



HOUSE OF LORDS

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Witnesses: Dr Ian Williams, Dr Keith Radcliffe and Ms Ruth Lowbury

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Members present:

Lord Fowler (Chairman)
Lord Gardiner of Kimble
Baroness Gould of Potternewton
Baroness Healy of Primrose Hill
Baroness Masham of Ilton
Lord May of Oxford
Baroness McIntosh of Hudnall
Lord Rea
Lord Ribeiro
Baroness Ritchie of Brompton
Baroness Tonge

Examination of Witnesses

Witnesses: **Dr Ian Williams**, Chair, British HIV Association (BHIVA), **Dr Keith Radcliffe**, President, British Association for Sexual Health and HIV (BASHH)/Chair of the Joint Specialty Committee in Genitourinary Medicine, Royal College of Physicians, and **Ruth Lowbury**, Chief Executive, Medical Foundation for AIDS & Sexual Health (MedFASH), gave evidence.

Q230 The Chairman: Good morning. Thank you very much for coming. Welcome to the Committee. I think you know what we are doing; we are looking specifically at HIV/AIDS in the United Kingdom and at progress over the last 25 years—what has gone right, what has gone wrong and what else now needs to be done. That is basically it. Perhaps you could briefly introduce yourselves. We have got some biographical details, but just tell us exactly who you are and who you are representing. Ruth Lowbury, would you like to go first?

Ruth Lowbury: Yes, thank you. My name is Ruth Lowbury and I am chief executive of a charity called the Medical Foundation for AIDS and Sexual Health, known as MedFASH for short. We were originally established by the BMA¹ and we have maintained strong links with the medical profession. Our role now is to support and inform health professionals and

¹ British Medical Association.

policymakers in pursuit of excellence in the prevention and management of HIV and other sexual health problems. We still link strongly with medical professionals, but we are not partisan, so we are not linked to any particular medical speciality or any particular profession. We have done a number of major projects at national level focusing on policy and good practice, including the review of the national sexual health strategy, a couple of years ago, with the Independent Advisory Group², the development of a number of sets of standards for different aspects of care in sexual health and HIV, a review of GUM services and a number of educational materials, especially around HIV and HIV testing for non-HIV specialist health professionals. We have worked for and with a wide range of stakeholders, including the Department of Health, BASHH, the RCGP³ and the European Centre for Disease Prevention and Control among others.

Q231 The Chairman: Thank you. Dr Radcliffe, you are wearing two hats today, I gather.

Keith Radcliffe: Yes, I am. I am the president of the British Association for Sexual Health and HIV, which is a registered charity. It is an organisation of over 1,000 members, which is chiefly built around the speciality of genito-urinary or GU medicine. It is especially devoted to sexually transmitted infections and it delivers the majority of HIV care in the country. It has over 1,000 members, including health professionals—chiefly doctors and nurses, but also scientists and others. Its remit is to raise standards in the clinical care of STI and HIV, write guidelines and conduct national audits—that sort of activity. There is also a plethora of educational activities for healthcare professionals in the speciality and it tries to feed into health policy in the field. Today, I have also been asked to represent the Royal College of Physicians, which oversees 20-plus medical specialities, including the speciality of GU medicine. I will be representing both.

² Independent Advisory Group on Sexual Health and HIV.

³ Royal College of General Practitioners.

Q232 The Chairman: Thank you very much. I think Lady Gould and I should declare an interest as honorary fellows of BASHH. Perhaps when you are giving evidence, perhaps you could make it clear if, for example, there is a specific issue that the Royal College of Physicians takes a strong view on. Dr Williams.

Ian Williams: My name is Dr Ian Williams. I am the chair of the British HIV Association. The association was formed in 1995. Its membership is health professionals involved with HIV care. Its main remit is the promotion of best practice and excellence in HIV care. Our activities include the development of best practice guidelines—for example, the UK treatment guidelines are the BHIVA guidelines on treatment of opportunistic infections. We are also involved in the development of the UK national testing guidelines and setting standards of HIV care. Our remit is very much involved in developing excellence of care of HIV.

Q233 The Chairman: Let's just ask one introductory question. If there was one reform or change that would make the biggest difference in reducing the number of new HIV infections, what would that be? Perhaps we could hear from each of you in turn.

Ian Williams: It is a very difficult question, Lord Chairman.

The Chairman: That is why we asked it.

Ian Williams: I do not think there is a single reform, in terms of answering all the questions. If you are looking for a single solution, then the Committee will not find a single solution.

The Chairman: No, we are not looking for a single solution, but is there a priority? What would be your number one priority?

Ian Williams: My two priorities would be in HIV prevention, because the number of people who are being diagnosed with HIV and acquiring HIV is continuing to rise, which clearly has a

long-term burden of HIV care for the future, because people's life expectancy is now near normal compared with the general population. Once you are infected with HIV, there is no cure, no eradication and therefore treatment is lifelong. I think prevention is very important. Equally, maintaining treatment outcomes and maintaining good care, with the evolution of HIV and the problems that occur as people get older, and remodelling how care is delivered in the current NHS are also a big challenge.

Keith Radcliffe: I agree with what Ian has said. Of course, there is no one answer. In thinking about this question, I was also considering whether the Committee is assuming that everything that has been achieved in the last few years is absolutely solid and it is simply a case of considering new initiatives. The thing that I would like to raise is that some very good things have been achieved in recent years and it is very important that we see we do not lose them at this stage, given the NHS reforms and the economic problems that the public sector faces. For me, it depends on whether the question is simply looking for new things. I would like to start off by saying that it is important to preserve some of the very good things that we have achieved in recent years. Perhaps we might come on to that later on.

The Chairman: That is very important. All the points that have been raised so far, we are going to cover in questions.

Keith Radcliffe: The specific thing, if you ask for one thing, and it is invidious to say just one thing, is about more rapid diagnosis of HIV—more widespread targeted HIV testing leading to more rapid and earlier diagnosis of HIV, with the resulting benefits of that.

Ruth Lowbury: I agree with both of the previous speakers in that there is no one solution. I also agree that more rapid testing is very important. What I would like to highlight is that, in order to implement policy, whatever that policy may be, there has to be leadership and there has to be priority at national and local level. When we have seen success in the field of

sexual health and HIV, it has been when an issue has been given high priority. Maybe there have been levers set in place to incentivise progress and I would like to see this issue—HIV and sexual health more broadly as well—being recognised as a public health priority with leadership and accountability at all levels.

Q234 The Chairman: Thank you very much. I was very interested in the UK national guidelines. I think that it was a joint effort by a number of the organisations. One of the statements is about deaths occurring among HIV-positive adults and that being related to late diagnosis. How serious an issue is that?

Ian Williams: If you look at the HPA data for last year, which came out last October, of the 500-odd deaths that occurred, 70% of them were in people who were diagnosed late. If you look at data from an audit that we conducted in 2005 of mortality of the patients who died with HIV, 25% of those deaths were avoidable, in that people presented too late for treatment. Late diagnosis is a serious issue when it comes to increased mortality. The other issue about late diagnosis is the fact that it has a long-term effect on life expectancy.

Q235 The Chairman: One individual case varies so much from another individual case that it is not possible to say that, if you are not diagnosed for five years, that has X effect upon your life expectancy?

Ian Williams: Data have recently been presented from UK CHIC⁴, a research collaboration of clinics across the UK, which looked at 17,000 patients. They showed clearly that, if you started on therapy on the lower CD4 count, you lost 10 years of life expectancy if you started late. That was observational data looking forward in terms of progression. For example, if you started on a CD4 count above 200, your life expectancy was about 54 years

⁴ UK Collaborative HIV Cohort.

at the age of 20, compared to a life expectancy in the general population for men of about 57 years and for women about 61 years. If you were started on therapy with a CD4 count of less than 200, then life expectancy was 41 years. You immediately lose 10 years of life expectancy by being diagnosed late.

The Chairman: Can we have those figures sent out?

Ian Williams: Yes, I am very happy to provide that as written evidence.

Q236 The Chairman: That would be very interesting indeed. What is your view, Dr Radcliffe?

Keith Radcliffe: Ian is absolutely correct in what he says. I am sure the Committee is aware of this, but the effective treatment of HIV is one of the biggest medical success stories of any of our lifetimes. We should start by recognising that. Those of us who have been treating patients going back before 1996, such as Ian and I, will remember that the situation before was essentially that people were basically all dying. Medical intervention could prolong life to a limited extent, but that was the very grim situation. It has totally transformed with effective antiretroviral therapy to a situation where, if people are diagnosed not desperately late, as Ian has described, and take treatment in the way that is prescribed, they can look forward to a very long and very healthy life. To turn it round the other way, I think all clinicians in the field will be able to describe incidents of people who present extremely late and ill with AIDS who cannot be salvaged and who die. The thought in my mind then is always, "If this person had had an HIV test six months ago, they would have been put on treatment and they probably would have lived for many years a very healthy life." Each case like that is a tragedy. Obviously in trying to avoid that the emphasis has to be on early diagnosis.

Ruth Lowbury: I agree with all of that. The other thing I would like to highlight about late diagnosis is that the longer somebody is undiagnosed, the more chance there is that they will

unwittingly transmit the infection to other people, both because they will not have the knowledge that might help them to change their behaviour and because, by not being on treatment, biologically they are more likely to infect other people. Modelling from the US, I believe, suggests that the majority of new infections are acquired by transmission from someone who did not know they were infected. We have two compelling reasons why we need to reduce late diagnosis.

Q237 The Chairman: Does testing automatically change behaviour?

