Greater Manchester Blood Borne Virus Strategy

Endorsed by Greater Manchester Director of Public Health Meeting 3rd December 2010
Table of contents

Table of contents ........................................................................................................... 2

1. Introduction .................................................................................................................. 3
   1.1. Vision .................................................................................................................. 3
   1.2. Strategic alignment ............................................................................................... 4
   1.3. National policy ...................................................................................................... 4
   1.4. Local Policy ......................................................................................................... 5
   1.5. Impact of BBVs ..................................................................................................... 5
   1.6. Best practice ......................................................................................................... 7

2. Where we are now? ....................................................................................................... 8
   2.1. Introduction to Needs Assessments and health equity audit for GM .......... 8
   2.2. Gaps in service provision .................................................................................... 9
   2.3. Recent initiatives ............................................................................................... 12

3. Reaching the vision ...................................................................................................... 13

4. How do we get there: recommendations for high risk groups .................. 13
   4.1. Active IDUs ......................................................................................................... 14
   4.2. Former IDUs ....................................................................................................... 20
   4.3. Non-injecting drug users ..................................................................................... 20
   4.4. Sexual Health ..................................................................................................... 20
   4.5. Babies, children and young people ................................................................... 21
   4.6. Ethnic minorities ............................................................................................... 21
   4.7. Occupational groups .......................................................................................... 21
   4.8. Prisoners ............................................................................................................. 22
   4.9. Contact sports ..................................................................................................... 22
   4.10. All service providers ......................................................................................... 23

5. Possible implementation plan for the recommendations Error! Bookmark not defined.

6. Horizon Scanning ...................................................................................................... 25

7. References ................................................................................................................... 25

8. Appendices ................................................................................................................... 26
   8.1. Levels of evidence and grades of recommendations ........................................ 26
Introduction

Blood borne viruses (BBV) provide a challenge to prevention services, not just for the nature of the viruses in question, but because of the lifestyle and behaviours associated with the main routes of transmission. Predominantly, individuals are exposed to the viruses through sexual behaviour and drug use. For the purpose of this strategy, we are focussing on Human Immune-deficiency Virus (HIV), Hepatitis B (HBV), and Hepatitis C (HCV). All three viruses have overlapping prevention recommendations, and where co-infection occurs, have implications on treatment.

Greater Manchester (GM) is made up of 10 diverse PCT areas, with a population of over 2.5 million and high concentrations of groups at high risk of BBVs. The majority of BBV infections in GM are HCV and the majority of these infections are attributed to the sharing of contaminated injecting equipment by injecting drug users (IDUs). The GM population is at increased risk of exposure to BBVs through sexual behaviour due to the concentration of several high risk groups, including: sex workers and their clients; a large population of men who have sex with men (MSM); and one of the largest student populations in Europe. The high numbers of people born in countries with high BBV prevalence now living in GM, results in a large population of hard-to-reach people with an increased risk of already having been exposed to BBVs. Individuals who regularly come into contact with blood or blood products are also at a higher risk of BBV infection than the general population. This can occur through unlicensed body piercing and tattoo practice, occupational exposure, healthcare related exposure, vertical transmission in pregnancy, and contact sports.

The GM Hepatitis C Strategy (GMHCVS) recognises the need for an integrated, city-wide BBV prevention strategy. To inform the BBV prevention strategy, GMHCVS has commissioned a number of needs assessments and equity audit. The aim of all the projects was to provide information on specific evidence based recommendations and identify the current gaps in service provision to inform the service redesign.

Hospital admission episodes for hepatitis C related disease are increasing year on year (31.2% change from 05-07 in GM) with an associated rise in mortality associated with HCV. At a time when resources are increasingly stretched and competition for funding is high, the need to deliver low cost evidenced based interventions for prevention of BBV infection has never been greater.

To maximise the impact of this strategy and to ensure both short-term and long-term health gain in the population, both primary (preventing incident infections) and secondary prevention (diagnosing those already infected) must be achieved.

Vision

The GMHCVS has been successful in bringing together all key stakeholders responsible for the prevention of BBV in GM including patient and public involvement.

