



**OFFICIAL REPORT**  
AITHISG OIFIGEIL

# Health and Sport Committee

**Tuesday 23 January 2018**

**Session 5**



The Scottish Parliament  
Pàrlamaid na h-Alba



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**Tuesday 23 January 2018**

**CONTENTS**

	<b>Col.</b>
<b>SUBORDINATE LEGISLATION.....</b>	<b>1</b>
National Health Service Pension Scheme (Scotland) (Miscellaneous Amendments) (No 2) Regulations 2017 (SSI 2017/433) .....	1
National Health Service Superannuation Scheme (Scotland) (Miscellaneous Amendments) (No 2) Regulations 2017 (SSI 2017/434) .....	1
<b>PREVENTATIVE AGENDA (SEXUAL HEALTH, BLOOD-BORNE VIRUSES AND HIV) .....</b>	<b>2</b>
<b>PETITION .....</b>	<b>31</b>
Mental Health Services (PE1611) .....	31

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**HEALTH AND SPORT COMMITTEE**

**3<sup>rd</sup> Meeting 2018, Session 5**

**CONVENER**

\*Lewis Macdonald (North East Scotland) (Lab)

**DEPUTY CONVENER**

\*Ash Denham (Edinburgh Eastern) (SNP)

**COMMITTEE MEMBERS**

\*Miles Briggs (Lothian) (Con)  
\*Alex Cole-Hamilton (Edinburgh Western) (LD)  
\*Jenny Gilruth (Mid Fife and Glenrothes) (SNP)  
\*Emma Harper (South Scotland) (SNP)  
\*Alison Johnstone (Lothian) (Green)  
\*Ivan McKee (Glasgow Provan) (SNP)  
\*David Stewart (Highlands and Islands) (Lab)  
Sandra White (Glasgow Kelvin) (SNP)  
\*Brian Whittle (South Scotland) (Con)

\*attended

**THE FOLLOWING ALSO PARTICIPATED:**

Dr Emilia Crighton (NHS Greater Glasgow and Clyde)  
Professor John Dillon (University of Dundee)  
Professor David Goldberg (Health Protection Scotland)  
Dr Duncan McCormick (NHS Lothian)  
Dr Ken Oates (NHS Highland)  
George Valiotis (HIV Scotland)  
Petra Wright (Hepatitis C Trust)  
Mildred Zimunya (Waverley Care)

**CLERK TO THE COMMITTEE**

David Cullum

**LOCATION**

The James Clerk Maxwell Room (CR4)



## Scottish Parliament

### Health and Sport Committee

*Tuesday 23 January 2018*

*[The Convener opened the meeting at 10:02]*

### Subordinate Legislation

#### National Health Service Pension Scheme (Scotland) (Miscellaneous Amendments) (No 2) Regulations 2017 (SSI 2017/433)

**The Convener (Lewis Macdonald):** Good morning, and welcome to the third meeting in 2018 of the Health and Sport Committee. I ask everyone to ensure that their mobile phones are on silent, and I remind people that although it is perfectly acceptable to use mobile devices for social media, there should be no recording or photography, please, as we have people in the Parliament to do that for us.

We have received apologies from Sandra White.

Agenda item 1 is subordinate legislation. As colleagues will know, we have two instruments that are subject to negative procedure to consider, the first of which is the National Health Service Pension Scheme (Scotland) (Miscellaneous Amendments) (No 2) Regulations 2017. No motion to annul the regulations has been lodged, and the Delegated Powers and Law Reform Committee has made no comments on them. As members do not wish to offer any comments on the regulations, does the committee agree to make no recommendations on them?

**Members indicated agreement.**

#### National Health Service Superannuation Scheme (Scotland) (Miscellaneous Amendments) (No 2) Regulations 2017 (SSI 2017/434)

**The Convener:** No motion to annul the regulations has been lodged, but the Delegated Powers and Law Reform Committee has made comments to Parliament on deficient drafting. I invite comments from members. We are required to report on the regulations by 5 February, which gives us a little time. Do members agree that we should write to the Government to ask it how it intends to address the point that the Delegated Powers and Law Reform Committee has raised?

**Members indicated agreement.**

## Preventative Agenda (Sexual Health, Blood-borne Viruses and HIV)

10:04

**The Convener:** We move on to the second item on the agenda. I welcome several guests who have joined us for a round-table discussion, and guests in the gallery.

Given that we have such a large collection of distinguished witnesses, it would probably be helpful to go round the table and introduce ourselves. This is one of our series of round-table sessions on the preventative agenda. On this occasion, we will specifically deal with sexual health, blood-borne viruses and HIV.

I am the convener of the committee.

**Ash Denham (Edinburgh Eastern) (SNP):** Good morning. I am the deputy convener of the committee.

**Dr Ken Oates (NHS Highland):** I am a consultant in public health for NHS Highland in Inverness.

**Miles Briggs (Lothian) (Con):** I am a Conservative MSP for Lothian and the Conservative spokesman for health and sport.

**George Valiotis (HIV Scotland):** I am the chief executive officer of HIV Scotland.

**Alex Cole-Hamilton (Edinburgh Western) (LD):** I am the Liberal Democrat MSP for Edinburgh Western. I am my party's health and sport spokesperson.

**Professor John Dillon (University of Dundee):** I work for NHS Tayside and the University of Dundee.

**Jenny Gilruth (Mid Fife and Glenrothes) (SNP):** I am the constituency MSP for Mid Fife and Glenrothes.

**Emma Harper (South Scotland) (SNP):** I am an MSP for the South Scotland region.

**Dr Emilia Crighton (NHS Greater Glasgow and Clyde):** I am the deputy director of public health for NHS Greater Glasgow and Clyde.

**Alison Johnstone (Lothian) (Green):** I am an MSP for Lothian.

**Professor David Goldberg (Health Protection Scotland):** I am from Health Protection Scotland.

**Ivan McKee:** I am the MSP for Glasgow Provan.

**Petra Wright (Hepatitis C Trust):** I am Scottish officer for the Hepatitis C Trust.

**Mildred Zimunya (Waverley Care):** I am a senior manager for Waverley Care.

**Brian Whittle (South Scotland) (Con):** I am an MSP for South Scotland.

**Dr Duncan McCormick (NHS Lothian):** I am a consultant in public health for NHS Lothian.

**David Stewart (Highlands and Islands) (Lab):** I am an MSP for the Highlands and Islands.

**The Convener:** We will move directly to questions. Before I ask Alex Cole-Hamilton to kick off, I note that some of you will have taken part in round-table sessions at the Scottish Parliament before, but some will not. We are looking to obtain as much understanding, evidence and information as we can over the next hour and a half. That will best be done through structured discussion—however, I want to encourage everybody who has something to contribute on a particular point to indicate that to me, and I will seek to call you to speak.

**Alex Cole-Hamilton:** I declare an interest as co-convener of the cross-party group on sexual health and blood-borne viruses. It has also been my privilege to have chaired the HIV anti-stigma consortium.

My question spans HIV and hep C. One of the biggest problems and barriers that we face in terms of the public health response to HIV and hep C is that identification is still difficult. I would like to hear the reflections of the panel on the correlation between the resilient levels of stigma around HIV and hep C and people not getting tested, seeking treatment or even admitting to themselves that they might have one or other, or both, those infections.

I am aware that the World Health Organization has set a target for HIV: in particular, its 90-90-90 target—that 90 per cent of cases be identified, 90 per cent be in treatment and 90 per cent have an undetectable viral load. I might have got that wrong, but you get the gist.

Let us open up the discussion with reflections on how stigma is still a barrier to people being diagnosed and receiving treatment.

**Professor Dillon:** Stigma is an issue. My expertise is in hepatitis C, rather than HIV, but some of the issues go across both.

The stigma with hepatitis C is usually because of its strong association with drug use and the negative connotations of that. Because of the fear of stigma, the people who are affected by the virus are likely to be fearful of moving out of the environment in which they are in. We can try to destigmatise the disease, but that will be a long-term and large issue. However, we can embed our services that are relevant to hepatitis C and HIV in

the places to which people are already comfortable going, rather than sending them to new environments and making them track across new barriers.

We need to adapt our services to facilitate people's access to care, rather than sitting in our traditional ivory towers and making people come to us. That will not destigmatise hep C, but it is one way of working around the stigma problem. We need another agenda on destigmatising the disease, but that is a practical action that we can take today for people who are in desperate need of treatment, and it should be the focus of much of our effort.