Ruth Lowbury: No, not automatically. I am probably not the best person to give evidence on this and I hope you will be talking to some social researchers, but there is some evidence that suggests that people, when they know they have HIV, are more likely to take measures to protect their partners. There was one meta-analysis from the US with eight studies, comparing self-reported sexual behaviour among people who knew they had HIV with that of people who did not know. When people knew that their partners were negative or did not know their status, the risk of unprotected sex was 68% lower when people were aware.

Q238 Lord Rea: Following on your answer, Ruth, what is the evidence of infectivity of people who are on treatment? Is the infectivity completely abolished? Is it lowered? What is the situation for someone on treatment as to how infectious they are and how likely they are to pass it on?

Ruth Lowbury: Could I defer to one of my clinical colleagues on that one?

Ian Williams: There have been quite a few studies that looked at transmission between discordant couples, largely heterosexual couples, and the evidence suggests that the risk is reduced by 94%. It is that sort of figure.

Lord Rea: There is a small risk left.

Ian Williams: The difficulty is because, if you look at the studies that have been published and if you look at people on therapy with an undetectable viral load, the number of people who have been reported as being positive in that is very, very few, if not zero. The overall study suggested there is an overall reduction of 94%.

Q239 Lord May of Oxford: Both for individuals and for trying to combat the rising incidence, we all agree it is important that more people get tested and that they get tested more promptly. I imagine you are pleased that the Health Protection Agency has made a recommendation in line with your voluntary recommended guidelines to expand the range of settings in which tests can be offered. I have two questions. First, do you think this is going to really be cost-effective and helpful? Secondly, what other things would you wish to see done?

Keith Radcliffe: In terms of cost-effectiveness, a lot of work remains to be done on many of the novel ways of delivering testing. We would acknowledge that. Certainly the American public health authority—the Centers for Disease Control, which is an extremely reputable body in the field—has made the recommendation that testing is cost-effective if the pick-up rate is more than one in 1,000, or 0.1%. Certainly most of the pilots that have been done in novel settings have picked up HIV at a higher rate than that. A lot of work remains to be done, but the current evidence suggests that it will be cost-effective.

Ian Williams: There are also data from the French, also published last year, which looked at cost-effectiveness with assumptions of an undiagnosed fraction of about 0.1%, which is very similar to the guidelines that we produced in terms of one in 1,000. They said that using one-off routine screening, compared to current practice, was cost-effective in terms of earlier diagnosis and prevention of disease. There is some data, but there is a lack of data within the UK. The HPA pilot studies will provide cost-effectiveness data probably this year.

Q240 Baroness Masham of Ilton: Do you think there should be more publicity to encourage people to come forward for testing? There are a lot of people out there who just do not know where to go. For women, it has worked rather well when they have come into hospital. What do you think? Should there be more? How can you get to the people who should be tested?

Ian Williams: Maybe you want to answer that one, Ruth, because it is about health promotion.

Ruth Lowbury: I will make a first stab. I agree: I think there needs to be increased awareness among the population. The general population probably needs to perceive HIV to be one of the range of things that they may need to get tested for, whereas particular groups who are at higher risk perhaps should be helped to have a better sense of the benefits of testing, if they are already aware of the risk but perhaps concerned about what that might mean for them. It is important not only to encourage people to come to the testing but to get the testing to come to people. There is a need to be opportunistic when people go to see their GP, for example, or when they are admitted into hospital for other procedures. If the prevalence in that local area is high enough to warrant it, I think it is going to be beneficial if people are offered a test. The more that that happens, hopefully the more there will be an acceptance that this is something that is not particularly unusual and it just makes good sense to do it.

Q241 Baroness Masham of Ilton: Find & Treat goes out to the difficult people to find for testing for TB. They could easily do HIV at the same time.

Ruth Lowbury: Yes. The two infections are very closely linked.

Q242 Baroness Ritchie of Brompton: To carry on with testing and following on from what you said, in your paper you do not support universal opt-out testing. I would just like to find out a little bit more about why that comes out of the paper. Secondly, the commissioning responsibility for testing is going to move to local authorities, so to what extent do you think the development of these national testing guidelines that you presented will help to maintain the momentum as that testing commissioning moves?

Ian Williams: We support opt-out testing, in terms of sexual health clinics, termination of pregnancy clinics, hepatitis clinics and TB clinics. In all places where there is potential prevalence of HIV infection in the patients attending, we would definitely recommend opt-out testing.

Q243 Baroness Ritchie of Brompton: If we are talking about extending the settings, from what I am reading in your paper, that is not what you are saying, but maybe I have misread your paper.

Ian Williams: It depends on the background prevalence. Certainly we would definitely recommend opt-out testing. The way to go forward, I think, is in extending opt-out testing, particularly in patient populations that have a higher prevalence. That may be by disease or by the fact that they are in a patient population that has a higher prevalence, or where there is a higher prevalence within a certain population.

Q244 Baroness Ritchie of Brompton: You would not broaden it out. You are being quite specific.

Ian Williams: It is about cost-effectiveness. If you have a very low prevalence and you want to test all general medical admissions, it then becomes an issue as to whether it is cost-effective to do that. We have suggested that a prevalence of two in 1,000 would be a

reasonable cut-off point in terms of opt-out testing in medical settings such as A&E departments and medical admissions departments. We also say quite clearly that, in patient populations of TB clinics, hepatitis clinics and lymphoma clinics, there should be routine testing of patients.

Keith Radcliffe: Opt-out testing is clearly the best policy where it is appropriate. The most successful HIV testing achievement is in antenatal clinics, where 99% of women accept the offer of a test. That contrasts with the situation before that, where healthcare workers were asked to offer a test to people whom they regarded as being at risk. That approach never worked very well; it is always problematic. It was problematic in GU medicine clinics as well, for two reasons. First, people do not like being singled out as being at particular risk of HIV, because that often makes them very uncomfortable. Secondly, healthcare workers often do not like to be put in the position of singling people out as being at risk of HIV and therefore tended to avoid the situation. We saw that, when that was the approach in antenatal clinics, it did not work very well, but the opt-out approach works very well. In GU medicine clinics, too, the take-up rates have gone up very substantially as people have adopted an opt-out approach. It is much easier to say to people that it is recommended that everybody—coming to the antenatal clinic or coming to this clinic for TB—has an HIV test. People are told, “It’s part of the routine. Is it okay?” People are very accepting of that, as against feeling that they are being singled out for special treatment. The opt-out approach is clearly the best approach. Ian’s point was that obviously you have to choose a population with sufficient risk to make it worthwhile testing that number of people.

Q245 Baroness Ritchie of Brompton: The other part of the question was regarding the new commissioning.

Ian Williams: Clearly the UK guidelines that we have developed are only guidelines and the issue is how we would want those translated into policy. I do not know whether the Committee is going to come on to talk about the NICE guidelines, but clearly the NICE guidelines, on the promotion of testing in MSM and in black ethnic minorities, did in fact draw on a lot of what the UK national guidelines say in terms of the promotion of testing. We would hope that the NICE guidelines would have more influence on commissioners in order to roll out testing through local authorities.

Ruth Lowbury: Perhaps I might just say something additional about the opt-out. To complement opt-out testing in a wide range of populations on a screening basis, we also need to concentrate on the populations that are most at risk. One of the things for gay men in particular is to encourage frequency of testing. There are significant numbers of men who have a negative test, maybe presume that they are not infected and go on to become infected and do not re-test. The two approaches need to be complementary. I do not know if we are going to go on and talk about testing anymore.

The Chairman: We are.

Ruth Lowbury: I would just mention that MedFASH recently worked with the Health Protection Agency to develop testing guidance and evidence synthesis on HIV testing for Europe, commissioned by ECDC. There is a lot of useful background information in there, which I will mention in my written evidence, but I would also like to suggest that the Committee look at it.

Q246 Baroness Gould of Potternewton: Another aspect of testing is the question of home testing, because there are obviously very differing views about whether it is a good thing or a bad thing. When one is looking at how we increase the number of people who get tested, do you think that home testing is a good idea? What do you think about the risks?

What do you think about the reliability of the tests? Also, what do you think about the follow-through from suddenly finding, if you take the home-testing kit, that you are positive? What about the follow-through in those instances?

Keith Radcliffe: I think it is a very difficult, controversial issue. I start from the situation that, if we are going to deny people the right to find out significant information about their own health, we need a really overpowering argument for that. There clearly are a lot of problems around home testing. The first is the reliability of the kits. Some kits that are available over the internet are probably not so reliable, but reliable kits certainly are available. Of course, there are a lot of issues around having HIV tests, apart from just having the test done. If it is done as part of a consultation, people's risks can be assessed; they can discuss issues; the health promotion message can be given; people can be screened for other things; and they can be followed up and referred into care if they are positive. A whole raft of things is delivered around having an HIV test, apart from simply the HIV test result. There is also concern about the psychological fallout from people testing in isolation with no immediate support.

There are a lot of problems around home testing but, at the end of the day, do I think that those are so overpowering that it should be ruled out? I would say probably not. The other question, though, is around cost-effectiveness. In terms of home testing, there is a difference between saying that people can buy a kit to test themselves, as people can for pregnancy, for instance, and saying that the NHS should provide these for free and that the kits should be ordered over the internet at the expense of the NHS. You then open up the question of whether that is the most cost-effective way to spend whatever resources you have to pick up new infections. I would be very doubtful that it would be.

Q247 The Chairman: What do the other two think on this?

Ian Williams: I agree with what has just been said. I think you need to look at innovative ways and innovative technologies. I would certainly agree that people should be given the opportunity to take control of their lives and find out about their problems. However, I have a concern about the possibility of false positive rates. That needs to be very clear from a technology point of view. What is a false positive rate? False-positive rates vary. It depends on the prevalence in the patient population. For example, a false positive result in someone in a patient population that is at low risk could have a very detrimental effect in terms of the psychological impact. That needs to be taken into account.

