Greater Manchester - Joint Strategic Needs assessment for HCV PREVENTION

Authors
Dr Katy Harrison, University of Manchester
Dr Arpana Verma, University of Manchester

Date: 4th November 2010
Acknowledgements

The Blood Borne Virus Research Team would like to thank the GM Hepatitis C Strategy and all the participants of the study for their time and patience. Special thanks go to Dr Erika Duffell, GM Health Protection Unit, Ms Siobhan Fahey, Project Manager for the GM Hepatitis C Strategy and Professor Sarah O’Brien, University of Manchester.
Executive summary

Introduction
The North West has the highest laboratory reports of HCV infection in the England. The Health Protection Agency (HPA) estimate that more than 90% of cases are in the IDU group [HPA 2009b]. Five out of six people, who have the chronic HCV infection, do not know. The Joint Strategic Needs Assessment (JSNA) for Hepatitis C (HCV) prevention for Greater Manchester (GM) was commissioned by the Greater Manchester Hepatitis C Strategy (GMHCVS).

This report will provide an important baseline reference document. It sets out the policy context and current service provision situation followed by an analysis of local data. A series of recommendations are made based on available research evidence that is aimed at supporting future commissioning decisions in each Primary Care Trust (PCT) area and across GM as a whole.

The objectives of the project were to:
- Estimate the prevalence of HCV within GM.
- Identify the current ‘picture’ of HCV infection within GM
- Describe current service provision for HCV in GM.
- Obtain the views of local service providers regarding current provision and gaps in the service
- Recommend an action plan for improving the prevention of HCV in GM

Methods
The best way to meet these objectives is through a Joint Strategic Needs Assessment (JSNA) approach. The findings of the JSNA will be a concise summary of the main health and wellbeing needs of a community as opposed to a large, technical document.

The data collected from all services in the nine PCT areas of GM was through a validated, systematic and comprehensive protocol by telephone or face to face interviews. All current and potential primary, secondary and tertiary prevention services for HCV were included. NHS Manchester data collated in another HCNA are included in the analysis for comparison. Analysis was performed for both quantitative and qualitative data sets.

Epidemiology, Results and Discussion
Estimates of HCV infections in GM range from 12,702 to 20,520. It is estimated that approximately 80% of these infections are currently undiagnosed. The prevalence estimates generated by the model for the 10 PCT regions within GM also vary widely depending upon which source data are used. A response rate of 84% was achieved from all the service providers who took part in the survey. The key findings are outlined below:-

- Demographics and GMHCVS
  - 40% of the population in GM live in the 20% most deprived areas of England.
  - There is a large ethnic mix with each PCT area showing diversity between and within their boundaries.
  - Prevalence of HCV is difficult to accurately measure. The North West has the highest number of HCV positive laboratory reports in England.
  - Predictive modelling is a helpful tool for commissioning services but is likely to underestimate the true prevalence of HCV in GM.
Total healthcare costs of over £260 million over next 15 years if HCV is left untreated.
Implementation of the HCV Action Plan in GM has been commissioned through the GMHCV Strategy. The collaborative approach has been cited as good practice.

**Overall Service Provision**
- Service provision varies across GM by number and category.
- Most services cater for all age ranges with specific services targeting a variety of ethnic backgrounds including recent immigrants, refugees and asylum seekers.
- Majority of the PCT areas have poor provision of voluntary services.
- There is a lack of on-call and weekend outreach which is mainly provided by homeless services.
- Data recorded by services is not optimised leading to estimates by service providers.
- Provision of training varies by type of service with no access to data on how many of the staff are trained.

**Primary prevention**
- NSP provision varies by area.
- Coverage is “low” in three PCT areas.
- Not all drug service bases offer NSP.
- Number of needles, syringes and other paraphernalia was not correlated to the respondents’ estimates on service user numbers.
- Not all NSPs distribute paraphernalia.
- Many pharmacists were unaware of constituents of the NSP packs and what is required by their clients.
- Provision of NES/LES clinics varies considerably across the GM PCT areas in relation to those on treatment.
- Health promotion not undertaken by all services
- Lack of free condoms across services.
- Paucity of data for service users.