Particularly with hepatitis C, the people who are prepared to come out of their environments and go to hospital and the traditional pathways of care have, largely, already engaged with treatment and been treated. However, the bulk of people who are still engaged with addiction services or other third sector providers are fearful of moving away from them, so we need to move into the areas where we can access those people and make our services more adaptable.

**Dr Crichton:** In NHS Greater Glasgow and Clyde, we carried out research with a view to conducting a campaign to address stigma, in particular among our staff. We had a huge poster that could be seen from far away, which said, "The same as you." We could see people being attracted to it until they got fairly close and saw the words "I'm HIV positive", and then they would swerve away. The subtle message is that we still have quite a lot to do with our staff because, particularly in relation to HIV, there are long memories.

When I was working with John Dillon's team in Dundee nearly 20 years ago, HIV was an incurable disease and people were dying of AIDS. Since then, HIV has become a long-term condition and people have long and fulfilling lives, but that message has not permeated through to everyone. We still have a challenge in saying, "This is like anything else. It's better to know, and if you get treated, you'll have a fulfilling life and you'll be no risk to anybody." We have a long journey to go on.

**Petra Wright:** I want to speak up for another group of people. The largest undiagnosed group are previous injecting drug users—people who may have been infected for 30 years or whatever. Not much is being done to find them. I feel that, even though they have recuperated, if you like, or have been rehabilitated and are working and contributing to society, the stigma around hepatitis C prevents them from coming forward, even when they remember that they were exposed to risk factors in the past.

Normalising testing instead of continually targeting harm-reduction services might have the impact of reducing stigma. For instance, pregnant women get tested for HIV and hepatitis B, but not for hepatitis C. A number of people to whom I have spoken had presumed that they were tested for hepatitis C before they had their babies. That is a missed opportunity.

**Mildred Zimunya:** I work for Waverley Care, and one of the projects that we work with is called the faith in health agenda. In that agenda, we are responding to the issue that Professor John Dillon mentioned, in that we go to where people are and seek to understand how they think and see the world around them. We work with faith leaders and faith communities and get messages from them about how they want to receive messages about HIV, and we seek to understand where they are coming from in terms of their faith.

That work began quite early on, around 2004, when we recognised that a number of patients who were coming in to clinics for treatment were stopping their treatment and not adhering to it because of their faith. As you will understand, people may see their doctor for just five minutes, but when they go out the door, they relate to their faith leader for the next six months. We understood that early, so part of what we are doing is working with faith leaders, who can talk to their faith communities about HIV. We should not exclude people's faith, which is an integral part of their lives. If a faith leader stands up and says, "Let's challenge HIV together," people are more likely to listen to that.

In relation to the national health service and the staff who work in it, we have continually been emphasising that, if someone says that they believe that they have been healed, the response to that should be person centred. That is an aspect that we are challenging. Also, when we look at the funding that is out there—besides funding from the Scottish Government, which has been very supportive of some of this work—we find that a lot of religion-focused work is excluded from funding, so it is a challenge to access funding to do the work.

Another point about the NHS is that there is a lack of visible volunteers who are African or from black and minority ethnic communities. We have a push within the NHS workforce on visibility of African and BME communities, but when we delve down into communities, we do not find the same effort to get representatives from within the community.

We are making a push in our peer-to-peer work, which involves us asking whether there are people in the community who will understand their peers. People's peers are more likely to tell the truth about what is going on for them, and to share the

issues that they face. As part of the peer-to-peer approach, we take those issues from the voice of the community and provide solutions in ways in which they want solutions to be provided, and not in ways in which we want them to be provided.

That is what I would like to say about our work to tackle stigma from the root. We would like more of that work to be supported.

10:15

**George Valiotis:** I thank Alex Cole-Hamilton for his opening question, which I think is the most important question to ask. In this environment, it is essential to think about the fact that, in Scotland, we have everything that we need to cure hepatitis C and to eliminate HIV—we have all the tools. Treatment works: we know that if someone who has HIV is on treatment, they will be uninfected. We know that we can cure hep C through treatment. We have PrEP—pre-exposure prophylaxis—which is an oral daily treatment. If people who do not have HIV take it every day, they cannot acquire HIV. We have condoms—you might have heard of them—which still work really effectively. We have everything that we need to stop HIV and hepatitis C, but we are not getting there, and that is because of stigma. It is important to begin the discussion by framing stigma as our key challenge.

I appreciate that it might, when it comes to monetary savings and so on, be necessary to consider technical measures in the NHS, but unless stigma is our number 1 focus, we will not get to zero and will not make further achievements.

We know that people who have HIV and who access treatment in the NHS have extremely good outcomes. Overwhelmingly, they love their clinicians and they love going to their clinic—well, they do not love it, but it works for them. There are problems here and there, but the overwhelming majority of such services are working. What consistently gets in the way of prevention efforts and treatment progress is stigma, so I again thank Alex Cole-Hamilton for beginning with that. I could talk a lot more about the issue. Perhaps other questions will help us to specify how we can address stigma at every level of the response.

**Professor Goldberg:** I totally agree that stigma is a major issue—although it is, of course, not the only issue. We should put things in context and look at HIV separate from hepatitis C.

As far as HIV is concerned, nearly 90 per cent of the infected population have been diagnosed. We are a bit short of the World Health Organization target, but Scotland has done extraordinarily well on that front. I am not saying that there are not challenges—we still face

challenges in diagnosing the 10 to 15 per cent of individuals who remain undiagnosed—but, over the past three decades, Scotland has done extremely well on HIV.

As far as injecting drug use is concerned—we know that there is a small outbreak of HIV among injectors in Glasgow—harm reduction services for injectors in Scotland have been absolutely outstanding. The general prevention of HIV among injectors over the past three decades has been one of the great public health achievements of all time. It is a phenomenal achievement that has saved the country incalculable human and economic costs. We must bear that in mind.

We must also accept that, when it comes to HIV and men having sex with men, a lot is being done on the pre-exposure prophylaxis front: a lot of new work is being done to reduce transmissions. Although there are challenges on the HIV front, we must recognise that health services and the Government have done a great deal. That said, I accept that there is more to be done.

The hepatitis C virus is a different ball game. The action plan came out in 2008. At that point, 38,000 people in the country were infected. Ten years on, 34,000 people are infected, so its prevalence has come down. The figure would have been much higher than 38,000 had it not been for the action plan, but the situation is a huge challenge. In 2008, 38 per cent of the estimated hepatitis C infected population had been diagnosed; now the figure is nearly 60 per cent.

A really good job has been done in contacting infected individuals, but there is a massive job still to do. As John Dillon pointed out, thousands of people have been diagnosed but are not engaged with services or able to take advantage of the new therapies.

The critical issue is making bespoke services for that very vulnerable and chaotic population group. NHS Tayside has done that extremely well: I would like to see its approach being rolled out to the rest of Scotland. There are islands of excellence and outstanding practice in other health boards, but that is not enough. We must tailor our services and make them user-friendly. We should not expect these guys to come to us in our hospitals; instead, we should get out into community settings and make sure that they are diagnosed and treated. By doing that, we will handle the problem.

Part of the issue is stigma, but other factors come into play.

**Dr McCormick:** David Goldberg has made a lot of the points that I had wanted to make.

Stigma is important but, although the people we are talking about may have HIV or hepatitis C,

they are frequently drug injectors, sex workers, homeless and poor, too. They are excluded from society in many different ways, so the infection itself is not the only barrier to accessing and benefiting from services.

In Lothian, we did a review of the people who had been referred for hepatitis C treatment and how they had dropped out along the pathway. A similar review has been carried out at national level, too. The drop-out rate is high—it is about 70 per cent following the first appointment. That is not just because of stigma but because of all the other factors in people's lives, which make the situation very complicated. That is something to bear in mind.

Again, although stigma is a reason why people do not access services, a lot of people do access services. They access services to get injecting equipment, to see their general practitioner, for addictions treatment, for sexual health treatment and for lots of other things. Those are opportunities when they could be tested. I do not think that it is stigma that prevents them from being tested; rather, I think that it is a lot to do with little barriers, such as testing not being routine practice. A lot of staff are very busy, particularly in addiction services, where there have been cuts, so they do not have time. Furthermore, third sector staff do not always have access to information to know whether a patient needs a test, because they cannot always access NHS records. There is the issue of getting people in; when they are in, there is also the issue of taking advantage of that opportunity to test them.

Petra Wright will be pleased to know that we are looking to start hepatitis C testing in pregnant women. It is very cheap to do, and it can just be added on to the polymerase chain reaction test. We will see what the yield is there.