Q248 The Chairman: You presumably would accompany it with advice to check with a professional.

Ian Williams: Yes, that is the thing. There needs to be very clear advice and contact advice, including telephone advice. It would not just be, "Go to this particular place." I think there would need to be contact and telephone advice.

Ruth Lowbury: Broadly I agree with my colleagues. In a way, we have got a train that is already running along the tracks and we are not going to be able to stop it. The test kits are available on the internet, if not from the UK then from abroad. In a way, perhaps we need to acknowledge that and try, if we are going to legalise them, to regulate and minimise the damage arising from the risks rather than trying to keep it away from the door.

Q249 The Chairman: There is one positive thing. Historically, we have all tried to find confidential ways of testing. You cannot get much more confidential than a home-testing kit, I would have thought.

Ruth Lowbury: I think that is right. There is also a move for people to take responsibility for their own health and that is in line with that. The big concern is whether people then seek

care, whether they seek a confirmatory test and whether they get into treatment. We have already heard about the implications of being HIV positive without access to treatment.

Q250 The Chairman: I cannot remember which of you was saying it, but you do not think there is any particular difficulty in getting the right equipment—not necessarily the right equipment as is available on all internet sites at the moment, but you could have approved equipment or something of that kind.

Keith Radcliffe: There are point-of-care tests, which are used in clinical services and perform to a high enough standard. They could potentially be used at home as well. As Ian says, tests need confirmation and that is one of the problems that need to be explained if people are going to sell tests. People need a lot of knowledge in order to do a test, interpret it and act on the result. Presumably, that could only be provided in written form as a leaflet or a web link. To my mind, people may not necessarily read or understand all of the information that goes around that. That is one of the problems about home testing.

Q251 Baroness Tonge: I just wanted to take up something that you said, Ruth, about testing for a whole raft of things at the same time and not just specifically for HIV. Do you think that this would help to reduce the stigma of HIV and would encourage more people to come along? Secondary to that, how costly would it be to do that? I am thinking particularly of things like chlamydia, which is almost endemic in the population at the moment.

Ruth Lowbury: Yes, I tend to agree. I cannot give you figures on cost-effectiveness. We worked with BASHH a couple of years ago to develop standards for the management of STIs. Those were designed not just for GUM clinics but for STI testing in a range of settings. One of the recommendations in those standards was that the standard STI screen should include four different tests, one of which would be HIV. That is a good principle to follow.

Q252 Baroness Tonge: That is encouraging. Will it happen?

Ruth Lowbury: It is recommended in the standards for STI management, so it should be happening. The question is whether the standards are being implemented, which perhaps BASHH might be better placed to talk about.

Q253 Lord May of Oxford: I have two quick questions, which just reveal my own ignorance and stupidity. The first one is: do the testing kits necessarily carry information about the incidence of false positives and false negatives? If not, they should, shouldn't they?

Ian Williams: I am not aware of that. It is something that I would have to provide evidence on at a later date.

Q254 Lord May of Oxford: That is something that we might keep in mind. The second question is, if I understood what you said, that a study shows that, if you are on antiretroviral therapy, that reduces infectivity by 94%.

Ian Williams: That is right, yes.

Lord May of Oxford: As I understood your quick description of the study, it was about couples. How on earth do you tease out the reduction that can come from knowing you are carrying the virus from the reduction in transmission that occurs as a result of the therapy? How can you tease that out of such a study, because that is a critical question?

Ian Williams: This was a meta-analysis of multiple studies that was published about 18 months ago. It looked at discordant couples who were on therapy and not on therapy and it looked at the difference. It looked at discordant couples where one person was on therapy and the other person was not and it also looked at couples where the positive partner was not on therapy. It looked at the incidence of transmission across those different patient

populations. It was quite clear that, in the couples where the partner who was positive was on therapy, the incidence of transmission was markedly reduced, to a point where the relative risk was a reduction of 90% or more.

Q255 Lord May of Oxford: Could you just please give us a reference?

Ian Williams: I will, definitely. I am happy to give you that meta-analysis and report.

Q256 Baroness McIntosh of Hudnall: I want to ask a question relating to home testing, but I also want to go back to something that Dr Radcliffe said quite a lot earlier in this session. You were talking about the difficulty of managing the outcome of having taken a home test. Two things: first, do you have any data at all yet on what happens to people who have taken home tests, because there are some of them already, presumably? Secondly, this is a kind of idiot's question, but if you are incentivised as somebody who might be infected to get a home test, does that not indicate that you are likely thereafter to want to do something about what you find out as a result of it? It seems to me that the worry that is hanging around this issue is partly to do with thinking that people might get home tests, find they are HIV positive and then do nothing. Why would they do that?

Keith Radcliffe: It is a very good question. There is very limited data on what happens. Home testing is not legal in this country, so obviously there is very limited data around it to answer your question. What you say is very sensible. For instance, we all have experience of patients who come in through mainstream services or GU medicine clinics, test positive and are referred quickly on into care, but who then disappear from follow-up for several years and, in some cases, then turn up very ill. Clearly that is not a sensible thing to do in terms of your own health, but some people do respond in that way. People do not always act in a totally logical way as regards very emotional issues.

Baroness McIntosh of Hudnall: It is just that if you have gone to the trouble of actually wanting to find out, I suppose—anyway, I take the point.

Ruth Lowbury: I do not have any information about people who have done home testing but, in some countries, anonymous testing is provided. In this country we have confidential testing and it is very rare that people choose not to give their names. In other countries, a system of anonymous testing has been adopted to encourage people who might otherwise feel too fearful or stigmatised to come forward. I understand that there are data that show that people who have tested anonymously are less likely to go into care—more are lost to follow-up—than people who have tested on a named basis. I am sure that is partly to do with the level of fear and stigma around being HIV positive, which in some countries may be worse than here. If the people who are seeking to do a test in private are the ones who have the biggest fears, we might think that the same sort of thing could happen.

Keith Radcliffe: One of the things to mention while we are on this subject is the difference between home testing and home sampling. It is possible to take a sample at home, which is then sent off to be analysed, and you ring up or are contacted with the result, which is legal and with which there is more experience. That is quite different from when you take the test on yourself at home and nobody else knows the result, unless you then pass the information on.

Q257 Baroness McIntosh of Hudnall: Could I just, as I threatened, go back to something you said? You talked about the extraordinary change that came about when the antiretroviral drugs became available in the mid-90s and the very dire situation that existed before that. The research that went into producing those drugs must have happened very fast in order for the treatments to be available as soon as they were. Could you give us, briefly, your view about how far we are at the moment from preventive treatments or

treatments that will cure? You mentioned they were not available. If you cannot give us a quick answer, the Chairman will make me withdraw the question.

The Chairman: We will be having a session on this.

Keith Radcliffe: I will try and I am sure that Ian will want to add to it. Treatments are already available in terms of suppressing the virus and maintaining pretty much full health for many years, so we have very effective suppressive treatment, but these treatments are not curative; they do not eradicate the virus. If the treatment is stopped, then the virus will rebound very rapidly. I think we have very effective suppressive treatment. In terms of cure, I do not see that as being on the horizon at the moment.

Ian Williams: Eradication therapy is an area of increased research. We will see more on this in the coming years. The other question, about using treatment as prevention, the recent iPrEx⁵ study looked at the use of antiretroviral therapy pre-exposure to HIV. It was conducted in South America, but there was clear evidence that it worked in MSM⁶ who had ongoing risk, in that it reduced transmission to the point where the authorities in the United States the CDC have recently changed their guidance on the use of PrEP⁷. As a biomedical intervention, pre-exposure therapy may well be a way forward, particularly in high-risk groups, but there needs to be further evidence.

The Chairman: But no cure and no vaccine?

Ian Williams: No.

Q258 Baroness Masham of Ilton: What do you think about testing in prisons, because many prisoners are at risk? They test a lot on hepatitis B and vaccinate, and prisoners will come forward if invited.

⁵ Pre-Exposure Prophylaxis Initiative - <http://www.globaliprex.com/web/index.do>

⁶ Men who have sex with men.

⁷ Pre-Exposure Prophylaxis.

Ruth Lowbury: They are an important population to offer testing to. I think it is important that the testing in prisons is done with informed consent and with full confidentiality. There are concerns about coercion or about disclosure in that setting, but they are a population that could be at high risk. Certainly in other countries there have been very high rates in prisons. We do not know very much about the rates of HIV in our prisons and I think it would be good if we had more information about that.

Q259 Baroness Masham of Ilton: There are generally quite a lot of people in prison who are HIV. I visited Holloway recently, and there were a few there. There were two with TB and HIV.

Ruth Lowbury: I think what I meant was that we do not really know about undiagnosed infection and how big the problem is in prisons.

Q260 The Chairman: Are there any international figures on this at all?

Keith Radcliffe: The situation varies tremendously in different countries. For example, the fastest-growing HIV epidemic in Europe is in Ukraine and Russia, where it is very much tied to injecting-drug use. There is a lot of evidence that there is a lot of ongoing HIV transmission in Russian prisons. It very much depends on the part of the world.

Baroness Masham of Ilton: Spain has done quite a lot of research.

Q261 Lord May of Oxford: Of course it should be confidential in prisons, but do you not think that talking about informed consent in prisons is elevating the interest of the individual above the interest of the prison community itself to a degree that is unacceptable?

Ruth Lowbury: No, I do not think it is ethical to test people without consent.

Lord May of Oxford: You belong in that camp.

