GMHCVS
Hepatitis C Health Equity Audit (2010)

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Executive Summary

Health equity audit (HEA) is a key tool used to identify how fairly services or resources are distributed between population groups. This HEA report was commissioned by the Greater Manchester Hepatitis C Strategy (GMHCVS) and is the first Health equity audit focussing on HCV in Greater Manchester. The report aims to explore how recent service provision around prevention, testing and treatment in services has reflected patterns of need in relation to 5 key dimensions; age, gender, socio-economic status, ethnicity and accessibility (service numbers and geography) across Greater Manchester. The scope of this Health Equity Audit is not intended to be comprehensive. Indicators used have been selected according to availability across the area covered, and represent only a part of the range of measures that could form part of a HCV equity profile and audit. Evidence provided from the HEA can be used to inform commissioning and planning.

Format

The HEA considers each dimension of equity in turn, looking first at measures of need, then each measure of provision used. Equity issues are explored for each dimension. Key findings are presented at the beginning of each dimensions results and equity issues at the end of each profile.

Key findings

- The HEA has identified a clear lack of available data and audits been conducted in this area of service provision/client monitoring.
- Monitoring and current data collection methods vary by service/within services and are often not been delivered consistently. Availability to data is often limited within services even to service leads.
- With regard to access there are clear inequities with regard to unmet need (needle coverage and drug treatment) and provision of services (availability with regard to hours/ number) of prevention and testing services. The distribution of services is largely equitable with the exception of a few isolated exceptions for the main at risk group. However awareness of services and a lack of provision in non deprived areas may limit access to testing by other at risk groups.
- The analysis has identified clear evidence of inequalities relating to gender with on the whole less females accessing services than expected.
- The analysis has identified clear evidence of inequalities relating to age with younger age groups less likely to access services.
- Similarly there was evidence to suggest variations in service provision related to socio-economic status.
- Analysis by ethnicity is difficult to interpret in terms of equity, as elements of service provision are affected by this factor. However there is clear evidence of inequities with regard to ethnicity with fewer numbers of White ethnicity accessing testing, referral and treatment services than expected.
- This is inequitable access to treatment by referrals based on at risk groups with IDUs less likely to be referred than expected.
- As with many other health conditions HCV is a complex area around which to undertake an HEA. Future audits may benefit from a much more specific focus, for example looking at a single measure of provision in more detail, perhaps focussing on a single dimension of equity.
Overall, on the basis of this analysis, the main evidence of variations in service provision appears not to be geographical, rather related to hours of provision and number of services. These variations do not appear to relate to need as measured by local need profiles (PDU, HCV rates or population numbers). There are inequities with regard to age, gender, ethnicity and socio-economic status of clients across the service provision which relate to access and awareness issues for services and their clients.

**Recommendations**

1. **Review data collection methods and improve the usability of recording systems**
   1a. Provide services with training and systems to improve the consistency of data collection between services and PCTs

   - Ensure all service providers have access to a monitoring/ data collection tool that meets PCT and their own requirements
   - Training for staff on data collection processes/requirements within their service
   - Training for service managers/leads on importance of audit

   1b. Collation of HCV-related data at a PCT level to assist both PCTs and future audits in identifying inequities and effective commissioning/recommissioning strategies.

2. **Encourage service providers to collect all relevant demographic data on service users**
   2a. Ensure that relevant data and all demographic data collection is taking place
      - Minimum data set defined for all HCV service providers
   2b. Commissioners should make it a target or requirement of recommissioning that basic annual audits are undertaken across all service providers

3. **Reconfigured NSP and SC pharmacy provision**
   3a. Commissioning a mix of generic and targeted NSP services
      - Developing new methods of delivering equipment.
        - Increase provider numbers
        - Increase provision types
        - Increase hours of service delivery
        - Redistribution of services
        - Increase service offered
      - Undertake consultation with local communities and service users about how best to implement new or reconfigured NSPs
      - Identify potential causes of, and address, the inequities for younger and female service users

4. **Increase Shared care/ drug treatment effectiveness**
   - Increasing the number Locally Enhanced Service clinics/ Increase number of GP with Special Interest posts
   - Increase out of hours provision

5. **Increase access to HCV testing**
   5a. Training on risk assessment and indications for HCV testing for all major HCV testing providers (GPs, IVF clinics, hospitals, drug services)
- Highlight need for testing younger service users within drug services
- Educating other healthcare professionals

5b. Offer testing in other services that at risk groups access

6. **Increase training/awareness of HCV referral pathway and availability of treatment**
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