**The Convener:** I am conscious that the question is so general that we could have a debate around it for the entire session. I do not want to do that, so I will ask Ken Oates, who has not spoken, to comment. After that, I ask that Alison Johnstone asks her second question, which I suspect will allow some of the folk who want to comment further to do so.

**Dr Oates:** My comment is on stigma in rural areas, which is still a significant issue because people are well known and it is difficult to hide. We have found that working closely with the third sector is beneficial in those parts of the country. We partner with Waverley Care's Highland service, and there are other third sector organisations as well. They do an excellent job, and people are more likely to approach them and discuss their conditions than they are to go to the statutory agencies, such as the NHS or the local authority.



**Alison Johnstone:** I address my point to Professor Dillon in the first instance. I want to understand why the pilot in NHS Tayside using the prevention as treatment model is so important.

**Professor Dillon:** Hepatitis C is still transmitted by injecting drugs. Even with the availability of opiate substitution therapy and needle and syringe provision, which has largely removed HIV from the drug-injecting population, injecting drugs still allows the transmission of hepatitis C to occur. In your career as an injecting drug user, you might inject for two, four or six years before moving on to recovery, but if you become infected with the virus during that time, you will potentially pass it on to six or seven other people you interact with before you move away from drug use—if you do, which is something that varies. If we can offer treatment at an early stage, when people who are infected are still actively injecting, when they have contact with other drug users and share equipment with them, the chances of transmission disappear because the person is no longer infected. That is the idea of treatment as prevention.

We have the idea of preparation before a sexual act to reduce the chances of getting infected, but the preventative approach targets the people who are infected and prevents them from infecting other people. The current standard practice is to wait until people are stable and have moved on to opiate substitution therapy or into recovery before treating them. Traditionally, that is perceived as being an easy population to treat because they are relatively stable and they have moved away from the chaos in their earlier lives. However, it means that the bucket is constantly being refilled and new infections replace those that you have treated. That is partly why all the hepatitis C treatment activity that we have carried out has had a smaller effect on hepatitis C prevalence than it would have if we had been able to cut down the incidence.

In Tayside, we are trialling a model in which we will dramatically increase the number of people we treat who are actively injecting drugs and have hepatitis C, which should bring the prevalence in that population down from about 30 percent to below 10 per cent, which means that transmission should fall from 5 to 10 per cent to below 1 per cent. That would lead to the extinction of the virus. We think that we can achieve that over two or three years.

If you can take new transmissions of the virus out, all of your subsequent treatment can be used to treat those older people who are stable in the community. We can potentially reach a situation where hepatitis C is eliminated in Tayside in four years' time.

**Alison Johnstone:** Thank you. That was very helpful.

**Dr Crichton:** NHS Tayside is not the only board in Scotland using such a model—I expect that all of Scotland would like to use it. In Glasgow, when we were faced with the HIV outbreak, we wanted—and we still wish—to use treatment as a way to prevent the further spread of HIV among the drug-injecting population. It remains a desirable way of tackling the outbreak. However, the addiction gets in the way of individual engagement with the treatment and the service, which is why we have proposed additional ways in which of tackling the issue. We will discuss those later.

**Ivan McKee:** I want to follow up on the specifics of treatment as prevention and the potential for the elimination of hepatitis C. Correct me if I am wrong, but that model works and the data behind it is pretty solid: if you do what you say that you are going to do, the effect will be to eliminate hepatitis C in that timeframe. That would apply across the whole country.

To what extent do the funding mechanisms for treatment cause problems? What you are talking about is classic prevention: spend a bit more now to save a fortune in future decades because we will not have to treat the problem. How much of a barrier is there to understanding that, directing the resources to the right place and putting in enough resources up front to make that happen? How easy would it be for the Government to fix that?

**Professor Dillon:** It is clearly a barrier. All the health boards have difficulties with cash flow. NHS Tayside has a particularly acute problem that I am sure the committee is aware of. We have managed to persuade the health board that the health gain benefit dominates the short-term costs. Clearly, there is a cost saving over a five or 10-year horizon, but it means investing more money this year.

Given that the drug costs have fallen, we are talking not about increasing the overall drug spend but about maintaining it. If you look back two or three years to see how much we were spending on hepatitis C when the new active drugs became available, you will see that the cost of those drugs has fallen substantially. We are talking about continuing to reduce that budget but being able to treat within that envelope. The money was there, but there are pressures on it.

I am able to make the argument to the finance director that, if they give me the money for three years, I will hand back my drug budget and not ask for any more. No clinician would be able to go to their finance director and say that, other than one who is treating hepatitis C.

**Ivan McKee:** Are you able to put some numbers on that? Specifically, how much are we spending

per year now and how much would you need to spend now to deliver what you need to do?

**Professor Dillon:** I can give you figures for NHS Tayside, but I do not have them for all of Scotland. Three years ago, we spent approximately £4 million in the first year that the new direct-acting antivirals were available. This year, we are likely to spend £2.2 million and over the next three years we plan on spending £2.1 million to deliver the elimination agenda.

10:30

**Ivan McKee:** Sorry—the recurring costs per year if you do nothing are how much?

**Professor Dillon:** We would carry on treating people who were coming through for treatment anyway, and that would cost in the order of £1.5 million to £2 million, so there is a small additional cost. The number of patients who need treatment as part of treatment as prevention in Tayside, given our deprivation index and our prevalent use of intravenous drugs, is about 350 to 400 people. That is the additional number of people who we need to treat—

**Ivan McKee:** Sorry—the question is, before you started doing this, how much were you spending per year, how much extra do you need to spend to eliminate hepatitis C and how much will you save?

**Professor Dillon:** I have given you the total figure, which is £4 million—

**Ivan McKee:** You were spending £4 million per year before you started doing it. How much extra did you need to spend to eliminate hepatitis C?

**Professor Dillon:** We have not eliminated it yet.

**Ivan McKee:** To do that. You know the numbers—how much?

**Professor Dillon:** Going forward, we can deliver the treatment of people who have advancing hep C disease and therefore need treatment, with the addition of treating active drug users, for within £2.1 million.

**Ivan McKee:** That is a six-month payback. Wow.

**Professor Dillon:** Yes.

**The Convener:** Thank you. David Goldberg might want to come in.

**Professor Goldberg:** To build on what John Dillon has said, HPS estimates that there are probably 4,000 to 5,000 individuals who actively inject drugs in Scotland who are chronically infected with hepatitis C.

Those are the people who have the potential to transmit to others. Outside of that group, by the way, the potential to transmit is incredibly low—it

happens, but the number of instances is incredibly low. Probably 98 to 99 per cent of all transmissions of HCV in Scotland related to injecting drug use.

We are talking about 4,000 to 5,000 people, and the cost of treatment for each one is in the ballpark of £78,000. You can do the mathematics. If we were to go for that group, we would be talking about drug treatment costs getting on to about £30 million, but there would also be the other costs of managing the whole effort—co-ordination and so on.

It is not an easy job, but the concept of treatment to prevent onward transmission is a really good one. It is intuitive. I have absolutely no doubt that it will help matters—it will reduce onward transmission. The big question is to what extent and for how long it will do that. The reason why we are doing the research in Tayside is to examine that, because we do not have all the answers. It is possible that the outcome will be different from what we thought it would be. It may be better, it may be a little worse—we are not sure—but we believe in the concept. Intuitively it is right, and it is right for HIV as well. Treatment of infection is good for the individual, but it is also good for the population if that individual has the potential to spread it to other people.

**The Convener:** That opens up to wider questions about cost benefit analysis.

**Ash Denham:** My question follows on from Ivan McKee's question about cost benefit analysis. I will pull out a couple of comments from the written submissions that we received.

John Dillon, you said in your submission that there is

"limited health economic input available"

and that

"the power of such analyses is not available to be utilised"

for this purpose. David Goldberg, you said that

"it would be helpful if the Framework could call upon a health economist".

That is the question. Should there be a health economist? Would that enable boards to make better decisions?

**Professor Goldberg:** I think so. There is no question but that all our activities, in both policy and practice, have been underpinned by good monitoring systems. We have good monitoring systems in this country, so we have good data. We can say how many people are infected and how many individuals have been prevented from going on to contract liver disease, HIV disease and that kind of thing. We have sound data, but we do not have precision in relation to the cost effectiveness of interventions. I accept that there is

such stuff in the literature from other countries, but I think that Scotland would benefit from a bit more precision in that area, working with health economic support. I have no doubt that most of our interventions are pretty cost effective, but our ability to demonstrate that is not as good as it might be.