Our mission statement is:-

The prevention of BBVs in the GM health economy will be achieved through multiagency collaboration. Our aim is to provide and deliver a comprehensive, integrated, equitable and cost effective approach to the prevention of BBVs across GM. Reducing the number of new BBV infections in GM will be achieved through a range of targeted primary and secondary evidence-based interventions.
Although there are few specific targets for BBV prevention, many of the Department of Health’s ‘vital signs’ are significantly and adversely effected by increases in BBV infection rates. Increased hospital admissions associated with increased morbidity from liver disease alongside increased mortality are the problems of failing to address this issue. GM is a progressive and diverse area, attracting businesses, tourists, students and professionals, choosing to live, work and visit the area. It is in keeping with this aspiration that BBV prevention will be embraced as a shared vision of universal training and awareness, starting in Sex and Relationship Education (SRE) and Personal Health and Social Education (PHSE) programmes and supported in Healthy Schools Teams. These will specifically target excluded children, looked after children and young offenders, then progress to the wider population via the training of health and social care workers and awareness raising programmes including the use of social networking sites.

To reduce BBVs in GM we need to deliver effective, equitable and value for money NSPs and opiate substitute therapy (OST) within NICE guidance. This includes delivering best practice procedures, maximising coverage and improving access for IDUs. Sexual health services and other service providers need to be engaged in BBV prevention including effective condom distribution, ensuring access to HIV and hepatitis testing with rapid results with referral to an evidence-based patient pathway. The delivery of effective HBV vaccination programmes to ALL identified risk groups including occupational and sports related exposure. This strategy is aimed at community based interventions excluding infection control, occupational health, renal patients and antenatal HBV screening which are all covered in other strategy documents.

**Strategic alignment**

This strategy should be considered with and used in conjunction with a number of existing local, regional and national policies, guidelines and strategies. These policies are listed in sections 1.3 and 1.4. The strategic partnership role is essential in ensuring the dissemination of information, training and raising awareness. The agreement of all 10 DAATs and PCTs across GM to promote a consistent approach to prevention, including testing policies and procedures, will be crucial to the intervention with PDUs who make up to 70-90% of HCV cases in GM. This will be linked to National Standards and best practice through the NTA. The alignment of this strategy with the Sexual Health Strategy for Greater Manchester will link harm reduction messages for the wider BBV prevention target groups including MSM, sex workers, BME groups and young people. BBV prevention cuts across different domains of commissioning including specialist commissioning, drugs and alcohol teams (DAATs), public health and infectious diseases. There is also a role of primary care commissioning in testing services and pharmacy provision of needle exchange and observed supervised administration of opiate substitute medication. To be able to achieve the vision, joint commissioning through the GMHCVS is essential.

**National policy**

Several National strategies in relation to BBV prevention have been published in the last decade with one of the most important milestones in the response in England to the HIV epidemic being the publication in 2001 of the *National Strategy on Sexual Health and HIV*. This document, the result of extensive consultation within the sector and affected communities, resulted in significant advances in an effective national response to HIV. Correspondingly the publication of *Getting Ahead of the Curve: a Strategy for Combating Infectious Diseases* in 2002, set out an infectious disease strategy for HCV, HBV and Approved 3rd December 2010
HIV for England. More recently, the publication of *Hepatitis C: Action Plan for England* in 2004, which implements the *Hepatitis C Strategy for England*, has been key in implementing a series of guidelines and updated policy within the National Health Service.

Five key documents were published during 2009 relating to future policy development and implementation on the prevention BBVs; all of which focussed on HCV. In January 2009, the All Party Parliamentary Hepatology Group (APPHG) released their report: *Divided Nations: Tackling the Hepatitis C Challenge Across the UK*. The report focused on the different approaches that England, Scotland and Wales have taken in tackling HCV. In February 2009, the UK Advisory Council on the Misuse of Drugs (ACMD) published its report: *The Primary Prevention of Hepatitis C Among Injecting Drug Users*. This report focuses on interventions aiming at preventing HCV transmission. Also in February, the National Institute for Health and Clinical Excellence (NICE) published guidance entitled: *Needle and syringe programmes: providing people who inject drugs with injecting equipment*. The report *Hepatitis C: Out of Control* released in July 2009 describes wide variation in SHA performance in the implementation of the Action Plan. Finally, in August 2009, NHS Scotland published the report: *Educational interventions to prevent hepatitis C: A review of the literature and published opinion*. This report presents the findings of a review of literature on educational interventions which may be effective in preventing the transmission of the HCV among IDUs or those who are at risk of injecting.

**Local Policy**

During the consultation period we will request all stakeholders to provide information to enable the accurate completion of this section.

Existing local policies include: sexual health, infection control, drug treatment plans, HIV, HBV and HCV strategies for each PCT. Greater Manchester Sexual Health Network also requires input.