Ruth Lowbury: I also do not believe that by enabling people to test confidentially you are putting other people at risk. HIV is transmitted only through certain behaviours and just because you test somebody—

Lord May of Oxford: You have just said that, if you test them and treat them, they are less infectious. You have just said that.

Ruth Lowbury: I would encourage people to test.

Lord May of Oxford: You really are not—

The Chairman: Lord May has very atypically become speechless. Lord Gardiner is going to take on this issue of public interest and individual freedom.

Q262 Lord Gardiner of Kimble: Yes, absolutely. I would very much like to ask the panel whether you believe that, in containing the spread of HIV, the balance between community interest has been properly struck against the individual right to informed consent to testing. In addition to that, do you think there are circumstances where you might support any effort for a national screening programme or indeed any form of mandatory testing?

Keith Radcliffe: I must say that I find it difficult to support mandatory testing. Now that we have effective treatment, the argument for an individual having a test for their own selfish benefit is extremely powerful, as we have said. Most people, once it is explained to them, will see the benefit in having a test for that reason. If you are unable at the end of the process of persuasion to make them realise it is in their interest to take a test, then I must say I find it very difficult to envisage circumstances where it would be justifiable to mandate testing. Obviously we are in a very wide field of human rights and human rights legislation, on which I am certainly not an expert, but I imagine there would be a lot of problems down

the human rights legislation route if attempts were made to mandate testing, but that is not my area of expertise.

Ian Williams: My own view with regard to mandatory testing is that I do not think you would achieve what you want to achieve. You have already achieved very high levels of testing—for example, in antenatal clinics—with a marked reduction in transmission through basic opt-out testing. I am not sure what added value you would have by having mandatory testing. Equally, it goes against the doctor-patient relationship. The GMC⁸ guidelines are about involving patients in their decision-making. The White Paper⁹ talks about “no decisions about me without me”. It just goes against the general ethos of how clinicians work in terms of care of patients.

Q263 The Chairman: You would not be opposed to more settings.

Ian Williams: I have no problem in terms of encouraging people to be tested through opt-out testing and saying that this is routine and recommended. That gives the people the opportunity to opt out. In those settings, very few people opt out because they feel there is benefit to it. I do not personally feel that mandatory testing will particularly add more cases.

Keith Radcliffe: I think it would probably be counterproductive. In this country, we are always taking the view that this is a health issue. People are concerned generally about their own health. We want to help, advise and assist people in promoting their own health. We want people to come forward voluntarily to identify themselves as at risk. Once you start raising this spectre of mandatory testing, you are adopting a police approach, where you have to track down and forcibly test people. Quite apart from the human rights aspects, I just do not think it would work. The health services are not run as police forces to try to make people do things that they do not want to do. I think the approach would not work

⁸ General Medical Council.

⁹ Department of Health, *Equity and Excellence: Liberating the NHS*.

and would actually make people go underground and not come forward for testing, for precisely the fear they would have of being treated in that way.

Q264 Baroness Ritchie of Brompton: Carrying on from that, is not part of the issue around this debate that, unless you are involved as a professional or through personal knowledge or experience, you do not actually know the success of treatment that has been achieved in the last number of years? Part of this thing would be to make that knowledge more generally available so that you reduce some of the fear.

Ian Williams: I entirely agree with that. I also think there is an issue around health professionals other than GU physicians. There needs to be improved competency, skills and ability for other health professionals to offer HIV testing. It is not just the uptake of testing; it is the increased offer of testing. Generally, when people are offered a test, they find it very acceptable; they do not feel in any way they are being targeted and they find it a valid thing to be offered.

Ruth Lowbury: I agree with that. There is a stigma connected to HIV, which makes people reticent about testing and makes professionals sometimes reticent about offering the test. We need to overcome that by normalising it. In terms of informed consent, there has been a tradition, which thankfully we are moving away from but which still remains in some quarters, of believing that in order to do an HIV test you have to have in-depth pre-test counselling. Although I would not argue that testing should be done without consent, I think informed consent can be a much more streamlined process than perhaps we have been accustomed to think it has been in the past. One of the key things about the pre-test discussion, which can be very brief with opt-out testing, is that people should be aware of what the benefits are of testing.

Keith Radcliffe: The point you make is right. We are in the middle of a long process, which is what you would expect. People who are dealing with this all the time are, obviously, well aware of the enormous benefits of treatment. It is going to take those in the healthcare professions who deal with it on an occasional basis a lot longer to catch up with this development. That is going to take several years. We are in the middle of a process of healthcare professions more generally catching up with that. Then you would expect the general public to come along a few years behind that. Therefore, I think it is going to take a number of years to get this message out to the general population.

Q265 Baroness Tonge: I do not actually agree with Lord May but, just to give him a little bit of support, when did the opt-out get introduced? I do not remember my patients or me, for that matter, being given an opt-out of finding out whether I had syphilis or gonorrhoea when I was pregnant. The Wassermann and Kahn tests were done routinely; no one asked you whether you wanted them done. When did this all creep in?

Keith Radcliffe: I think it is a very interesting question. In many ways, as HIV has evolved, it has driven practice across the whole of medicine, moving from a more paternalistic era where doctors did things to patients because they thought it was in their best interest but did not necessarily fully explain what they were doing—which I think would have been the situation with syphilis testing in pregnancy for a long period of time—to a view where you should be telling people what you are doing and why. HIV has led the way in this, because of the particular stigma attached to it and the emotional baggage that it carried. People had to raise the issue of informed consent. The rest of medicine, to some extent, is being pulled behind.

Q266 Baroness Tonge: There was a lot of stigma if you had syphilis, for goodness' sake. It was a horrendous diagnosis.

Keith Radcliffe: I agree, but there was not the public debate about syphilis that there was about the arrival of HIV, which has pushed this on.

Ian Williams: I entirely agree with my colleague in terms of the practice of medicine. The involvement of patients in their care is an evolution that has occurred over the last 20 years. To go back to a point of view where doctors determine what happens to patients without their involvement would be a retrograde step.

Q267 Lord May of Oxford: To make an observation, in just the general question of childhood vaccination, for example, the UK is quite unusual. In the States, where you would think they would be more extreme, you cannot get your kid in school unless they have been vaccinated. Here we just forget the interest of the community. We have had MMR and we are going to have childhood infections and damage. We are almost unique in the G7 in the way we do this. I think that is partly part of a tradition, but maybe we are more virtuous than everybody else.

The Chairman: To put it another way, do we know of other countries that carry out compulsory testing?

Ian Williams: No, I am not aware of any at all. The United States adopted opt-out testing back in 2006. The evidence from there suggests that there has been a marked increase in the number of people being tested, with an increase in the number being found to be positive and a reduction in the undiagnosed fraction. There is already evidence from the United States suggesting an opt-out testing policy has worked. I take the points that have been made about mandatory testing, but I do not think there will be the support—

Lord May of Oxford: If you want a green card for the US, you have got to have a Wassermann test.

Ian Williams: I do not want a green card.

Q268 The Chairman: Just before we leave testing, because I want to go on to treatment, one thing that is rather troubling me about it is that your basic case was that, if you explain it, then people will have testing. We also talked a bit about stigma. I am just a little concerned that publicity, which is in fashionable jargon now called “targeted campaigns”, is doing exactly what you do not want it to do, in the sense that it is singling out people. I can see why you have targeted campaigns, but do targeted campaigns have to be against a background of a more general sexual health campaign?

Ruth Lowbury: I would say yes, they do. The general public—young people and people of all ages—need to understand the risks that they face and the context for the society they live in. HIV is stigmatised, and public education can help to combat that. That will set a backdrop against which we can target messages directly at the groups that are at higher risk.

Keith Radcliffe: I think there is a real difficulty around this; it is not an easy subject. We know that the epidemiology of HIV is very much focused in certain groups. We know that. Therefore, to target efforts preferentially towards those groups is clearly a very logical thing to do. At the same time, it has to be done in a very subtle way, because otherwise we get back to the situation of the antenatal clinic where people do not want to single out, for example, African women for an HIV test in that setting and, therefore, it does not get done. Somehow you have to target groups without doing it in a way that alienates them. That is difficult.

Ian Williams: There is a difference here in terms of targeting high-risk populations. You want to test black ethnic minorities or Africans because the prevalence of HIV in that

population is high, not because that individual is undertaking risky behaviour. Because the prevalence in the population is high, the cost-effectiveness of doing the test is likely to be positive.

Ruth Lowbury: Following on from what Keith said, the thing about targeting is that it should not be something that is done by 'us' to 'them'. It needs to involve the communities affected. It is absolutely crucial to involve communities and to get the leaders of those communities engaged and speaking to their own populations. Faith leaders are an example of people who have been targeted in the African populations in this country. We did not properly address, I think, the question earlier about the role of local authorities and commissioning—hopefully we will come back to commissioning—but I think that one of the potential advantages of having local authorities involved in commissioning prevention and testing is that they may have more experience of working with and engaging local communities.

Q269 Lord Gardiner of Kimble: If the numbers in particular groups were to escalate strongly, would your answer still be the same on the community and individual freedom element? We have heard that there are certain groups where this is growing quite strongly. If it were to become much more prevalent, would you still have the same view about the balance of individual freedom and community interest in terms of testing and those sorts of things?

Ruth Lowbury: I think I would. I am not an expert on international epidemiology but if you look at somewhere like Russia, where HIV has spread very rapidly among drug-using communities, you see that the policy on drug use and in relation to HIV has been quite repressive and coercive, and the epidemic is escalating among those populations. The UK sets a very good example in the way it has approached HIV in terms of confidentiality and informed consent. We have been incredibly successful in reducing HIV among newborn

babies and in containing the epidemic among drug users. I think it would be a mistake to go back from that.