**Secondary prevention**
- Not all expected services e.g. drug services, primary care offer BBV testing.
- Lack of staff training for testing, pre and post test discussions.
- Numbers tested are not recorded.
- Low numbers of tests are performed in prisons.
- Large variation in number of samples taken for HCV testing between PCTs areas.
- Referrals for HCV testing are made to and from a number of sources, with some services making referrals to inappropriate destinations.

**Tertiary prevention**
- Most services referred to NMGH or local gastroenterologists.
- Services did not systematically record where referrals were being made.
- Data on referrals should be interpreted with caution as they are estimates from the service providers.
- Detailed analyses of access are discussed in the Greater Manchester HEA and BBV HCNA.

**Development and Auditing**
- Staff training was identified as a need by a large proportion of services in all PCTs.
- Lack of training was felt to be the most prominent factor in preventing improvements to the service.
- Services in all PCTs also identified a greater availability of service user advice and information as a factor that would improve services.
Client anxiety, embarrassment and lack of client support were highlighted as a barrier preventing clients from taking full advantage of the services available.

Auditing varies widely between service type and PCT area.

Recommendations

- **Training of Staff**
  - Workforce requires further training and development to ensure that staff are competent and confident in providing advice for HCV and other BBVs.
  - Awareness raising for all professionals has been highlighted as a priority. In the annual HCV report, the HPA lists the professional bodies who endorse awareness raising together with partnership working, professional events and sharing of good practice [HPA 2009b].
  - Brief information packs, alongside training and support for general pharmacy staff may be important particularly in the high volume pharmacies.
  - Ensure that all needle exchange providers receive appropriate training, particularly in relation to injecting techniques, *prior* to providing a needle exchange service.
  - Ensure that pharmacy needle exchange providers receive on-going training and support from a specialist harm reduction provider.
  - Provision of referral pathway information and pro formas for staff including drug service, secondary care staff and GPs, regarding both testing and treatment.
  - There are growing numbers of steroid users accessing both specialist and pharmacy based NSP services. There is a need to;
    - Assess the workforce training needs in relation to this group of IDU.
      - Provide information or training where identified around the management and provision of injecting equipment and harm reduction advice for steroid users.
      - Investigate funding sources for the provision of needles and syringes to steroid users.
      - Assess the public health implications of working with this group.
      - HBV vaccinations should be made available to all staff in contact with high risk groups or potentially contaminated equipment.

- **Data and monitoring**
  - Data collection procedures are inconsistent and analysis of this data is problematic across all service types.
  - Surveillance of all BBV infections requires the integrated and co-ordinated actions to adequately monitor the true incidence and prevalence of BBV in GM to commission services.
  - Local analysis of injecting groups and their needs is urgently required alongside evaluations of effectiveness of both specialist and pharmacy exchange schemes.
  - Establish a monitoring programme and data collection tools/databases to measure testing, training, referral and client groups within NSP and drug services.
  - Development of a GM HCV Database for all professionals working with high risk groups.

- **NSP Coverage**
Based on the estimates of injecting PDU/IDU in GM and the analysed activity data, there is a sub-optimum level of syringe and needle coverage across the area. There is no accepted or standard definition of NSP coverage.

NICE guidance recommends (NICE, 2009) that local DA(A)Ts and PCTs consult with people who inject drugs and others in the local community to assess the need for, and the planning of, NSPs. In particular, the consultation needs to identify potentially inadequate provision in relation to site, situation or occasion, and type of IDUs (e.g. hostels, out of hours, commercial sex workers); this is in accordance with the Department of Health (DH) HCV strategy and action plan (Department of Health, 2002 and 2004). Prevention efforts may need to be intensified, and that local PCTs may need to review their local harm reduction services.

In line with NICE guidance (NICE, 2009) local PCTs and DA(A)Ts need to commission services in relation to the level of risk (such as disease prevalence, number of PDUs and IDUs) of their services.

