populations.

2. **Support for sharing and wider implementation of good practice across the SHBBV Framework.**
   There are a number of pilots that show effectiveness in some parts of Scotland but are slow to get rolled out elsewhere. We maybe we need to think about better sharing and support for implementation of good practices (some preventive others not). We need more examples such as from the Scottish Abortion Care providers network that with Scottish Government support resulted in developing the national protocol for early medical abortion to make sure that this service was introduced evenly across the country.
   The existing structure does provide some opportunities and the new short life working groups looking at HIV and HCV testing will be useful as pulling together the many innovations and experiences to date. But there are other areas where national coordination is weaker.

   One area is harm reduction; the current national arrangements with PADS includes many able national experts, but regional health boards, ADPs and key parts of the workforce (e.g. addictions nurses, third sector providers) are under-represented, and the groups can appear exclusive and obscure. It would be helpful if national groups could provide more support and resource to update national guidance such as the IEP guidance under review.

   Another area is around the structural determinants of health and ways to develop interventions that place these as the heart of prevention in the SHBBV Framework.
4. Given the high cost of new medicines, what cost–benefit analysis has been done of primary prevention in general, and the role of the new medicines as a means of primary prevention?

**Cost benefit analysis of primary prevention in general**

Public health intervention for primary prevention is highly cost effective. A recent paper by Masters et al. estimated a return on investment of 4 for local public health interventions while ‘upstream’ interventions delivered on a national scale yield a 10 fold higher return on investments.

It would be useful to have more national and local evaluation of primary prevention for socially excluded groups. As set out in the Lancet papers conclusions about effective interventions tend to veer more towards proximate interventions that can be evaluated; such as case management, harm reduction, needle exchange, and pharmacological treatment for substance misuse, HCV and HIV.

There is much less evaluation of structural interventions such as improved housing and poverty alleviation, and also many of the target groups of the SHBBV Framework, such as sex workers, homeless people and prisoners, are not well represented in studies.

In NHS Lothian and elsewhere in Scotland work is being done on multiply excluded groups such as homeless people, street injectors, vulnerable women and people in police custody but there has not to our knowledge been comprehensive cost benefit analysis of these interventions or comparison with other more clinical or service led interventions; and the tendency has been to focus recommendations on mitigation such as improved or novel service provision rather than primary prevention.

**Cost benefit analysis of pharmacological prevention**

The majority of medicines required for the treatment of sexually transmitted infections and the prevention of pregnancy are relatively inexpensive. Treatments and prevention of HIV and HCV are the exception.

International cost-benefit analyses for HIV ‘Treatment as Prevention’ are widely accepted and robust. Reduction in costs of HIV treatment due to the availability of generic medication has been well supported in Scotland through HIV Lead Clinicians and SMC. Significant cost savings have already been achieved and further savings are anticipated.

The evidence base around hepatitis C ‘treatment as prevention’ is in its infancy due to the relatively recent availability of affordable and tolerable treatments. Research in this area should be encouraged and funded though not at the expense of non-pharmacological primary prevention measures.

The HIV PrEP Short Life working group and SMC both assessed available evidence on cost-effectiveness of HIV PreP in 2016/17. Cost effectiveness was supported by the available evidence. Since then the cost of drugs for PreP has reduced by 95%. A CSO Grant has recently been awarded to review the effectiveness of PrEP in Scotland Optimising Services for People at Highest Risk of HIV: Developing Best Practice in Delivering HIV Pre-Exposure Prophylaxis (Prep) Through Evaluation of Early Implementation Across Scotland. Although this is not a cost-effectiveness analysis, it will help to inform interventions to ensure that PrEP is equitably and effectively provided to those at the highest risk of infection.

NHS Lothian have been awarded a NIHR HTA funded grant to evaluate (and this includes cost benefit analysis) provision of bridging contraception from the community pharmacy. This is a multisite (Lothian, Tayside, London) cluster randomised cross over study the Bridge it Study. The aim is a reduction in unintended pregnancy and will determine if this
The approach is effective and cost effective, plus the process evaluation will inform any future roll out if it is shown to be a successful strategy.

There are other possible cost benefit analyses that could be conducted but that are not ‘preventive’ – although they could generate cost savings that could lead to reinvestment elsewhere.

For example:
- cost savings from home administration of misoprostol for early medical abortion could lead to fewer visits, more women able to choose this option etc
- cost effectiveness of self referral for abortion- i.e. no need for GP visit and also if this results in improved access to abortion, possibly fewer late abortions
- cost effectiveness of treatment of uncomplicated Chlamydia at community pharmacies using a text voucher etc

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