**Impact of BBVs**

**Current impact of BBVs**

There is an upward trend in the number of HIV and HCV diagnoses in GM, whilst the number of HBV diagnoses remains relatively stable (figure 1). It is important to emphasise that these data illustrate the number of diagnoses of HBV and HIV occurring in GM rather than the number of incident infections. It is also important to note that the HCV data are based upon hospital episodes and therefore do not relate to diagnoses and may include the same individual several times. Estimating the incidence and prevalence of BBVs raises several methodological difficulties, resulting in great uncertainty see GM JSNA and Manchester HCNA).
Impact of low HBV immunisation coverage
At present there is no immunisation against HIV or HCV. Low levels of immunisation against HBV remain a risk due to the erratic levels of contact with the high risk groups of sex workers and PDU's. There are three specific risks to low levels of immunisation; firstly, the potential for transferring the virus within situations where a risk of an outbreak is higher, secondly; the clinical governance risk of failing to protect an individual where a clear method of prevention is available. This could lead to personal litigation and accusations of 'professional neglect'. A third risk is that of increasing prevalence of HBV co-infection with HIV or HCV thus impacting upon treatment cost, effectiveness and outcomes.

Future impact of BBVs
Figure 2 illustrates the projected number of diagnoses of BBVs in GM between 2007 and 2015, by using the data presented in figure 1 as predictors of trend. The percentage change between 2005 and 2006 extrapolated to subsequent years until 2015. These figures are not comparable to the true data from 2007-2009 due to baseline, changes in diagnostic criteria and increased awareness. The model is for estimation only.
Figure 2. Projected number of HIV and HBV laboratory reports (incident cases) and number of persons with 1 or more episodes of HCV (all diagnoses, hospital admissions) in Greater Manchester 2007-2015

**Best practice**

The prevention of BBVs is a challenging and important aspect of public health. Success in this field often relies upon partnership working, collaboration and effective communication. Two examples of best practice in the UK are found in Knowsley and Bradford.

- Knowsley provides a home outreach service comprising of nurses and outreach workers. The service is a partnership between the Lighthouse Project (the community drug services provider) and Knowsley PCT. The nurses have a general nursing background and have experience of working with drug misusers. The outreach workers and nurses visit clients in their homes and deliver a range of harm reduction interventions including blood-borne virus testing, HBV vaccination, wound care and safer injecting advice.

This outreach serves both to provide interventions to clients who are unable to attend the fixed-site harm reduction services, and to encourage people who are resistant to come into the fixed site services to attend these services in the future and benefit from the full range of harm reduction interventions available.

Some partnerships perceived harm reduction as a partnership venture with primary care and emphasised the necessity of strong links between drug services and primary care services. In addition to drug-specific harm reduction services, some services also gave sexual heath advice and a few services had links to genitourinary medicine (GUM) clinics.

- The local drug partnership in Bradford set up a comprehensive harm reduction database, which has a full range of information on clients, from pharmacy and specialist needle exchange services.
Harm reduction services collect a range of client data as well as asking the client for a password, which enables staff to identify their records on the database on each visit. Data collected includes personal client information (e.g. date of birth, postcode area and ethnicity) and the injecting equipment and paraphernalia they receive and return.

Recording the client's drug of choice enables treatment staff to monitor whether clients are being given the right equipment. Information recorded on the distribution of paraphernalia can be used to check if enough is being given out to reduce the risk of blood-borne viruses.

The database is live, so once the data is uploaded, drug service staff across the city have access to it. The database allows client tracking across the local treatment system and makes a range of information available so clients, reducing the need for clients to be asked the same questions repeatedly, as well as prompting staff to current issues relating to that client, such as vaccination schedules and health problems).

Where we are now?

*Introduction to Needs Assessments and health equity audit for GM*

From 2007 onwards a series of needs assessments for BBV Prevention or HCV Prevention have been conducted by the Blood Borne Virus Research Team (BBVRT) which is part of the Manchester Urban Collaboration on Health in the Manchester Academic Health Sciences Centre at the University of Manchester.

The Joint Strategic Needs Assessment (JSNA) for HCV prevention for GM, HCV Health Equity Audit (HEA), GM HCV Teaching and Training Needs Assessments and were commissioned by the Greater Manchester Hepatitis C Strategy (GMHCVS). The Healthcare Needs Assessment for BBV prevention in Manchester was commissioned by Manchester City Council Drug and Alcohol Strategy Team (DAST).

Each document (where appropriate) sets out the policy context and then details the current service provision situation followed by an analysis of local data. Each also provides a series of recommendations which are 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.