Q270 Baroness Masham of Ilton: Russia does not have needle exchange, does it?

Ruth Lowbury: Not to my knowledge, no.

Baroness Masham of Ilton: That is one of the problems.

Keith Radcliffe: To go back, quite apart from the human rights thing, as I said, I do not think the mandatory approach would actually be effective. You would have to imagine some colossal police state intervention, where everybody is permanently tracked through their life and the most intimate aspects of their life are monitored and regulated. I just think it would be completely impractical, even if you thought it was—

The Chairman: I think we have the general view of how you feel about this. We have a tradition in this House that other Lords who are not actually on the Committee can come, and Lord Ribeiro has come and would like to ask a question.

Q271 Lord Ribeiro: Just one clarification, which really follows on from Lord May's comment about the green card. Are you making a distinction between black, ethnic and other people who have immigrated into the UK and the indigenous population? When you look at the ethnic population as a whole in the UK, spread across the country, there may well be different levels of HIV risk, whereas if you have a targeted population, whether it is somebody who had tuberculosis or somebody who is coming from overseas, there may well be specific indicators for testing. Could you comment on that?

Ian Williams: If you look at the prevalence data from the anonymous testing in GU clinics of heterosexuals, where the data on migrant status are not collected, you see that the prevalence of HIV in heterosexuals attending GU clinics who are of black African or

Afro-Caribbean origin is very high, compared to heterosexual white Caucasians of UK origin. We also know that transmission among black ethnic minorities is increasing—your assumption is that it is only migrants who acquire HIV, because they have acquired it abroad, but there is evidence that there is increasing transmission occurring within black ethnic minorities. Qualitative evidence from a colleague of mine suggested that HIV was acquired in the UK in something like 17% to 20% of all diagnoses among black Africans.

Q272 Lord Ribeiro: But is it locality driven? That is the point. In other words, do you find that concentration—the 17% increase—in London, Glasgow, Edinburgh or Brighton, or is it universal across the UK?

Ian Williams: They are certainly within London. If you look at the prevalent population in GU clinics, both in gay men and in heterosexuals of black ethnic minorities, the prevalence is higher in London compared to that in GU clinics outside London. However, the prevalence is still at a level outside London where routine testing would be advocated.

The Chairman: I would like to move on to treatment and particularly measuring outcomes.

Q273 Baroness Tonge: I would like to ask first of all whether you had any targets that you worked to under the last Administration. Then turn your mind to the reforms of the NHS, which are going to depend on public health outcomes. Could you tell us what you see as an outcome? Only one, I think, relates to HIV and that is on the proportions of persons presenting with HIV at a late stage. Is that going to be a useful outcome measure or should we have additional outcome measures? Should organisations have a role to play in raising and maintaining standards of care? I am really trying to tease out how you see the difference between a target and an outcome and whether the new system is going to be beneficial.

Ian Williams: Clearly all clinicians want to ensure that their patients have good response to therapy. Our desire is to ensure that the patient in front of us has good treatment and has a good response to treatment. What we are trying to achieve is a good response in everybody, not just in a target population. Three indicators of quality of care have been developed by the London consortium. One is the entry into care—when the first CD4 count was done following diagnosis. Then there is the proportion who are undetectable at one year. The treatment suppresses viral loads, so one of the biological outcomes of therapy is to keep the virus suppressed and undetectable. The third one is the proportion who had a CD4 count above 200. A CD4 count of less than 200 is associated with an increased risk of disease.

If you look at those quality of care outcomes in London, the quality of care is extremely good, in that 90% of people who are on therapy after one year have an undetectable viral load. My audit of my own clinic suggests that, when people are on therapy, more than 90% of them become undetectable and remain undetectable. Equally, if you look at those accessing care, 80% of them will access care within a month of diagnosis and, equally, the proportion with CD4 counts above 200 is 95%. There are quality of care outcomes that have been developed, but I would like to see a good outcome in all patients. Often the difficulty is those patients who do not adhere to therapy, who are more chaotic, who are difficult to engage—those are often the difficult patient population. With regard to public health outcomes in terms of the proportion less than 350 and whether other outcomes might be developed, clearly I have stated three but one might be the population's CD4 count, in that we know that there is an association between life expectancy and a population's CD4 count.

Keith Radcliffe: I agree with what Ian has said. It is important to draw a distinction between clinical outcomes in managing an individual patient and outcomes at the level of public health,

which are far more removed from what clinicians are doing and which are influenced by many social, cultural and economic factors. Clearly outcomes are what we are trying to achieve, aren't we? If the outcomes are chosen correctly, we must support them. The idea of diagnosing HIV sooner is an outcome that we clearly support, but many things are going to influence that. It would be difficult always to know what is leading to a change in one direction or another. There is going to have to be a lot of detail in terms of the steps that are going to be taken, which we hope will lead to that outcome of earlier HIV diagnosis.

Q274 Baroness Tonge: Will that involve a lot of bureaucracy, recording, tabulating, reporting back and sending figures up the line? I am always concerned about this, particularly for the clinicians.

Ian Williams: You are absolutely right. What we were asked to produce by the London consortium involved an awful lot of administrative work to feed back the data, so there was administrative work. The task is to choose an outcome that is routinely collected and to improve the data collection routinely. That will improve, because a lot of clinics are moving to electronic databases. There is definitely within the HIV field a feeling that there should be some common data sets and that some common outcomes should be developed. I agree entirely.

Q275 Baroness McIntosh of Hudnall: Can I just go back to the question of the outcome for the individual patient? If you are a young gay man, say, in your 30s, which sounds as if it is the population that is most likely to be diagnosed, among the MSM group anyway, and you are not diagnosed too late, what is your life going to be like as an HIV-positive patient? You talked earlier, Dr Radcliffe, about people living a very healthy life; I think that those were your words. You just talked about undetectable viral load. As long as

somebody adheres to the therapy, is there anything else that they can expect to have to do over their lifetime in order to manage their illness?

Ian Williams: Certainly suppressing the virus is the key aspect to good treatment outcomes, but other things may well happen to them over their lifetime. There is an increased risk of psychological comorbidity in patients with HIV, with things like distress anxiety and depression—a huge level of that. That needs to be screened for. There is an increased risk of cardiovascular disease and renal disease, and issues around neurocognitive impairment as people get older.

Q276 Baroness McIntosh of Hudnall: Can I just stop you on the cardiac and renal disease? Is that an increased risk directly related to the HIV infection?

Ian Williams: Yes. This is an evolving field, but HIV causes inflammation in the body, and inflammation is not good for the body. Also some of the drugs have an effect on things like lipids, which contribute to heart disease. Although treatment of HIV infection will reduce the risk, other chronic medical conditions such as cardiovascular disease are likely to be higher in patients who are HIV-positive on treatment. The impact of ageing on treatment is something that is of concern to a lot of community groups and patients—they are all getting older, but will they have more disability as they get older compared to someone of the same age in the general population?

Q277 Baroness McIntosh of Hudnall: Is there any evidence that the effectiveness of the drugs themselves diminishes over time?

Ian Williams: No. Generally, the view is that, if you take your therapy, the virus does not escape treatment. The main reason why people fail therapies is that they do not take their

therapy very well. People's lives change; events happen that may impact on adherence. That is clearly all part of living life.

Q278 Baroness McIntosh of Hudnall: This is the last thing. If, as an HIV-positive person, you subsequently contract other diseases, which are unrelated to your HIV status, are there diseases that would make it difficult or impossible for you to continue to take your HIV therapy, and what would be the difficulties that people might face?

Ian Williams: There is an increased incidence of hepatitis C and hepatitis B among people who are HIV positive, but generally the main concern about other comorbidities is drug interactions between the therapy for one and the therapy for the other. That is manageable, as long as we are aware of them. Definitely treatment of comorbidity in patients with HIV is the same as for the general population. There are no specific things you need to do.

Q279 Lord May of Oxford: Given the current rise of incidence of HIV among all groups—heterosexuals, drug users and men who have sex with men—would you not agree that one of the central public health outcomes might have been, as well as getting people diagnosed sooner, reducing the incidence?

Ian Williams: Yes, absolutely, I entirely agree. Reduce the incidence, but the difficulty is how we measure that.

Lord May of Oxford: For God's sake.

Ian Williams: There are issues around how that is measured and the HPA¹⁰ is looking at ways of trying to do that.

Lord May of Oxford: You measure it by the ways of the measures that are showing it all going up, I would have thought.

¹⁰ Health Protection Agency.

Ruth Lowbury: There is a difference between the numbers of diagnoses and the numbers of new infections that are occurring. The HPA has recently been developing measures so that it can tell, when somebody is newly diagnosed, whether that was a recent infection or not. You are right, but it is important to know whether people are becoming infected as opposed to being diagnosed.

Lord May of Oxford: I take the point, but surely there would be a way of defining that one's doing better?

Ian Williams: I agree entirely, but this is more difficult. It depends on people having repeat tests, which they do not always do, so you have to have a recorded negative test and they may have a negative test somewhere else. Equally, the algorithm that has just been referred to is suitable only for subtype B infections not non-subtype B, which comes from heterosexuals. Our association recently reviewed 1,100 new diagnoses across the UK as part of an audit and we were surprised that 27% of new diagnoses between August and October in 132 treatment centres across the UK had acquired their HIV infection since 2008, so 27% were new diagnoses. There is some indication there, but mapping incidence is very difficult. I am sure that the HPA has given you the same answer.