**Professor Dillon:** To echo that, when people bid to a health board and ask it to make a decision, they can manipulate models from the literature on health economics and say, "If we did this in our territory, we think that this would happen." However, that is not as convincing as having someone who has personalised the models and the projection or actually done the analysis on the data. As a clinician who appears in front of a health board saying stuff, I suspect that it is assumed before I start that I am being economical with the truth and gilding the lily somewhat. Therefore, using a personalised specific analysis—rather than extrapolating data that many people on the board do not particularly understand and then trying to apply it to a particular territory or intervention—would strengthen the case that we are trying to make.

**Dr Crighton:** Before any drug can be taken up by NHS Scotland, it has to go to the Scottish Medicines Consortium, where clinical and cost effectiveness issues have to be considered before the drug can be used. Beyond that, there is no requirement for NHS boards to carry out additional economic analysis, because that has been done up front to allow us to use it. When we move on to novel approaches or public health analysis, boards sometimes resort to health economists, particularly when assessing new interventions, but not all boards have access to health economists, as there are not many of them. Another issue is about tracking the impact of our interventions, which involves the economic evaluation of the impact of our actions.

It is a complex issue, and we could do better, although some work is already done up front. Boards have to be pragmatic in the way in which we carry out business so that we maintain our financial envelope.

**Ash Denham:** What prevents Health Protection Scotland from carrying out that type of health economics work? Should it play that role?

**Professor Goldberg:** The framework that started in 2011 basically says that we will monitor our performance against certain outcomes, using outcome indicators. Since December, the public have been able to access the data portal and see how boards are doing in that respect. However, moving forward, in the framework for 2020 to 2025 or whatever, it would be helpful to have not just outcome indicators but more on the cost effectiveness of interventions, particularly in the

preventative area and on the behavioural front. On the more complex interventions, I totally accept that, for treatment purposes, the drugs have to go through a rigorous process, but we should have something in the framework that says that we want to know about not just the changes in prevalence and incidence and all that but the cost effectiveness of spend in relation to interventions.

**George Valiotis:** I echo my peers' comments, and I add an example of good practice. HIV Scotland administered the PrEP short-life working group last year or the year before. We looked for good evidence in the international literature about the cost effectiveness of PrEP in Scotland—that work had already been done. We then assembled an expert group, which included clinical expertise, people from the Scottish Medicines Consortium and people from academia, and we did a cost-implications exercise, because obviously we could not do a cost-effectiveness exercise. The report that we generated was used by the SMC when it did its assessment, so, all told, that created a portfolio on cost effectiveness. We were able to ascertain approximately how many people we thought would benefit from PrEP and so on. We thought that that was a pretty good model.

As we go forward, there are limitations on how we measure cost implications. However, we know that the approach works and is cost effective; that model worked for us. That is just an example of how we have been operating so far.

**Jenny Gilruth:** I have a question for HIV Scotland and Waverley Care, whose submissions flagged up inequalities in the provision of sex education. HIV Scotland said:

"two young people between the ages of 15 and 24 are diagnosed with HIV each month".

I found that quite shocking. HIV Scotland is asking the Government for legislation on relationship, sexual health and parenthood education, which it wants to be

"a compulsory component of the curriculum to guarantee equality of access".

Waverley Care said that there is

"varying delivery and quality of sexual health education".

I did my homework last night and went through the content of the health and wellbeing curriculum. Three pages of content in the curriculum guidance are dedicated to RSHP, from the early years right through to the fourth level. Are you aware of areas in which RSHP is not being taught at the moment? Do you have evidence of that?

**George Valiotis:** Yes, we absolutely are aware of areas in which it is not being taught. We are conducting research at the moment and so far we have heard from 2,000 young people about their experience of learning. I do not have the figures

yet, because the research is on-going, but I can tell you that there are gaps. It is not essential for schools to teach the subject. A child might be sick one day and miss the class. We have clear evidence that such teaching is not going on. It depends on the school and the choices of parents. There is absolutely a gap.

We know that, because two young people a month are being diagnosed with HIV. If kids are to have access to what they need to know to protect their health, we adults have to make choices that are in their best interests. The evidence is telling us that kids are not getting the information that they need to keep themselves safe. That is why education is a priority issue.

**Mildred Zimunya:** Waverley Care recognises that kids are not getting the sexual health education that they need. We have a funded project in the Highlands at the moment—the wave project—which is about filling that gap by sending people into schools to teach the subject. As George Valiotis rightly said, teachers are not obliged to teach sexual health education. They have the materials, but there is no assurance that they will teach the subject. When projects such as ours offer to send people into schools to do that, the schools open up for us.

We are calling for consistency among all the NHS boards. Where good models are working, we encourage boards to take them on. Right now, we are working in the Highlands, but the model could be rolled out across Scotland. We need not depend on schools to deliver sexual health education; projects such as ours can do that.

**Jenny Gilruth:** In your submission, you referred to the sexual health and relationships education resource. I had never heard of the SHARE resource, so I had a little look at it. Am I correct in saying that it was developed by Waverley Care and Education Scotland?

**Mildred Zimunya:** Yes, that is correct.

**Jenny Gilruth:** Of course, the use of a teaching resource is not compulsory—much like the experiences and outcomes. Is there content in the SHARE resource that is not currently in the health and wellbeing curriculum content? Is there something missing in the curriculum content, which SHARE offers?

**Mildred Zimunya:** The resource that we have at the moment is very interactive. The approach is different from one in which a teacher is expected to deliver content and tick a box; it is about interacting with the children and letting them have discussions and ask questions, in a peer environment, of a non-threatening individual who is in the school and then out of it. That works better for students than does listening to a teacher who the students see in the corridors week in and

week out. A group of people comes in; they are separate from the school staff and so they are able to elicit questions that teachers might not be able to get from their students.

**Jenny Gilruth:** Do you recognise that as a strength? In my experience, someone may teach a child English and also have to teach them sex education. Do you think, from your experience, that it is a strength to have an outside agency coming in and delivering that education?

10:45

**George Valiotis:** Always—absolutely. However, I think that there are things missing from the SHARE curriculum, because HIV has changed. We know a lot more about treatment as prevention and we also know about PrEP now. It is time that the curriculum was updated, and I believe that there is some work going into that—it has to be done. However, most importantly, we in the third sector cannot be everywhere. It is important to involve us, where possible, but we need some statutory changes so that every child gets the same access, no matter where she is living.

**Jenny Gilruth:** I have a last wee question on that point for David Goldberg, with regard to the data gap that we seem to have. The most recent data that we have on young people's experience of sex education was collected in 2012, when MORI conducted a survey on outcome 1 of the sexual health framework. No other data is currently available through HPS. Why is that, and are there plans to do more data gathering?

**Professor Goldberg:** Here is my opportunity—thank you for asking that question. That is outwith HPS's scope. We cover infectious diseases and environmental incidents but not the sexual health territory, which is non-infection related. The organisation that covered that territory was Health Scotland—it was fairly active on sexual health over many years, but it does not specifically cover it any more. It might cover it a little bit in the area of inequalities, but it does not have a visible national presence in sexual health. Indeed, there is no national agency in Scotland that covers that area.

**Jenny Gilruth:** Are you aware of the reason for the change?

**Professor Goldberg:** I do not know the reason for the change. I do not want to say any more about Health Scotland in that respect, because I do not have all the facts available to me. However, there is a gap in leadership, co-ordination and data at national level. The gap is not so great at local level, where there are boards that do a hell of a good job, but from a national perspective there is a major gap.

This is not the first time that I have brought the matter up. I have brought it up with the executive leads of the sexual health and blood-borne virus framework, so they know about it. However, it is good to be able to air the matter in this forum, because it is a problem. HIV Scotland and other third sector organisations have done a tremendous job, but we do not have a national statutory organisation leading in the area of sexual health, relationships education and all of that.

**Jenny Gilruth:** Do you have a view on who should do that? Should it be the job of Education Scotland, for example, to go into schools and survey pupils about their experiences?

**Professor Goldberg:** I do not know. The operational side is one thing, but there is a strategic side that is missing, and that is what I am focusing on.

**Alison Johnstone:** I would be grateful for advice from the witnesses. I am hosting an event in the Parliament tonight for the Royal College of Paediatrics and Child Health, which is looking at the state of child health in Scotland. One of the recommendations is the introduction of statutory sex and relationships education in all schools. Would everyone here support that? Perhaps it would be quicker to ask whether anyone would not support that.

