HCV management model in Cornwall

An example of good practice in developing a treatment pathway

Key points:

- Prior to the inclusion of community-based treatment in the HCV management model in Cornwall, patients had to travel significant distances to access treatment, leading to high DNA rates.

- Now, treatment is delivered in the community at the most convenient location for the patient.

- Of the 600 of Addaction clients in Cornwall who are current or former injecting drug users, 86% have now been tested for HCV.

- The model has facilitated an increase in the numbers of people receiving testing and treatment; increased awareness of hepatitis C, and eased pressure on out-patient clinics.

- The Cornwall HCV management model offers a highly effective example of how to develop an integrated treatment pathway in a high prevalence area, and of how close collaboration between primary and care services can markedly improve the regional management of HCV.

Overview

A largely rural and sparsely populated county, Cornwall has a population of 550,000 and covers more than 1000 square miles. With many areas of high deprivation, it also has high levels of injecting drug use and high levels of hepatitis C infection.

The hepatitis C management model that has been developed in recent years in Cornwall provides an integrated model of care for people with hepatitis C in the county, incorporating partnerships between hospital-based hepatology and drug and alcohol services and spanning testing, treatment and care. Since 2008, the model has incorporated and facilitated community-based treatment, leading to a significant increase in the number of at-risk individuals tested for hepatitis C; a significant reduction in Did Not Attend (DNA) rates, and a marked increase in the number of people in Cornwall accessing HCV treatment.

It serves as an excellent example of how NHS providers can work together with third sector providers to develop a regional hepatitis C management model which is fully cognisant of the often-complex needs of people with hepatitis C, and which works in an innovative way to address these needs. Importantly, the model can be easily replicated in other areas. Whilst a rural model, it can be easily adapted for use in other areas, where the need for community-based treatment is just as pressing.
Issues that the service aims to address

Prior to 2008, hepatitis C treatment in Cornwall was delivered at the Royal Cornwall Hospital (RCH) in Truro, with outreach clinics in Bodmen, St Austell, and Camborne/Redruth. As such, the hard to reach population of injecting drug users, who tend to be more chaotic and deprived than the population at large, were being asked to undertake roundtrips of up to 80 miles, at substantial cost on public transport with numerous stops and changes.

This required commitment and motivation which predictably led to poor attendance, owing to the significant social, geographical and financial barriers in place. **One of the key aims of the model is therefore to increase the number of people accessing hepatitis C treatment in Cornwall by delivering nurse-led treatment in a non-hospital community setting.**

Historically, hepatitis C testing provision has been poor across Cornwall, and prior to 2011 only venous testing was available. This represented a serious barrier to testing, with many patients being needle-phobic and others having very poor venous access. **A second aim of the model has therefore been to raise the profile of BBV screening amongst all patients and to sizeably increase the numbers of people being tested,** principally through the rolling out of dried blood spot testing.

How the model was established and developed

In 2008, the secondary care hepatology team based at RCH identified that Penzance, in West Cornwall, had a disproportionately high number of patients with hepatitis C who were failing to attend hospital for treatment, owing to a combination of social, geographical and financial barriers. In order to address this and to increase the number of people accessing treatment, the team worked with Cornwall Drugs and Alcohol Team to develop a plan for the delivery of community-based treatment in the area.

A GP surgery in Penzance, Morrab Surgery, was subsequently identified as being an ideal location for a pilot project delivering community-based treatment to those who required it. A GP with a special interest (GPi) and a community psychiatric nurse (CPN) were chosen to participate in the pilot, a general nurse was employed, and the pilot was subsequently established. Specialised training was delivered to the team by the hepatology team at the RCH, with the nurse receiving specialised training through working alongside the hepatology consultant and advanced nurse practitioner at liver clinics; attending a liver course at Kings College London and completing non-medical prescribing and physical examination modules.

10 chaotic patients (genotypes 1 and 3) were initially treated via the pilot with standard combination therapy. It proved to be an overwhelming success, with 100% adherence to the programme, and a 70% sustained virological response (SVR) across genotypes being achieved. This success acted as proof of concept; with community-based treatment clearly proving to be a significant improvement on the previous treatment options. Very simply, these chaotic patients would not have been able to complete their treatment in a hospital environment.

Following on from the success of the Morrab pilot, a roaming nurse-led community-based treatment service covering the north of the county was incorporated into the Cornwall model, with the aim being
to ensure that those groups who find it difficult to access treatment, such as those in rural areas and injecting drug users, are provided with the opportunity to do just that.