Q280 The Chairman: I thought that Baroness McIntosh had a very important question, because there seems to be this rather general view that, when you get HIV, all you do is you take a pill and that is it; you live happily ever after. From everything you are saying, that is not the case. It is quite difficult to put that message over, because obviously you do not want to demotivate—if that is the right word—people who have got HIV, but there are consequences of HIV, are there not? I just wonder to what extent those are understood.

Keith Radcliffe: It is very interesting, trying to convey the message. Most of the patients we look after in our clinic are extremely well. There may well be considerable psychological

problems but, if they adhere to treatment, their state of physical health is very good. We believe they are not going to live quite a full lifespan yet, and they may not live a full lifespan in as great health as if they were HIV negative, and Ian has covered that. Nevertheless, they are going to live several decades of almost normal health in my view, apart from having to take medication and be monitored three times a year. That is the current situation as best as I can describe it. You are absolutely right: that is clearly a less frightening prospect than the prospect of dying within a few years, which was the situation before 1996, but nevertheless that is the truth. We obviously cannot pretend that anything is different, but the thought of having HIV and having to live with the consequences of that—lifelong therapy, the implications for your sexual life, etc—is surely something that people would very much want to avoid if they possibly could, even if that prospect is a lot more hopeful than it was before 1996.

Q281 Baroness Gould of Potternewton: You talked about the health consequences. You are obviously right, but within that whole package of course are the social consequences as well. I do not know how you separate those out, whether it is about people who cannot get a job or whether they get the sack because their colleagues have discovered they have got HIV and, therefore, the boss sacks them or whatever. There is a whole lifestyle problem, it seems to me, that has to go alongside any sort of discussion around the consequences of having HIV. I do not know whether that is something you take on board or whether it is something that is left to the aftercare that follows from your treatment.

Keith Radcliffe: I think you are right; there is considerable psychosocial morbidity, without any doubt. That will very often impact on treatment. As we have said, if people take treatment as prescribed, they will do very well. The problem comes when people do not

take it as prescribed and very often that is because of psychosocial problems, which make it difficult for them to do what is in their own best interest. Most HIV care at specialist centres is delivered as part of a multidisciplinary team. In my department, we have a psychiatrist, a clinical psychologist and a counsellor. We have people as part of the team who try to help as best they can with that side of it.

Ruth Lowbury: I think it is really important that the commissioners of HIV treatment and care understand the breadth of provision that is needed—not every aspect of social and psychological care for every individual, but that breadth should be available for those who need it. That will impact on their mental health and on their well-being generally, but also on their adherence to treatment and their clinical outcomes. In a climate where we are looking at cost pressures, if it is possible to develop some kind of treatment outcome measure that will capture whether we are successfully supporting people in the round and whether there is a package of care that enables people to go on adhering to treatment and that enables them to keep well mentally, I think that would be great. I do not know exactly what that measure would be.

The Chairman: I would like to move on to the costs of treatment.

Q282 Baroness Masham of Ilton: Given the increasing pressure on NHS services from increasing numbers of those accessing care, to what extent does the existing model of HIV care, with treatment primarily delivered in a specialised setting, need to be reconfigured, for example by the greater involvement of primary care? I will take all the questions together. What are the risks and opportunities of any reconfiguration? What mechanisms, financial or otherwise, would be required to drive forward any reforms? Will any reconfiguration have an effect on the ever growing financial pressures that HIV treatment and care places have on the NHS? I have great admiration for specialised units, because they give support and they

know what they are doing. There might be fragmentation; I want your views on that. Also, when you have patients gathered together, you can then do research.

Ian Williams: If I can start off, I think the model of care at the moment is unsustainable, in terms of the fact that the prevalent population is increasing; they are living longer. That is an extremely good thing, but as people get older they develop other chronic medical conditions that are normally looked after in primary care but involve many other specialists. There is not the resource capacity within the current system to allow the current model to continue. Irrespective of cost, there needs to be an evolution of model of care that greatly involves primary care. Primary care is traditionally involved with the management of chronic medical conditions and I feel that it will have a role in the care of patients with HIV, in an integrated pathway with secondary care, which will allow for better use of resources. It is in the interests of patients, to be honest. They will get better care by involving primary care, because primary care is very good at looking after chronic medical conditions and looking after the comorbidities that I was not trained in as a GU physician. I think that we need to use a multidisciplinary approach, involving primary care in what it does well.

Q283 Baroness Masham of Ilton: What about confidentiality? Many GPs only give five minutes. What can you do in five minutes if somebody is depressed?

Ian Williams: I am not saying it is easy. There are a lot of barriers. Many GPs do not feel they have the confidence or skills to deliver primary care, so a lot of education and resources need to go with that. Confidentiality in primary care should be as watertight as confidentiality in any other aspect of medical care and medical facility. If it is not, that needs to be taken up with the individual GP.

Q284 Baroness Masham of Ilton: It is not. Anybody can look at the computer. If I order my drugs, one of the receptionists will look at the computer to see what I need.

Keith Radcliffe: You raise a valid point. Within the NHS, everything is meant to be absolutely confidential but, in reality, there are different grades of confidentiality. Because of the nature of the work in GU medicine, everybody is absolutely obsessed about confidentiality, and we give that a very high priority. In my department in Birmingham, for a number of years we very much tried to encourage all the HIV patients to inform their GP and the majority have done so and the majority of those have had no problems as a result. Generally speaking, people can involve their GP. The GP may not want to get very actively involved in their care, but there have not been problems about informing them in the main. Some patients certainly are concerned about confidentiality with their general practitioner, for exactly the reasons you give: the receptionist looks in the notes or the receptionist knows my mother. That is the sort of issue that people are concerned about. Some people will not tell their GP because of that sort of concern but, in my experience, the majority can be persuaded to tell their GP and, in the majority of those cases, there has not been a problem as a result.

Q285 The Chairman: Dr Williams, just so that we are absolutely clear, what you are saying is unsustainable is the present GUM-based system.

Ian Williams: Yes. The reason I say that is that, for example, at the clinic I work at in central London, there has been a 400% increase in the patients we treat over the last 10 years. There has not been a 400% increase in staff and, although we are seeing patients less frequently, patients are remaining well and there is not that intensity about it, we cannot continue to provide the continuing good care arrangements. What will happen is that a small proportion of patients will continue to get very good care, but a lot of patients will not get

very good care because they cannot get appointments. There has to be a change in the model of care that allows for maintaining quality-of-care outcomes, but my view is that, as people get older, if you have a chronic medical condition that disables you, which is a consequence of HIV, having a good local practitioner is extremely important. You get involved with local services. I have had many conversations with GPs where the care of patients has been improved by their involvement. There are a lot of barriers; there are a lot of difficulties. Many patients do not like to involve their GPs but, as a model of care, we need to move towards that of a chronic medical condition: focusing secondary care on complex problems; allowing annual reviews but involving all the best multidisciplinary aspects that NHS care can deliver to the best advantage of patients.

Q286 Baroness Ritchie of Brompton: I have two issues about the model that you are proposing. First of all, in effect what you are doing is cost-shunting, because you are moving it from one section of the health service to another. That would be the first issue it might be interesting to discuss. The second one is the ability and the capacity of the GPs to deliver that care. If you were going to that model, you would have very much to be looking at the engagement of GPs and the training of GPs to pick it up. We have not even started on commissioning in the public health area, if we are talking about cost-shunting.

Ian Williams: I do not see it as cost-shunting. I am here looking at what is the best model of care.

Baroness Ritchie of Brompton: Sorry, that was rather crude; I apologise.

The Chairman: Is that a particularly local authority phrase, cost-shunting?

Baroness Ritchie of Brompton: I am afraid it probably is, yes. I apologise; it is rather crude.

Ian Williams: My main aim is to ensure that patients continue to get good care. Excluding primary care from that care package is to the detriment of patients. That is my whole thesis. I do not feel that secondary care can continue to provide total care. We have to involve all aspects of NHS care. It is to the benefit of patients.

Q287 The Chairman: What do your two colleagues feel about this?

Keith Radcliffe: I think I agree with Ian. The parallel that is often drawn these days is with diabetes, which is a chronic condition with not that dissimilar an effect on life expectancy. Primary care plays a very large role in that. I do not see any reason why that should not come to pass with HIV. I think it probably will. There are particular issues around HIV to do with sexuality and to do with the stigma, which makes it a little more difficult than diabetes, but general practitioners have many skills in these areas and, with the adequate training, they will gain the confidence. I think they will be able to deliver a large part of the care.

The Chairman: And the training of everyone who is working for the GPs as well.

Keith Radcliffe: Yes. The other thing about costs is that the bulk of the costs of managing HIV are drug-related. Probably 75% of the considerable costs of treating somebody are to do with the drugs, so the savings that are going to be made are going to be about negotiating better deals on drugs, which is probably best done at a very large scale. That is why I think the idea of HIV care being commissioned at a national level makes sense.

Q288 Baroness Masham of Ilton: Will the GPs have the expertise to understand the drugs when they react against each other?

Keith Radcliffe: The way I would see it working is that many patients, once established on treatment, are actually quite stable, and they could be monitored periodically in primary care with the option to send them back to the specialist centre if something untoward happens

and then maybe once a year they are reviewed in hospital—a model like that. GPs would be given clear parameters and, if something goes outside those parameters, they would be able to send them in for an expert opinion.

Ruth Lowbury: It is essential that GPs become more involved. We heard earlier about testing and I think all GPs need to get better at being able to diagnose HIV when it walks through their door. When it comes to complementing the care that is provided by specialist treatment centres, it may be that some GPs have more of an interest in that—more of a willingness to take it on—than others. I do not really see why it should not be that certain practices may develop an expertise in that area, so that people with diagnosed HIV may choose to register there. That would mean that you would get good complementary care and good communication with the specialist service. I believe that there have already been some local enhanced service contracts in Brighton, which have been exploring that model, so I think there is potential there. I am not a clinician but it seems to me that, in the good services and the good specialist centres, you get economies of scale and you use the multidisciplinary team effectively, so nurses have a really important role to play, as do other professionals within the team. Possibly, if you are looking at costs, that is another thing that needs to be looked at, wherever services are centred.