**The Convener:** The silence is a fairly loud response.

**Alison Johnstone:** As part of our recent committee work, Miles Briggs and I visited a drug partnership in Edinburgh and heard from a group of people who are now in their 30s, some of whom were in recovery and some of whom were aiming to be so. Some of them said that they had been introduced to heroin by family and/or friends as young as 13. They were absolutely determined that we need to get better at introducing people to the subject far earlier than we do.

At the recent Hepatitis C Trust event in the Parliament, we heard again that more information has to reach people so that they can then make decisions before family and friends approach them. What are we missing here? It seems very frustrating.

**The Convener:** I will take Duncan McCormick first, with his Lothian hat on, and then Emilia Crighton.

**Dr McCormick:** On the SHARE training, I agree completely that we need to have people coming in, but we also need to have teachers who are trained. Young people have questions all the time and must have someone they can speak to. Teachers may need to be able to access more expert advice, but young people need to have someone to go to who is there all the time.

I do not think that it is happening everywhere, but in NHS Lothian, at least, there has been a decrease in the uptake of condoms among young people. I am not sure how it would work, but access to condoms without any hassle—maybe in school settings or elsewhere—is something to think about, because it is definitely a problem in Lothian. We are thinking about offering access online, because people do not like the amount of paperwork, and we are rethinking the traditional ways of getting condoms.

**Dr Crighton:** First and foremost, we need to highlight the successes in sexual health over the past 20 years and the extent to which what happens now is a consequence of previous successes.

Health Scotland has revised its strategy—indeed, it has decided to move more into inequalities as opposed to covering all the health education topics. Sexual health is now part of the curriculum, as Jenny Gilruth has said, which means that everybody delivers a variation on sexual health education as they see fit. There is also additional top-up training. The health improvement network for sexual health in Glasgow provides additional training for schools, but it is not compulsory. We do not go to every school—it is a matter of relationships, who asks for training and where we see the need.

The other major success has been the reduction in the number of teenage pregnancies, which we use as an indicator of what happens in sexual health, but we are not there yet—we still have a lot to do. A major concern right now, as the sexual health services are being passed on to the integration joint boards, is that, in Glasgow in particular, we will see a revision of the provision and we will have more cuts, with money being taken out of the service. We are concerned about what funding will be available in the future, because, unless there is a major crisis, sexual health is not seen as an issue.

We need to put sexual health education in the curriculum, but we also need to monitor its delivery and have additional ways of engaging people. I completely agree with Mildred Zimunya that education that is delivered outside the curriculum is really valuable for individuals, particularly those who are at risk.

Alison Johnstone spoke about people being introduced to drugs, alcohol and so on while they are teenagers—some at the age of 13—and asked what we can do. The only evidence that we have from elsewhere in the world is what the Icelanders have done. They got families to spend time together, empowering young people to look at alternatives to being out, hanging out on the street and drinking, smoking and doing other things. It is about having sports and cultural activities

available and getting the young people to spend time with their families—it is about taking a whole-person approach. That is the only approach that works.

**The Convener:** Thank you very much. Alex Cole-Hamilton has a brief supplementary question.

**Alex Cole-Hamilton:** It is more of a reflection than a question, but perhaps the panel members would like to comment on it. It is about putting sexual health education in schools on a more statutory footing. We covered this to a certain degree in the Equalities and Human Rights Committee's inquiry into school bullying, particularly around homophobia.

I will speak about something that I have experienced in my personal life. My wife teaches in a Roman Catholic primary school, and I spoke to many teachers from Roman Catholic schools during the inquiry. Although there is no diktat or anything like that from the Roman Catholic church on this, there is still an anxiety and a tension for teachers in Roman Catholic schools in addressing the subject because of the tension that exists between what is normal, healthy education on these issues and church doctrine. We need to be mindful of that. Perhaps legislation would give teachers cover in that context. I do not want to cause a controversy—I stress that there is no pressure from the church for teachers not to talk about sexual health. However, a tension exists because of the clash with church doctrine.

**The Convener:** I do not know whether any of the witnesses want to comment on that at this stage—they might wish to comment on it at the same time as answering other questions.

**Miles Briggs:** I want to pull together some of the discussion that we have had about hep C, specifically with regard to those who are in treatment. In 2016-17, just over 1,500 new cases were diagnosed and 1,700 people commenced treatment. Given that low level of incidence, what work is being done and what should be done to extend the opportunities? It looks like there is no way that we will meet the Government's target of elimination by 2030.

My other question relates to some of the evidence that we received about identifying new patients. The work that the committee did around prisoner health showed a lack of opportunities being realised. The fact that mandatory testing was not in place meant that many people were not tested in prison, which meant that their opportunity to start on a treatment pathway was not realised. Do the panel members have any views on that?

**Mildred Zimunya:** We have been delivering a project for people in prison—especially people who inject drugs—which is a link service that involves handholding and continuing to support

people from the prison setting when they go back into the community. That link has been missing. When someone is tested in prison—say, when they are on a short sentence—what happens to them? The situation is changing because of the shorter treatment cycle that is in place. However, a lot of the time, after people are tested in prison, the follow-up is lacking, which means that people get lost along the way.

Waverley Care's project has helped to engage people along their treatment pathway. That could be expanded into other areas, with that link between treatment and care extending right from diagnosis to the completion of treatment. That touches on what NHS Tayside's pilot is doing around handholding through the process of treatment. Sometimes it is about attendance for appointments. If people are accessing their treatment, that is okay, but we know that we are dealing with people with chaotic lifestyles and Waverley Care has found value in handholding people through the process. A cost benefit analysis shows that handholding people along their pathway is helpful.

I believe that work such as our prison work is limited. Whether we test people or whether people opt in or out, the opportunity is there to handhold people through the process.

**Petra Wright:** Testing people who use harm-reduction services is not compulsory either, but it is something that I would like to see. I would like everybody who accesses harm-reduction services to get a blood-borne virus test—I do not see why that does not happen—which would take some of the stigma out of testing for that population. There needs to be more testing in other areas, too, such as among pregnant women.

People with hep C are known to have rheumatoid arthritis, thyroid problems and many other health conditions. We need a list of conditions that people with hep C could present with, which might indicate that they need a test—something along the lines of what happens with HIV, for which not only risk factors but other health factors are looked at. It should be written into harm-reduction services' service-level agreements that they aim to test 100 per cent of their service users and refer 100 per cent of those who test positive directly to specialist services.

Historically, there were issues because the drug worker would test the person, deliver the test and then decide that the person was not ready to be referred to hospital to engage. I would like testing to be compulsory.

11:00

**Professor Goldberg:** We estimate that between 20,000 and 30,000 of the 34,000 people

who are chronically infected with hepatitis C are undiagnosed. They are, in essence, lost to follow-up, or they might never have had follow-up, so there is a huge challenge.

In 2015, the Government asked HPS to examine the cost effectiveness of birth cohort screening. The United States Centers for Disease Control and Prevention have recommended that measure and it is being implemented in part throughout the United States. The US has a mixed problem, as about half of its infection is healthcare associated and the other half is injecting drug use associated.

We considered the matter in association with Glasgow Caledonian University at a time when the cost of therapy was high—it was around the £30,000 mark per course of therapy—and the cost benefit analyses did not look particularly promising. However, things have changed dramatically. The cost is now down to under £10,000 and there may be a compelling cost effectiveness case to be made for universal screening of a certain age band in primary care settings—possibly confined to certain geographical areas, as we know that most of the hepatitis C in Scotland is located in areas of deprivation.

Nevertheless, there are challenges. If we come up with an analysis that says that such screening will be really cost effective, it will still be necessary to put money into it. We have to invest in work with general practitioners. It will be costly, but I suspect—we will produce the data soon—that it will come out as highly cost effective, with the consequence that treatment costs will come down. Critically, once we diagnose we must be able to offer treatment there and then in the primary care setting.

One of our problems is that we have a limit. The Government has, understandably, set minimum treatment targets, which, to a certain extent, has hindered our ability to go down the path of screening and being innovative in such settings. Once we diagnose, we want to be able to do the next bit but, at the moment, we have to think about the fact that, if we diagnose, we might not be able to do that.

The two issues are linked but, if we were to agree a universal, United States-type model, we could make real inroads into hepatitis C.

**Dr McCormick:** I agree that opt-out testing is the best approach to take. However, there are lots of challenges, because people might choose to opt out. People get discharged from prison quickly, before they get an appointment to have the test.