*GM HCV JSNA*

- Acts as a baseline reference document. Split into a core (all GM) and one for each PCT area.
- Needs assessment of service provision for HCV.

*GM HCV HEA*

- The current issues for GM concerning access to HCV services.

*GM HCV Teaching and Training Needs Assessments*

- Needs assessment for all professionals working with patients with HCV and prevention services.
- Needs assessments for specialist nurses and consultants.
Manchester BBV HCNA

- The original health care needs assessment provided a baseline of current service provision, a detailed review of the literature and evidence based recommendations for the prevention of BBV in Manchester.

Gaps in service provision

The various need assessments and HEA (detailed above) identified the following gaps in service, which have been grouped into key provision areas. These areas are: overall service provision; primary prevention; secondary prevention; data collection and audit; and training.

Overall Service Provision

The majority of the 10 PCT areas across GM have poor provision of voluntary services.

Primary prevention

1. Needle and Syringe Program

- Needle coverage varies significantly across the 10 PCT areas of GM. 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 many of the PCT areas.

- Needle and Syringe Program (NSP) provision (number and tier) varies by PCT area. This is not correlated to need and results in inequitable access for users.

- There is clustering of NSP service providers within many PCTs. There are distinct pockets of deprivation with no coverage which results in inequitable access for users.

- The NSP provision varies in service time offered by PCT area with decreased provision in services open and reduced hours at weekends. There is a clear shortfall in the provision of out of-hours NSP across GM.

- Not all services that could potentially offer higher tier NSP provision do so (drug service bases).

- The number of needles, syringes and other paraphernalia is not correlated to the services estimates on service user numbers.

- Not all NSPs distribute paraphernalia (filters, spoons).

- Many pharmacists are unaware of constituents of the NSP packs and what is required by their clients.

- Seasonal variation in NSP uptake is not accounted for in the literature and impacts upon coverage estimates.

- There are inequalities relating to gender and age with less females and younger IDUs accessing NSP services than expected.

- There is evidence of increasing numbers of PEIDs accessing NSP across GM which varies by PCT area.
• A lack of National guidance on the provision of silver foil for promoting the move from injecting to smoking heroin makes it difficult to implement consistently across GM due to differing governance arrangements and interpretation of professional accountability.

2. OST provision
• Unmet treatment needs for OST varies considerably across the 10 PCT areas.
• The analysis has identified clear evidence of inequalities relating to gender and age with less males and younger clients accessing OST treatment than expected.
• There is variance in the availability (with regard to hours/ number of services) of pharmacies providers of supervised consumption, LES/NES clinics and drug services across GM in relation to need.

3. Health Promotion
• Health promotion is not conducted by all services that provide care or provision for those at risk of BBV
• There is a lack of provision of free condoms across many services that provide care for those at risk of BBV.

4. Immunisation
• On average 65% of patients completed HBV vaccination programmes in services across Manchester

5. Information, education and support
• There is a clear need for increased/improved service user advice, support and information to improve services across GM

Secondary prevention (BBV testing)
• There is a large variation in the number of samples taken for HCV testing between PCTs areas which are not related to modelled estimates for those at risk.
• Many services do not record the number of individuals tested for BBV
• Due to conflicting guidance for different professional groups, many service types will offer testing for one BBV and not the others.
• Not all expected services offer BBV testing (drug services, GP and sexual health clinics).
• There are low numbers of HCV tests been performed in prisons.
• Referrals for HCV testing are made to and from a number of sources, with some services making referrals to inappropriate destinations and referring patients onwards when they should be conducting testing themselves (GPs, drug services, sexual health clinics).
• There is a clear lack of staff training around BBV testing, pre and post test discussions in many services across GM.

Approved 3rd December 2010
• There is clear evidence of inequities with regard to ethnicity with fewer numbers of White ethnicity accessing testing than expected across GM.

• Pre and post test discussion/counselling is not always offered for BBV testing. This is a missed opportunity for secondary prevention and public health interventions.

• Few services offer out of hours (including weekend), outreach or on call provision. This results in clear inequities for those wishing to access testing services.

• Limited awareness of services and a lack of provision in non deprived areas may limit access to testing by non-IDU at risk groups.

• There is some evidence that targeted testing of those from an Asian background is proving successful in identifying those from other risk groups that are not in contact with drug services needs to be expanded (ex-IDUs)

**Data collection and Auditing**

• There is a lack of reliable, usable, linked and validated epidemiological data for BBVs. This includes an accurate estimate of HCV incidence/prevalence in GM.