The Chairman: Could I then go on to commissioning? We are putting an awful lot on GPs, aren't we, at the moment? This seems to be the drift of general policy just now.

Q289 Baroness Gould of Potternewton: One of the things within the programme of looking at the whole question of commissioning has been to try to provide a holistic commissioning service for sexual health. What we have now, of course, is that HIV treatment and care are going to be commissioned nationally by the NHS commissioning board. You have indicated that you already think that is a good thing, but then you are going

Keith Radcliffe: Obviously the reforms are a work in progress. I presume none of us knows exactly how it is going to work out in the end. Given what we know at the moment, I am quite pleased with what is being said, because I do think it is very logical that HIV treatment is commissioned at the national level, so I am pleased that that is going through at the level of the national commissioning board rather than going down to GP consortia. I am also pleased that other sexual health services to do with diagnosing and treating sexually transmitted infections, and diagnosing HIV before expensive treatment begins, are going to be commissioned by Public Health England, because that is a public health service and it is very important that that is recognised in the way it is commissioned. Given the options available to us, I am quite pleased with the way this seems to be shaping up. I agree there is a difficulty that the people providing those services are often the same people, although not always, and they will therefore be dealing with two different commissioning arrangements for the two areas of work, but I think that the expensive management of HIV as a chronic condition is a different sort of service from running a sexually transmitted infection clinic, even though they are both to do with sexual health. They are different kinds of service, quite qualitatively, so perhaps there is no alternative to this leading to different commissioning groups.

Q290 Baroness Gould of Potternewton: Is that going to affect the possibility of, for instance, testing across the board for very different aspects of sexual health? Are we going to find that the testing stays where it is and it is actually the treatment that is moving on for HIV, but not for the other areas?

Keith Radcliffe: The key, in whatever the commissioning arrangements are, is to have the correct standards for delivery of clinical care. That is the key issue. Whoever is commissioning the service, it has to be commissioned according to the correct standards, and standards have to be maintained. To some extent, whichever body is commissioning it, more important at a fundamental level are the standards that they are commissioning that service to. For example, there should be STI testing within HIV treatment services, so that must be one of the standards that is commissioned, whoever is responsible for it.

Q291 Baroness Gould of Potternewton: What about the reverse?

Keith Radcliffe: HIV testing in STI clinics is obviously a very fundamental part of what they do and, yes, absolutely they should be expected to continue to do that.

Ruth Lowbury: My understanding of what is proposed is that the HIV prevention and HIV testing would be a part of the public health commissioning at local authority level. I certainly welcome the integration of testing for different STIs and other aspects of sexual health at local level, and I think that that is good. I also think that, in some parts of the country, especially where prevalence of HIV is low, it is difficult to put HIV treatment and care commissioning at that level, because the costs are high but the individual patient numbers are low and the risks are quite difficult to manage at local level. There is a risk of not having the prevention and the treatment joined up. One of the things that I am a bit concerned about is, with the cost pressures facing local authorities; particularly, the cost-effectiveness argument needs to be really strong. I started this session by saying it is important there

should be leadership and priority. The cost-effectiveness argument may be what wins the case, in terms of encouraging priority investment in prevention and testing. If the budget for the public health aspect sits with the local authority and the budget for the treatment and care sits with the NHS, then will the incentive for local authorities be strong enough to invest and to save money that will not be in their own budget? That is a concern and I do not know how we address that.

Q292 Baroness Ritchie of Brompton: You have led us into the area that I was wanting to question on: the risks and the opportunities in the new commissioning proposals. You might want to make some comments about the Director of Public Health, for instance, and about making sure that we do not lose that regional commissioning expertise that was been in place to date. Any comments around those sorts of issues would be useful.

Ian Williams: May I comment on the HIV side? That is a concern that I definitely have. The commissioning arrangements for HIV services have developed on a regional basis—for example, London. There has been a lot of development of expertise within that. The outcomes associated with treatment have been very good, so we have had a system where there was commissioning expertise and very good treatment outcomes. We are now moving to a situation involving the national commissioning board, but I am not sure how the national commissioning board will function. The London consortium negotiates with 23 different providers. How is the national commissioning board going to negotiate with 100 providers throughout England? The function of the national commissioning board is still of a concern to me, but I would echo Keith's remarks that one of the key things that needs to happen is the establishment of quality standards and outcomes for commissioning purposes and the establishment of service specifications. Whoever is commissioning, the model of

commissioning is not, to a certain extent, the problem; the issue is the terms of the commissioning tools and the quality standards that are being commissioned.

Q293 Baroness Ritchie of Brompton: Who will be developing that?

Ian Williams: The White Paper suggests that NICE will be developing that, but I wrote to the Department of Health saying that, as an organisation, we would very much welcome the chance of being involved in developing quality standards for HIV treatment. I hope the department will involve professional associations such as ourselves and BASHH.

Q294 Baroness Ritchie of Brompton: They also ought to be involving the commissioners.

Ian Williams: Yes, absolutely right, but the London commissioners do that. The London commissioners are extremely good in terms of involving patients. The other thing that I am concerned about in national commissioning is patient involvement. Patient involvement within the London consortium and other areas is extremely strong. I have not seen how patient involvement will be expressed at the national commissioning board.

Q295 Baroness Gould of Potternewton: What about the training of the commissioners? This is a new environment and, while we have had some very good commissioners, we have also had some very bad commissioners in the past. What do you think should be the process for making sure that the commissioners really do understand what the new expectations are?

Ian Williams: You need to retain the expertise you have. You should not lose the expertise. Commissioning expertise needs to be retained. A different model is being proposed, but we are not trying to say we are going to lose all the expertise that we have got. It may well be

moved around, but it is vitally important that we retain the expertise that we have and that it is used appropriately.

Q296 Baroness Tonge: I have been hanging on every word that you guys—sorry, Ruth, you are included in the “guys”—have uttered until now. You said that a person with HIV is like a person with diabetes and needs the same sort of follow-up care in relation to the extra infections and conditions that the GP has to deal with. Therefore, you want to involve the GPs in the care of the patient. Let’s leave the public health element to one side for a minute. If the NHS Commissioning Board is commissioning HIV treatment and care, how is it going to deal with the fact that we want a lot of the follow-up work to be with the GPs, who are in fact the commissioners? Is there going to be a payment from the NHS commissioners to the GP commissioners to pay them for providing the follow-up treatment and care of the patient with HIV? I do not get it.

Ian Williams: I would argue that what we are asking GPs to do is to deliver primary care to their patients, which is what their responsibility is. I am asking that GPs do what they already should do with their patients, which is to deliver primary care. The aspects of specialist HIV care, in terms of complex care arrangements and management of antiretroviral therapy, should still sit with secondary care. All I am asking is that primary care gets involved with the management of patients in the way that it gets involved in the management of other chronic medical conditions and that it delivers primary care to its patients. That is what I am saying.

Baroness Tonge: I do not understand the pathway.

The Chairman: You said that at the last session as well, Baroness Tonge.

Baroness Tonge: I do not understand.

The Chairman: We will eventually have a Government Minister and all will become clear to you. I just want to bring in somebody who has not had the opportunity to ask a question.

Baroness Healy, I wonder if you have anything to ask. We have rather gone over your treatment and prevention.

Q297 Baroness Healy of Primrose Hill: I understand what you are saying about no likelihood of a vaccine, but I was just wondering if you think clinicians can play a part in HIV prevention beyond purely medical interventions, for example through behavioural interventions. Are there roles for clinicians in prevention?

Keith Radcliffe: Yes. The first thing I would say is that a lot of the medical intervention is in itself prevention. The early diagnosis, antiretroviral treatment and partner notification all have a role to play in prevention. On the specific point you raised, on behavioural interventions, there is evidence that that can be effective to an extent and, indeed, there is current NICE public health guidance that such interventions should be delivered in a range of settings. To the best of my knowledge, it is not being delivered very well and I think that is largely an issue of resources in that it is actually quite time-consuming to deliver such interventions. This is work on top of work that the services are doing, but there is no mechanism available to get the additional resources to do the extra work so, to the best of my knowledge, this is not really being done very widely.

Ian Williams: I think there is a very big role that treatment and care centres can play in positive prevention. That would involve coming to the point of integration with sexual health services, screening for STIs, identifying patients who are at high risk of transmission, partner notification and getting people to take their therapy effectively. There are biomedical and behavioural issues. For example, the psychologists and health advisers, who are a very important part of our treatment and care, also look at sexual risks and help people to overcome that. Treatment and care services have an important part to play within positive

prevention. I would still want to see integrated sexual health services within HIV treatment centres, definitely.

Q298 Baroness Masham of Ilton: Who is going to measure the individual outcomes, because the Government are saying that the outcomes are the priority?

Keith Radcliffe: If we mean the clinical outcomes of individual patients, what one would expect is that whoever is commissioning the treatment service will want to see a regular report on your performance, so I think it will be a report to the commissioners. In terms of the public health outcomes, I imagine that will be the role of Public Health England and the HPA as is.

Baroness Gould of Potternewton: The Health and Wellbeing Boards.

The Chairman: Okay, I would like to, just for the last few minutes, deal with one or two of the issues of stigma and discrimination.