We are doing things in Lothian that, I think, people are doing elsewhere as well. We use OraQuick, which is a rapid test that allows people

who are in police custody but will leave it soon to get a result pretty quickly and then go home with the knowledge that that gives them and be more motivated to link into services.

When we are out in the field, testing people, we have a portable fibroscanner. We are going to buy a second one so that we can get people in for testing. When someone has a fibroscan, it can look at their liver and give them a test result, so they can start to get a bit more engaged with the process. However, it is a challenge to do that.

We need to look at the cost effectiveness of the whole wraparound service, not just do a cost benefit analysis of the pharmacological part of the treatment. We also need to consider how to maintain stability and primary prevention in other areas of stigma and difficulties that people face, such as sex work, homelessness and poverty. There is not much cost benefit analysis anywhere of those kinds of intervention, particularly among female, drug-injecting sex workers who are homeless. We need to think about that kind of vulnerable group, and a cost benefit analysis of measures that work to keep them in treatment is important.

**Professor Dillon:** The clinical networks in each health board across Scotland, which deliver the care, have an individualised health board target that is based on the overall Scottish minimum number. Given the financial constraints that health boards face, the target treatment number for a health board has often become the minimum number plus one, which has led to a constraint. David Goldberg made the valid point that, if we are bringing people for diagnosis and then saying, “Yes, you’ve got this nasty, transmissible, fatal disease, but we’re not going to treat you,” we are giving them exactly the wrong message, particularly if they are vulnerable and we want to engage them in wraparound, holistic care.

We should not view hepatitis C treatment or HIV treatment in isolation; we should be encouraging other healthcare behaviours in those groups of patients. Many of you will be aware of our work to reduce the number of drug-related deaths in Tayside, in which we have seen the risk of drug-related death among those people who have hep C and have engaged with care fall dramatically. In fact, that is the biggest life-saving benefit in the short term, rather than prevention of death from liver disease. That is important.

We had treatment pathways that were set up largely on the basis of interferon treatment, and then we had the joy of the new, very effective drugs that are easy to give. We have cleared out, if you like, all those people who were waiting for treatment. To rise to the challenge in the targets, the Government has, in the past week, committed to increasing the treatment target from 1,800 to

2,000 in the next year, to 2,500 in the year after and to 3,000 in the year after that. That puts us back on track to move to elimination by 2030. We would have liked the 3,000 target now, but some health boards are taking time to adapt their pathways, as we need much more integrated care pathways whereby we can reach in to people.

A short-life working group has been brought together to highlight the best practices from across the world, as well as in Scotland, and to come up with a toolkit for each health board to develop. There are differences between the health boards in terms of the distribution of their patients and how their services are organised, and we need integrated care services. Equally, we need to take away some of the medicalisation and gear that went with hep C treatment when we had just interferon therapies, because the field has changed and the drugs now are very safe—it is almost a treat-and-forget situation.

**The Convener:** Thank you. Before I bring Doctor Crighton back in, Brian Whittle wants to follow up the line of questioning.

**Brian Whittle:** Thank you, convener, and good morning, panel. The evidence shows the link between the drug-using community and the prevalence of HIV and viral hepatitis. I wonder where the pressures are in that environment vis-à-vis the work of drug rehabilitation units. Is cross-referencing being done with other agencies that work in that environment? Is there a correlation between the pressures on their budgets and the rise in the prevalence of HIV and hepatitis? How do you play in between those agencies and how does that correlate?

**Professor Dillon:** In the original action plan, we acknowledged the overlap, particularly with hepatitis C and the drug agencies and drug treatment services. There was a requirement to have integrated treatment services so that hepatitis C treatment services were available in addiction centres. That has worked well in some areas but less well in others.

Clearly, the loss of budgets associated with the alcohol and drug partnerships last year has put more pressure on the drug services, and so on. We try to get them to work more holistically with their clients. If someone has made a point of contact and moved from injecting to opiate substitution therapy or interacting with drug services, to be able to offer them treatment for their hepatitis C is an advantage. Delivering treatment in those services means that that client does not have to go elsewhere and does not have to face new barriers and new stigma. In addition, the treatment for drug addiction is often relatively confrontational. Moving on to hepatitis C treatment is neutral ground, if you like, for both the person infected by hepatitis C and the worker, who views

it as a good thing to do. That helps to build relationships and trust.

We therefore need to convince our partners in drug services that there is a win-win situation for them in offering more services, because they will get more buy-in to the whole treatment process. Where that has worked well, it has been really successful and we have had huge uptakes. Part of the reason for NHS Tayside's success in having the highest diagnosis rates in Scotland and some of the highest treatment rates is those integrations with drug partnerships. That is the way that we should be going.

**Dr Crighton:** I must advise the committee that I am the vice chair of the Glasgow ADP. In that role, I have led on work that looks at the addiction needs of individuals who are HIV positive, and that has given me a lot of insights that I did not have before. It became very clear that there is a group of individuals who shift between prison and homelessness, are addicted to drugs, and have experienced multiple traumas in their childhood, and it is very difficult to find a way to bring them into mainstream services and keep them there. We have found that although they know about HIV and can be hep C positive, they continue to share equipment such as needles and drugs. They say, "I know I'm hep C positive. So are you, and it makes no difference." Unfortunately, their priority is the addiction.

We have pooled together homelessness, addiction and community justice services in Glasgow. We are all working together, and we still have not cracked it. We have NHS Health Scotland with us, and academia is trying to create additional insights, but those individuals face difficult issues. Until we work with the users and understand their true needs, it will be very hard to deliver the services.

The budgets are an issue. The Government wants us to deliver very aspirational and challenging treatment numbers in Glasgow. As an NHS board, we are looking at finding massive savings, so we are looking at every single budget line that could be reduced. We need to find a way of treating individuals who are most in need, we need to be mindful of reinfections that we have already seen in individuals who have been treated for hep C, we need to live within the financial envelope, and we need to address the needs of users, who are among the most vulnerable people in society. The academic debate and the education mean nothing to them. We need to be where they are and take them with us.

**Dr Oates:** One of the key successes of the hep C programme initially was the way in which it was funded. There was ring-fenced funding to deliver an action plan, and it was easy for health boards and other partner agencies, such as alcohol and



drugs partnerships, to utilise that money. In the past few years, there has been a drive in the NHS to simplify funding so that it all gets lumped in together and there has been the outcomes framework. Health boards are now allocated a massive sum of money to do a whole bunch of stuff instead of having ring-fenced programmes.

I know that there are diverse views on that, but I think that it is detrimental to those vulnerable people and vulnerable groups in society who previously had protected funding for streams of work through alcohol and drugs partnerships and harm reduction services, for example—the so-called Cinderella services. When the NHS looks at global sums of money, it inevitably prioritises acute services and waiting lists—that is where all the political and media focus is—and the so-called Cinderella services lose out. Alcohol and drug addiction services, harm reduction services and the things that we utilise to tackle the problems of those vulnerable people will miss out, and they have missed out in the past two or three years because of the funding mechanism.

I make the plea that we look again at that and see whether we need to target funding at such vulnerable people and specific programmes of work on homelessness, for example, within the NHS and council streams, and not just give a global sum of money. If we keep doing that, they will never be funded. Their services are always the first to be cut.

**The Convener:** Thank you very much. I am aware of the time, and I would like to move on now.

**Emma Harper:** I am interested in the multi-agency approach. The framework and update highlighted the importance of effective interagency working. Dr Emilia Crighton has already mentioned that. Dr Ken Oates talked about the third sector being really important in the Highlands. I am sure that it is also really important to have the third sector involved in the rural south of Scotland.

Are the agencies working together appropriately and effectively, or is the health and social care integration process still at an early stage at which we do not have buy-in or engagement from the IJBs?

11:15

**Dr McCormick:** The agencies are working together as well as they can currently. We work a lot with third sector organisations such as Waverley Care and change, grow, live, or CGL. One challenge has been data sharing. For example, we have tried to do some work on homeless people who are drug injectors, but the City of Edinburgh Council's homelessness

database does not record risk factors such as drug injecting, sex work and violence, which makes it difficult to join up services. There are things that third sector organisations could do, but they cannot because they do not have access to NHS data such as information on when people last had a hepatitis C test. If an organisation can check and see that someone is due a test, it is simple to then do that, but it is more difficult if the organisation cannot get that information. In my experience, data sharing has been a really big issue.