There is a need to increase local needle and syringe services in order ensure access and availability to sterile injecting equipment and to increase the proportion of injectors who receive 100 per cent coverage of sterile injecting equipment in relation to their injecting frequency.

- Need to investigate gaps in provision by geographic area within each PCT. Drug services offer the ideal location to offer more NSP provision in most PCT areas and would be able to provide Level 2 care (NICE).
- There is a clear shortfall in the provision of out of-hours needle exchange. Consideration should be given to developing new methods of delivering equipment, either by piloting automated dispensing facilities or by generating greater coverage of GM through the recruitment of additional pharmacy services.
- There should be no arbitrary limit set on the number of syringes/packs distributed.

Work with user groups and pharmacy working group to develop strategies for improved overall levels and consistency of penetration into this population. This should also include work to increase the uptake of needle exchange services in harder to engage groups such as BME and female IDU.

Few DATs reported targeting specific populations of injectors through the allocation of specific resources or dedicated workers. Homeless injectors, female injectors, sex workers, stimulant or steroid injectors service provision needs to be assessed.

Improve the quality of NSP service. Renegotiate service contracts/service level agreements to monitor performance including fulfilling mandatory training requirements for NSP staff. Commission a mix of generic and targeted NSPs; also introduce a tiered level of service linked to cost.

**NSP- Integration of services**

- Needle exchanges/drug services need to provide or ensure access to a range of other services including HBV vaccination, referral to opiate substitute therapy and BBV testing. Referral for HCV treatment should be provided in drugs services offering diagnostic testing services. Local services need to provide a comprehensive intervention so that those offering substance misuse treatment also provide access to needle exchange and those providing sterile injecting equipment facilitate entry into substance misuse treatment.
- Ensure that harm reduction and treatment options information/advice are available to these clients to maximise the opportunity of signposting into...
structured treatment, including options for early onsite brief motivational interventions.

- Improve integration between needle exchange and other local services, by arranging on-site access to primary care sessions, wound clinics, nutritional advice and housing, social welfare or legal advice where possible.
- Reduce barriers to accessing BBV testing and immunisation services, by making such services available through needle exchange facilities.

**OST**
- Increase numbers in treatment by increasing the available treatment service delivery sites. This will include shared care provision, satellite, outreach and mobile models of working, as well as targeting specific groups and services such as women only prescribing clinics and “migrant worker” targeted outreach services. Flexible opening times are required, alongside a range of “out of hours” availability. Encourage NSP provision in line with NICE recommendations.

**Contraception**
- Increase number of outlets that supply/distribute free contraception including condom distribution to this at risk group.

**Health Promotion**
- Increase number of outlets that supply/distribute health promotion and education (leaflets etc.) to this at risk group. Include these in ‘pharmacy’ NSP packs

**Testing**
- All services (especially specialist drug clinics and low threshold agencies) in regular contact with IDUs and high risk groups need to increase the frequency of BBV diagnostic testing among their service users.
- Case finding strategies should be employed in line with current guidance.
- Dry blood spot testing to be offered where appropriate.
- Establish guidelines on frequency of test/re testing.
- Any increase in testing should be mirrored by an increase in treatment capacity.

**Treatment services**
- Increase treatment services to match current demand and commission for future demands using estimate modelling
  - Waiting times should be reduced from the current level to the 18 week target
  - Investigate other non-acute settings for treatment services
  - Integrated clinical care pathways for treatment services
  - Improve staff training for referral guidelines
  - Improve data collection for all service types for referrals

**Development of standards and guidelines**
- In co-ordination with all stakeholders and partners, develop standards for IDUs to enter drug treatment services and needle exchange services in GM. Different standards may be required for specialist drug services, pharmacy, and other potential NSP sites i.e. A&E exchanges, police custody suites and mobile distributors.
- In co-ordination with all stakeholders and partners develop guidelines regarding paraphernalia distribution in GM, and put in place mechanisms to ensure compliance with the guidelines by PCT Boards/LA.
- Introduce standards and guidelines to improve the volume /quality of data collected about service users across all service types. Currently it is not possible to accurately measure service provision in terms of capacity or effectiveness. In order to improve BBV prevention services in GM it must be
possible to monitor and evaluate service provision. It is recommended that a system should be introduced where a minimum dataset of service activity and service user information is reported to the HCV prevention strategy lead. Routinely collected data must then be routinely analysed.