In addition to the development of treatment options, the model has also significantly developed and improved the way in which testing is carried out in Cornwall. Previously, only venous testing was available in the county, which resulted in low numbers of people being tested. However, in 2011 funding was obtained for the introduction of DBST across the county. However, many workers were not clinically trained and found it a challenge to offer and deliver testing. Ongoing support and raining, therefore, was extremely important in improving the confidence and competence of the workers delivering the tests. However, once trained and provided with ongoing support, the confidence and competence of workers delivering the tests significantly increased.

How the model works

Testing

The model used in Cornwall is explicitly aimed at increasing the numbers of injecting drug users who are tested for hepatitis C; something which is achieved primarily through the work of Addaction. Addaction is the sole provider of drug services in Cornwall, and all Addaction drug and alcohol workers in Cornwall, including those working in homeless services, are trained to use dry blood spot testing (DBST) kits, with all new staff receiving DBST training as part of their induction package and DBST refresher training being delivered to all existing staff.

These Addaction workers carry out BBV screening in the community, with each result being reviewed by a BBV lead nurse. The BBV lead nurse then discusses the positive results with the patients and when ready for treatment takes each case to the monthly hepatology multi-disciplinary meetings (MDM).

Treatment

After a new diagnosis is made, patients are discussed in depth at monthly MDMs. Issues such as when to commence treatment; where the location of the treatment could be; whether the patient could be referred for a clinical trial, and whether the patient requires additional support are all discussed. However, the final decision in terms of whether or not to commence treatment is made by the patient themselves.

Significantly, given the barriers faced by many of those needing to access treatment services, the choice of treatment location is decided on where the patient lives and how accessible the service is to them. Secondary care services currently have nurse-led community hospital sites in Truro, St Austell, Camborne/Redruth and Penzance.

A recent addition to the treatment model delivered in Cornwall is an innovative Addaction pilot which delivers a roaming community based nurse-led hepatitis C treatment service via the Addaction BBV lead nurse, Helen Hampton. Helen, who has an honorary contract with the hospital as an independent prescriber, treats people in the most convenient and accessible location to them. She does this by coinciding visits with other appointments (such as keyworking sessions and criminal justice-related
sessions), and in doing so ensures that treatment is made possible for even the most chaotic of patients.

**Outcomes**

*Increased awareness of hepatitis C*

Increasing the awareness of hepatitis C is an indispensable component of improving the management of the virus, particularly among those working in primary care. The Cornish model recognised this, with educational events being set up and at GP practices to raise awareness of BBV screening, as well as hepatitis C treatment options and management.

*Increased numbers of people being tested*

Of the 1200 service users in the Addaction treatment service in Cornwall, 600 are current or former injecting drug users. Of those 600, **86% have now been tested for hepatitis C**, a significantly higher proportion than the national average of 70%. This has been made possible through the training of all key workers in DBST, which is easy to carry out and delivers results in two weeks.

*Increased numbers of people receiving treatment*

By incorporating community-based treatment into the hepatitis C management model in Cornwall, the number of people receiving treatment has significantly increased. Whereas previously the absence of treatment locations and focus on hospital-based treatment prevented many people from accessing treatment, now the variety of treatment locations and options means that those who were previously unable to access services are now able to do so.

The increase in treatment numbers has also been facilitated by the intensive nurse support which is made possible in a community setting. By linking in with other key workers, and through maintaining regular communication with the service user (for example, reminding them about appointments via text message), the nurse-led service in Cornwall helps to ensure that patients are able to see their treatment through to completion.

*Increase in multi-agency working*

The high numbers of hepatitis C patients that complete their treatment in Cornwall is a reflection of the excellent collaboration between secondary and primary care hepatology services. Data collected from MDMs, for example, is used to follow patients throughout their treatment journey and to ensure that they are fully supported by all relevant agencies. Without this multi-agency working, patients may be more likely to drop out of treatment, owing to their often chaotic and transient lifestyles.

*Decreased pressure on out-patient clinics*

By reducing the need for hepatitis C patients to attend out-patient clinic hospital appointments, referral to treatment times are significantly improved and the workload for hepatology clinical nurse
specialists, who are often working at full capacity, is sizeably reduced. An associated outcome is the reduction in the number of hepatology consultant hours required, which delivers the additional benefit of a considerable cost saving.

For more details, please contact:
Helen Hampton, Addaction Cornwall BBV & Wound Care Lead
h.hampton@addaction.org.uk