**Dr Crighton:** Certainly, the Glasgow IJB has completely bought into that. There was massive commissioning of third sector provision for individuals, but the IJB has pulled everything together. There is now someone who is in charge of addiction, homelessness and mental health. We are trying to work together better, but data sharing has indeed been an issue. The Glasgow needle provision service has been carrying out testing, and all that data is sitting there in the needle exchange surveillance initiative, so we know that, if we look there, we will see what the situation is.

Through the Medical Research Council, NHS Scotland is about to carry out a big study that will link various data sets on addiction services, homelessness and mental health. The results will not be available until 2022, but that is really exciting because, for the first time, we will have a clear view of what the needs are and what is happening in the population. In the meantime, the direction of travel is right, and it involves getting everything together, but we will need money to deliver and address what the users truly need. Just working together without involving the users will not get us anywhere.

**Emma Harper:** I assume that you know which integration joint boards are performing well and which ones might need a wee bit of help. We perhaps should explore that on another day in a separate discussion.

**The Convener:** That is certainly an important question.

**David Stewart:** I want to reinforce the point about information sharing, which is certainly an issue that came through in the written evidence. For example, there are issues about general practitioners not being able to share information with pharmacists or third sector groups. However, it is interesting that the Scottish Information Commissioner has suggested that there is more leeway than is often thought to be the case. Obviously, new data protection regulations are coming into force, which will affect our thought processes on the issue.

**The Convener:** I think that that is right, but I am interested in comments from witnesses.

**Professor Goldberg:** Looking back over decades at national networks and leadership in the area, the third sector has fantastic integration from a national perspective—it is absolutely amazing and hugely important. However, with local authorities, that has been really difficult. I can hardly remember anyone representing local authorities at national level or being on our committees and networks. Maybe there is a logistical issue about who should be the representative, because there are so many local authorities but, believe you me, it has been a real struggle. One of the few actions in the action plan that we have failed on is the one about getting local authorities embedded. That is a problem. We have the new public health agency just over the horizon, and one of the issues with that is to try to ensure that it is integrated. My experience so far has been that integration is a problem area.

**The Convener:** Are there other comments on those important questions?

**Petra Wright:** I want to pick up on what David Goldberg said about the various networks in the framework and the third sector. Initially, a third sector network meeting happened maybe four times a year, but there has not been one for three or four years. Who represents patients and their views? I have no idea. Also, the information does not come back to the third sector from those who represent us at those meetings. I do not know the reason for that.

**The Convener:** That is a question that other witnesses might be in a position to assist with.

**Professor Goldberg:** There are other national networks. Yesterday, John Dillon chaired the hepatitis clinical leads network on which clinical leads from throughout Scotland and all the health boards are represented, with Hepatitis Scotland in there representing the third sector. The same applies to other national networks, with HIV Scotland being well integrated.

Petra Wright is right in that there was a network specifically for the third sector. I understand that it was a very difficult one to run, which was to do with the dynamics within the—

**Petra Wright:** Patients disagreeing with clinicians.

**Professor Goldberg:** I do not know the full story, but if the third sector said to Health Protection Scotland, which runs all the framework-related networks, that it wanted us to get the third sector network back up and running, we would do that. There would be absolutely no problem in doing that, but it is over to the third sector to push for that.

**Petra Wright:** Nobody had even communicated to me that the network had stopped meeting.

**The Convener:** We can claim an early achievement for this committee meeting if we can see progress made on that ask.

**Dr McCormick:** On networks, in the past couple of years, I have experienced a gap between opiate substitution therapy and harm reduction. The non-sexual prevention part of the hepatitis C network does not really link into the opiate substitution therapy part. The national organisation for that, which is the partnership for action on drugs in Scotland—PADS—seems to me, as somebody on a board, rather obscure and maybe a bit exclusive. I am not clear that all constituencies, such as the third sector, front-line workers, local authorities and so on, are represented, so there is a gap in joint working at the board level.

**Dr Crighton:** The third sector is certainly represented on the ADPs that work well. Beyond that, I cannot comment.

**George Valiotis:** On a policy level, which is where HIV Scotland operates, we have various interactions with IJBs. The best recent example is our fantastic exchanges with the local authority in Glasgow when looking at the closure of the clean needle programme. That really points to the challenges that you have regarding the prevention agenda. To get prevention right, you need to get the treatment right, because those are almost the same things for hepatitis C and HIV. When the focus has been only on prevention, we have had challenges in engagement. Prevention may not seem relevant to local authorities, which have many other things to do.

David Goldberg pointed to the problem of there being so many people to represent. When there is a challenge and something specific needs to be done, we have really good exchanges. However, in general, when we are just looking for policy brainstorming, getting representation to do that is a challenge.

On confidentiality and information sharing, one of the main issues that people with HIV raise when they ring HIV Scotland with a concern is how their information is being dealt with. We have published guidelines and done a lot of work on that because it is a priority issue. For example, we often get asked by someone whose GP has found out that they have HIV how they can get the GP to take that information off their database. People's concern over control of their information is at a whole new level when it comes to HIV, which is really important to keep in mind when looking at information sharing.

**The Convener:** Thank you for that. I see that there are no other comments on that issue.

On the general issue of whether IJBs are helping or hindering, which Emma Harper raised, we have heard some answers, but we have also

heard useful suggestions about renewing contact across the sectors.

David Stewart has a question.

**David Stewart:** On the future strategy for sexual health, are we adapting enough to changes in society such as, for example, the use of social media, new psychoactive substances and the issue of the sexual health of older people? Are those issues already incorporated into our strategy, or do we need to adjust it for the future?

**The Convener:** Who would like to take on a couple of important questions on some of the issues that have recently been raised and how well prepared we are for dealing with them?

**Dr McCormick:** I can give an initial response. The sexual health and BBV programme is well set up, and it empowers a lot of people in health boards and ADPs to do what they think is necessary. At NHS Lothian, we have identified the issue of ageing people with HIV through one of the groups that is chaired by Waverley Care—that is a good role for the third sector—and we are doing some work to identify what those people's needs are and how we should change our services. There is a probably an opportunity to take on such work across all the boards, where necessary.

**Dr Crichton:** David Stewart mentioned social media, and the Glasgow health improvement team for sexual health has used social media for a long time. It has targeted campaigns that are aimed at particular groups as, more and more, we are coming to understand which groups in society use different media. For example, the only way to get in touch with young people nowadays is to use the appropriate social media. There have been lots of successful campaigns that have been aimed at men who have sex with men.

We need to be mindful of the socially excluded group of people with multiple social issues, which has been the subject of debate this morning, as they are completely out of reach of social media or any other interactions. We also need to be savvy about how we tackle the issue of people living longer and how to reach older people, because there is always a need to keep up to date and to update our messages according to the needs of individuals. We are considering all sections of society, and we need to prioritise our resources and to adapt our communications.

In terms of drugs more widely, Glasgow held a big event through the ADP last summer that looked at the issues around new drugs. They are not called psychotropics any more, because they go beyond that. We are thinking about how different things come together—drugs, sex, alcohol, multiple risks and behaviours—and how we segment different individuals and bring a harm reduction approach to tackling the issues.

**Professor Goldberg:** I think that it was Jenny Gilruth who pointed out the report on sex education in 2012, which was a one-off. If you look at the framework's data portal, you find really strong data on infection by hep C, HIV and the STIs, so we know what is happening out there.

There are five outcomes. Outcomes 1 to 3 are fine but, for outcomes 4 and 5, which are on sexual health, there is no infrastructure. What I mean by that is that there is no data at the national level. There might be data at the local level, and I think that some health boards will have information, but there is no co-ordinated approach to monitoring. There is also no co-ordination infrastructure that can deal with that, which goes back to my earlier point about the leadership territory, and we really need to address that.

**The Convener:** I am looking around to see whether there are any colleagues who are anxious to ask one final question. There are not, so I thank the witnesses very much for their attendance this morning. It has been an extremely instructive session, which we will consider in some detail later on.

11:29

*Meeting suspended.*

11:34

*On resuming—*

## Petition

### Mental Health Services (PE1611)

**The Convener:** Item 3 is consideration of petition PE1611, in the name of Angela Hamilton, on mental health services in Scotland. Members will be aware that we have considered the petition previously, as part of the committee's work on mental health. The committee's work on the petition included writing to Sir Harry Burns, in his role as the chair of the review of targets and indicators, to make him aware of the petition and the petitioner's call for a reduction in mental health waiting times. We have also heard from the Scottish Government on its mental health strategy.