- **Research and audit**
  - Systematic updates of the literature and evidence base together with dissemination are important parts of service improvement.
  - Updating the JSNA, HEA and needs assessments are essential actions to ensure the success of any interventions and continued action against the objectives of the GMHCVS.
  - Audit against standards, practice and guidance should be encouraged for all services.
  - Research and development in line with the gaps of the local, national and international evidence base should be through multi-disciplinary partnership work. Priorities should be discussed in an open forum. Professionals with a research track record should be encouraged to work together to apply for funding from national and international bodies e.g. National Institute of Health Research, Department of Health, Medical Research Council and the European Commission.
  - Ideas for research from this JSNA using the current evidence base include:
    - What is the true prevalence of HCV in GM?
    - What are the barriers to current IDUs gaining access to drug treatment and harm reduction services especially new initiates in GM?
    - How can testing in high risk groups in GM be increased?
    - What settings outside of the acute sector are appropriate for HCV treatment?
    - What is the best method to collect and analyse the core data needs for commissioning services, providing services and surveillance for patients with HCV or at high risk of developing HCV?

**Conclusion**

There is a vast evidence base in the peer-reviewed literature for the primary, secondary and tertiary prevention of HCV. It is imperative to formulate an evidence-based, holistic, integrated, seamless GM prevention strategy for the prevention of HCV with locality based interventions.

The undiagnosed population with HCV remains a high priority for public health and policy makers. Though other high risk groups are important, the burden of the illness remains with the IDUs and ex-IDUs. Therefore, for greatest gains in population health, primary prevention for the IDU population requires urgent intervention. Targeted secondary prevention interventions through case finding require different strategies to encompass all high risk groups. Again, the IDU and ex-IDU populations should be highlighted as priority groups to tackle the prevalence pool effectively and efficiently. Once diagnosed, an increase in treatment centres, referral pathways and follow-up is essential for tertiary prevention. Staff training and systematic data collection including a GM HCV database have been highlighted as major recommendations. JSNA updates, audit and research are highlighted as priority areas to ensure the GMHCVS actions are successful, clinically effective and cost efficient.

It is difficult to accurately estimate the true prevalence of HCV in GM from this JSNA, however estimates from modelling can help with commissioning and planning of services.
The current picture, service provision and views have been obtained through a rigorous, systematic, validated and high quality data collection of current service providers in GM.

The JSNA has provided evidence based recommendations to address unmet need for the prevention of HCV in GM. It is vital for each PCT to validate the data and recommendations set out in the JSNA core and PCT files.

**Consequences of no action**

Treatment costs may appear to be large. If these costs are compared to the costs of not treating, the quality of life and mortality from untreated or undiagnosed chronic HCV infection, the initial costs are significantly less. “No action” is not an option in order for GM to follow DH and HPA guidance.

Therefore, the strengths of the GMHCVS lies in the co-ordinated, multi-disciplinary approach. It is essential for the Strategy aims and work programme to continue to help in the prevention of HCV in GM. We hope the JSNA helps in determining the true need and recommendations to achieve health gain and well being for the population of GM.

**Action Plan**

- The JSNA reports have been sent for external evaluation
- All associated documents and the JSNAs will be circulated to all PCTs for comment and revision.
- The recommendations will then be prioritised for GM and each PCT.
- The amended reports will be sent for external peer-review and internal scrutiny.
- The findings will be incorporated into the GM BBV Prevention Strategy (NHS Manchester) for a stakeholder event.
For further information please contact
Siobhan Fahey, Programme Manager,
The Greater Manchester Hepatitis C Strategy
siobhan.fahey@hmr.nhs.uk

www.gmhepc.com