Q299 Baroness McIntosh of Hudnall: You have talked a lot about stigma, as we have gone through the morning, and so quite clearly you regard it as a serious issue in the sense that it obviously impedes progress towards getting people to get testing and so forth, but there is a particular issue to do with discrimination against one or more groups of people, particularly migrants, who may be diagnosed but are then not able to get free treatment. The rationale behind this appears to be that successive Governments have thought that, if free treatment were provided, it would encourage people to leech off the NHS effectively. Do you have a view about whether that is a well founded fear? Also, do you have anything you want to say to us about the impact of there being groups of people who are possibly carrying the infection—and may indeed find out that they are carrying the infection—but cannot access treatment, other than by paying for it?

Ian Williams: I personally and the association that I represent strongly believe that there should be a change to the overseas regulations to allow free treatment to non-resident migrants, because I think it is in the interest of public health to do so. We, with BASHH, submitted a paper to the Department of Health a year ago supporting that proposal and giving evidence to the Department of Health with regard to the public health benefit. We have covered some of the points of the public health benefit already. I do not think there is any evidence that people come to the UK for healthcare tourism. People who are migrants often get tested two or three years into coming to the UK, not immediately. There is anecdotal evidence that someone who was ill was tested across the way at St Thomas's Hospital and was allowed access to treatment but would have had to pay for it. This patient was then admitted to hospital six months later and it cost the NHS another £28,000.

Baroness McIntosh of Hudnall: Because he was admitted in an emergency?

Ian Williams: Absolutely, yes. This is a progressive disease. To allow people to progress to become unwell and have a further burden on the NHS through cost, to my mind, is madness. Equally, to have people who have a diagnosed HIV infection at risk of transmitting HIV to other people, and we know that transmission occurs among black ethnic minorities, and not offer them treatment is also nonsense. As a clinician, I want to treat my patients the same, irrespective of where they come from.

Q300 Baroness McIntosh of Hudnall: Have you at any time in your dialogue about these issues with the Department of Health, for example, ever been given any evidence, other than a belief, that demonstrated that there was abuse of the system from any of these groups?

Ian Williams: No, not at all. I surveyed members of the association about 18 months ago, asking what their views are. There was no evidence there. There may be one or two odd

cases of people coming off the aeroplane and coming to treatment, but that occurs across all aspects of the NHS. People come for treatment for renal disease and renal dialysis. That occurs; it is not a particular problem for HIV. The public health interest in allowing free treatment is overwhelming in terms of non-ordinary residents.

Ruth Lowbury: Could I make one additional point? I agree absolutely with Ian and my organisation has taken the same position. It is recognised that, if people do not have access to treatment, the incentive to test will be much lower. In a climate where we are trying to encourage testing and to do everything we can to attract the communities that are most at risk into testing, we do not have the incentive to offer them, so we are undermining our own policy if we are not allowing people to have access to treatment. In the guidance that we developed for ECDC for Europe, one of the strongest points we made—one of the key principles—was that there should be access to treatment, to encourage testing.

The Chairman: We would be quite interested if you have any more specific cases of the kind that you mentioned, of people who have not been tested then going on to emergency treatment, which obviously costs quite a lot of money. Now, I am being waved at frantically by Baroness Ritchie and by Baroness Gould.

Q301 Baroness Ritchie of Brompton: As a corollary to that, do you have any evidence—and you may not have it here but in written evidence—about the onward transmission of the disease by the group of people that we are talking about? I am not asking you to answer the question now.

Ian Williams: We do not have particularly that sort of data about non-ordinary residents, but we have data about black ethnic minorities, who clearly are more likely to be non-ordinary residents, about ongoing transmission.

Baroness Ritchie of Brompton: I am trying to make the case that is the sort of evidence that might be useful.

Ian Williams: We will look into it.

Q302 Baroness Gould of Potternewton: I wonder if I can stand it on its head. Evidence has gone in to Government from a lot of organisations, including your own, over a fairly long period of time now. Has the Government ever produced any evidence to show that everything that has gone into them has been wrong and that they are actually right in saying that HIV should be excluded for free treatment? And why HIV? Something must have sparked that off. Why HIV and not any other disease that people might come in the country with?

Ian Williams: I have never heard any convincing argument from anybody that HIV should be excluded. I really do not think that there is an interest in the public health to exclude it at all. I have not seen any evidence, other than political evidence in terms of the health tourism issue.

Baroness Gould of Potternewton: Have they produced any figures, any evidence, to show that?

Ian Williams: No, not at all, no.

Baroness Gould of Potternewton: Why HIV? I do not know when this started; I do not know what set the ball rolling on this issue. Why HIV and not something else?

Ian Williams: I do not know, but the National AIDS Trust produced a paper a couple of years ago that looked at this issue and debunked the idea of health tourism with regard to HIV.

Q303 Baroness McIntosh of Hudnall: Is it possible that the answer to Baroness Gould's question is to do with the long-term cost? I have to say that personally I entirely accept what you say about the public health benefits of not letting a group be excluded in that way, but what are the long-term costs per patient of somebody being diagnosed, say, in their 30s and living into their 60s and 70s? What would it cost the NHS to treat such a person?

Keith Radcliffe: The figure that is the best current estimate of lifetime direct treatment costs is about £300,000.

Baroness McIntosh of Hudnall: That is £300,000 over a lifetime.

Keith Radcliffe: Yes.

Q304 Lord Gardiner of Kimble: If a migrant came and was treated, what would be the cost to the person, in terms of the charges that would be levied, per year, say, if they wanted full treatment?

Ian Williams: The average treatment cost for antiretroviral therapy is about £6,000 a year, but that clearly does not also include add-on costs such as tests and suchlike. That is just the antiretroviral therapy, which is about £6,000 a year. You are often looking at a population that in no way can afford this at all. What happens is that treatment is given, because it is felt to be immediately necessary to do so by a clinician, which is allowed under the overseas regulations, but then the trust tries to pursue that and causes an awful lot of distress and anxiety. The trusts write off the costs eventually because they are unable to get that cost. To my mind, it is just a constant circle of nonsense.

Lord Ribeiro: I must declare an interest. For a while, I was on UKAP¹¹ and EAGA¹². One of the issues around this was over a period, if you remember, when the NHS was actively

¹¹ UK Advisory Panel for healthcare workers infected with blood borne viruses.

recruiting overseas for nurses et cetera. The question that we had to discuss was about testing. I certainly put a very strong view that testing should take place in the country of origin before they came to the UK. The UK Government's decision was that it was not going to go down that route. I do not know whether, as consequence of those sorts of actions, this has been one of the reasons why the question of not providing this free has come up, but there was great concern at the time that we would in fact have a large population coming into the UK possibly with HIV, and there would be cost implications.

Q305 The Chairman: I am just going to go back one step to prisons and what you were saying about that, because the two issues are related. Am I right that, in the evidence that you have given, testing is not offered at all? Is that right, in prisons?

Keith Radcliffe: I would not say that it is not offered at all. I think that there are services offering testing in some prisons.

The Chairman: But not in all?

Keith Radcliffe: I could not give you a precise answer to that. I do not know how generalised the services are, but many prisons have sexual health clinics attached to them where testing is done.

Q306 The Chairman: What I wondered related to the question that Lady McIntosh was asking on migrants. What do you think the underlying attitude to prisons is? Is there an underlying attitude that sexual activity does not take place in prisons? I am asking the question: is that the basis of the attitude?

Keith Radcliffe: Clearly delivering healthcare in prisons is very different from delivering it in the normal set-up. There are particular problems around it and there are always debates

¹² Expert Advisory Group on AIDS.

around provision of condoms and provision of needle exchanges in prisons. Obviously there are legitimate security concerns, which certainly make it a much more complicated proposition than in normal civilian life, if you like, so there are particular issues around delivering sexual healthcare in prisons.

Q307 Baroness Gould of Potternewton: Prison health, not that long ago, came under the PCTs¹³ and now, of course, the PCTs are disappearing, so the question is who will take over that responsibility. On prison health, I once made a speech in the Lords—in fact, somebody came to me and said, “I do not know how you dared spend a whole speech talking about condoms,” which is what I did, and the fact that you had to get a doctor’s permission before anybody was allowed to have a condom in prison, as though sexual activity did not happen. There was certainly some background there. If one takes the example of the Isle of Wight, where there are three prisons, they have regular visits from their clinic, but my impression is it is all governed by the prison governor, in the sense of when he allows them to go in and whether it is convenient or not convenient. If we have the loss of the PCT, we are going to have to have a fairly strong force, I would have thought, in order to be able to maintain the services in prisons. I do not know what your thoughts are on that.

Ruth Lowbury: As I understand it, the proposals are that prison health should be commissioned by the national commissioning board, which may have some advantages if it means that the specifications for services and the standards can be put in place and the provision can be standardised. One of the problems with prisons, as you say, is that so much depends on the individual institution and the governor in charge and whether there is an approach that enables people to access healthcare in a confidential way and, if they have got

¹³ Primary Care Trusts.

HIV, to access their treatment in a regular way. There are obviously heightened concerns about confidentiality, about bullying and the risk to individuals if they are seen to have HIV or to be getting tested for HIV. There are a lot of issues in prison that are not quite the same as in the outside world.

The Chairman: Thank you, all three. Baroness Gould makes the point that there are three prisons on the Isle of Wight, so perhaps we should do a trip there, which would suit at least two of us rather well as we both have houses there. Thank you very much for coming. If I may say so, you have given your evidence in an absolutely exemplary way and, for the first time, we have got through all the questions that we wished to ask, but the answers have also been extremely illuminating and extremely useful. Perhaps if there are other issues that come up, which I am sure there will be, we could correspond on that and get it down in writing. Thank you very much for coming this morning.