Members will have seen the paper from the clerks, which invites us to consider whether to close the petition in the light of the commitment that was made by the Scottish Government in its mental health strategy to a change of approach in developing a system of indicators for mental health provision. Are members minded to close the petition?

**Alison Johnstone:** I am not entirely clear on whether the Government's refreshed strategy and Sir Harry Burns's work have answered the petition. Sir Harry Burns's review simply said that waiting time targets

"should be subject to clinical prioritisation".

His review has not called for any change to those targets.

The Government is obviously increasing the level of investment—it has spoken about having 800 more workers, and its commitments include a change of approach in developing a system of indicators for mental health prioritisation. I am not clear that that will impact on waiting times. That is my concern about closing the petition—I am not entirely sure that the points that it raises are being addressed elsewhere.

**Alex Cole-Hamilton:** I share Alison Johnstone's concern about closing the petition prematurely. Although the rhetoric from the Government, tying in as it does with the review of targets by Sir Harry Burns, is welcome, I think that we need to keep a watching brief on the matter. I think that the petition still stands—we are not reducing mental health waiting times; if anything, they are travelling north.

For example, at our last meeting, I raised the fact that although £17 million in the budget is certainly welcome additional spend, it is trying to do rather a lot at the same time. The £17 million is

an initial investment towards those 800 new members of staff—I remind the committee that 800 members of staff will cost £20 million a year—yet it is also to deliver a transformation in child and adolescent mental health services. I am not entirely convinced that it can do that, although I hope to be proved wrong. I would be very reluctant to close the petition until we see some tangible progress in relation to waiting times.

**Brian Whittle:** To add to what Alex Cole-Hamilton said, the direction of travel is very welcome and all the rhetoric is very positive. However, before we can close the petition, we have to have some indication of outcomes. Like others, I would rather have a bit more of a watching brief before we close the petition so that we understand that the direction of travel is being adhered to and is having an impact. I would be reluctant to close the petition at this point.

**Ash Denham:** The petition specifically refers to

"Reducing the mental health waiting time target from 18 weeks to 14 weeks for adult therapies".

I imagine that the Government is not going to do that. Should we keep the petition open if that is not going to happen? The Government's response is that it is trying to improve outcomes with regard to the targets that we already have, and Harry Burns has suggested maintaining the targets as they are and not making any changes to them.

**Jenny Gilruth:** The petitioner also refers to reducing the mental health waiting time target

"to 12 weeks for child and adolescent mental health services".

As we know that five health boards, including Fife, are not meeting the 18-week target, are we not better off saying that we should hang on a bit and try to hold the Government to account on the current numbers, which it is not reaching?

**The Convener:** There is a judgment to be made about how we proceed. Members have indicated that the responses have been broadly positive but have not yet reached the point at which they can make a decision.

I think that everyone would agree that we want to keep the Government's propositions on mental health treatment and treatment times under review. The only question is whether the petition, which is somewhat dated because of developments since it was submitted, is the right vehicle or whether we should close the petition and look at finding other means of maintaining that review process in the months ahead.

**Alex Cole-Hamilton:** Jenny Gilruth made a good point about the fact that we are not achieving the 18-week target so we should focus on that. However, the petition reflects the public's expectation of where the agenda should be driven

further. They throw our metaphorical cap over the wall. We do well not to lose sight of that and to be reminded of what the public would like to happen on waiting times. That is all the more reason to hold on to the petition, irrespective of the fact that we are not even meeting the Government-set waiting times.

**The Convener:** Are there other views?

**Alison Johnstone:** I point out that, in a previous letter to the minister, the committee said:

“we make no recommendation on a reduction to 12 weeks as we think the target needs a fundamental rethink.”

I am not entirely sure that that has happened. However, we also said:

“we cannot see the justification for a continuation of different waiting time targets between mental health and physical health conditions.”

I am reluctant to close the petition in case it is thought that we accept the current situation. The fact that the current waiting times targets are not being met is, I am sure, of huge concern to all members of the committee. It is not good enough for any young person to have to wait for the number of weeks that they are currently asked to wait, and most of us would agree that being seen within 12 weeks is not exactly a speedy service.

**Ivan McKee:** If we are going to address targets and indicators, we need to do that in a structured, coherent fashion. We cannot just pick this one or that one based on whatever petition comes in on a given day. We have gone through a process, and that process has more ways to run in terms of determining what the targets and indicators should be. However, that is the forum for doing that, rather than looking at things randomly. We could have 100 petitions on any old indicator and we could sit here all day asking whether the indicator should be this, that or the other.

**Emma Harper:** NHS Dumfries and Galloway is 95 per cent meeting its child and adolescent mental health services target, so it is doing really well. There are services that need to perform better and others that are doing okay. I am not sure that keeping the petition open is the way to hold the Government to account. Ivan McKee makes the point that there could be lots of petitions on targets, but we are already examining targets that we are not meeting. Therefore, I am not sure that the petition is the best way to proceed, but we still need to keep an eye on a process for analysing the information.

**Brian Whittle:** On Ivan McKee's point, the call for a reduction in the target waiting times is one part of the petition, and it is probably the part with which I am least engaged given that we are not hitting the original targets. For me, it is more about getting some sort of feel for whether what is said

in the response to the petition from the Government and agencies is coming to fruition—that is, whether we are moving in the right general direction. For that reason, I am hesitant to let the petition go. There have been a lot of positive and welcome indications from the Government, but I would like to see some movement.

**The Convener:** There are clearly different views around the table. If we do not close the petition, what else do we need to do with it? It has been well used as a vehicle for raising questions and has allowed the committee to keep a focus on the issue for some 16 months, for which I give credit to the petitioner, but is there anything further to be done with it? Alternatively, are there further steps to take to hold the Government to account on its strategy and the priorities that it will set?

**Alex Cole-Hamilton:** That poses a wider question to the committee and the Parliament about the use and life of petitions. I am struck by Alison Johnstone's point that if we close the petition now, we are admitting defeat—it would be an admission that what it calls for is unachievable or that we have done all that we believe it is possible to do on the matter.

I am yet to hear an argument from committee members about the negative consequences of keeping the petition open. The committee could agree to revisit the petition in a year to benchmark progress. If at that point we are closer to achieving its aims, I would welcome the opportunity to close it as a sign that the nation was doing something tangible to close the gap that the petition addresses. We are not there yet. I do not see any cost in keeping the petition open, and I think that it is important that we keep it open as a demonstration of our view that we do not think that much progress has been made.

11:45

**The Convener:** Your point is valid in the sense that there is no negative consequence of keeping the petition open. The only negative is the fact that the petition was lodged before the Burns review took place and before the mental health strategy was published. Therefore, I am not sure that it is the most useful basis for the committee's future consideration of the issue. In itself, keeping a petition open does no harm but, as time progresses and as things roll out, the petition will become less and less related to circumstances.

**Emma Harper:** We will continue to hear directly from the NHS boards about their performance and I am sure that we will have the minister, Maureen Watt, in front of us in the future so that she can answer on targets. I agree that there is no negative consequence of keeping the petition open. The question is: what is the best process for

assessing mental health, physical health and wellbeing? It is all part of what we heard about this morning.

**The Convener:** I think that we are coming close to a consensus.

**Alison Johnstone:** The petitioner has gone to the trouble of raising the issue with the Parliament. The Government has said that it will develop new mental health indicators, but I cannot see how developing that new system of indicators relates to any clear commitment to change the targets. Sir Harry Burns's review has not called for such a change, so I would like the committee to have more information on what the Government intends to do. Will the new indicators impact on the targets? If so, we would at least be able to give the petitioner a clearer answer, instead of just closing the petition.

**The Convener:** In light of what members have said, I suggest that we do not close the petition today but await the development of the indicators. There is no great advantage in getting ahead of ourselves on that. Let us see what is developed and produced and then ask the questions that we must ask. In any case, Alex Cole Hamilton's suggestion that we use the petition as a benchmark to return to in January 2019 if we are not satisfied that progress has been made by then seems reasonable.

**Miles Briggs:** It was pointed out that a progress review is planned for 2022. I am specifically concerned about that. That will be halfway through the Government's 10-year strategy, but issues are already being highlighted to MSPs about the strategy. We should discuss whether there can be an earlier progress review to ensure that we maximise effectiveness.

**The Convener:** That is helpful. If that is agreed, we will proceed on that basis and continue to keep a watching eye on the matter.

**Members indicated agreement.**

**The Convener:** That concludes the committee's public business.

11:48

*Meeting continued in private until 12:45.*

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