• There is a clear paucity of data on service users with data been either unavailable within services or unreliable.

• There is a clear lack of data regarding service provision with data on NSP and testing activity been scarce.

• Monitoring and current data collection methods vary by service/within services and are often not been delivered consistently.

• Auditing of service provision varies widely between service type and PCT area across GM

6. **Effectiveness and cost effectiveness of service**

• Only a small proportion of service providers are evaluated for effectiveness /medical outcomes.

• There is a lack of awareness within services on their annual budgets and service costs.

**Training**

• Provision of training in BBV is inconsistent both across services and PCT areas in GM.

• Staff training was identified as a need by a large proportion of services in all PCTs.

• A lack of training was felt to be the most prominent factor in preventing improvements to the service provision around HCV and BBV

• There are very limited formal and informal training packages for professionals working in the field of BBV around testing health promotion, vaccination and policies
• The majority of training that is delivered is not accredited, externally validated, assessed or fully evaluated and has a limited use of the current evidence base
• Where training is been delivered, it is often without adequate resources
• Staff wish to access training across all services

Recent initiatives
There are several ongoing and recently completed initiatives in Greater Manchester related to the prevention of BBVs. Many of these initiatives were driven by the Greater Manchester Hepatitis C Strategy. These projects include:

• The appointment of prison nurses with a direct role in BBV and infection control.
• The appointment of a Registered Nurse to deliver HBV vaccination, testing for BBVs and support to other nurses delivering the same interventions in Manchester services. This is a pilot programme targeting the current gaps in service provision.
• Awareness raising (films and communications).
• Hepatitis C training for healthcare professionals and voluntary sector staff (Manchester Community Health). This training is delivered with support from service users who have undergone treatment for HCV using a co-production approach to training delivery (expert patient).
• Dried blood spot testing to facilitate BBV testing of patients with poor venous access
• Service redesign project which aims to reduce the number of undiagnosed infections and increase the numbers receiving antiviral treatment
• Peer support groups
• Hepatitis C case-finding pilot study
Reaching the vision
There are nine key objectives which must be achieved in order to fulfil the aims and the vision of this strategy. These objectives are:

- **Produce mandatory training packages for those who work directly with the following risk groups:**
  - Injecting drug users
  - Sex workers
  - Men who have sex with men

Also, to make available, training packages for those who work directly with the following risk groups:
  - People from countries of high prevalence
  - Vulnerable children and young people

- Ensure agencies working with identified risk groups provide and deliver health promotion and health protection against all BBVs.

- Promote the use of targeted prevention tools when working with young people.

- Ensure occupational exposure procedures are in place with clear written and accessible policies for immunisation against HBV, appropriate access to testing and PEP.

- Ensure NSP and OST provision is within NICE guidance and planned with the available local HCNA evidence.

- Make available guidance and policies for working with young people who require NSP services.

- Ensure through service level agreements the requirement of a minimum data set captured by ALL relevant service providers to facilitate service based clinical governance procedures, (i.e. audit) monitoring and research.

- Ensure a reduction of inequalities and inequities to promote ease of access into services.

- Further engagement of prisons within all aspects of the BBV prevention strategy via the GMHCVS Prison Task and Finish Group.

To fulfil these objectives and reach the vision outlined in the strategy, there a series of recommendations have been produced. The recommendations, outlined in the following section, are specific to local need and are based upon the available evidence in the published literature, national guidance expert opinion and best practice.

How do we get there: recommendations for high risk groups
Each recommendation is followed by a grade (A-D). These grades refer to the level of evidence supporting the intervention, in terms of quality and volume. The classification system can be found in Appendix 8.1 and is based upon Harbour and Miller’s grading system. In addition, NICE have produced specific guidance for NSPs (Needle and syringe programmes: providing people who inject drugs with injecting equipment). Where
a recommendation in this strategy relates to implementing this guidance it will be followed by NICE.

**Active IDUs**
For the recommendations of this strategy, active IDUs are considered in three subcategories: active IDUs accessing NSPs; PIEDs; and active IDUs not accessing NSPs.

**Active IDUs accessing NSPs**
The recommendations specific to active IDUs accessing NSPs are outlined in the following 12 subsections.

7. **Data and monitoring**
- Conduct commissioning and NSP delivery audits to identify areas of non-compliance with NICE Public Health Guidance 18. **NICE**
- Introduce standards and guidelines to improve the volume/quality of data collected about service users and service provision. 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. **D**
- In co-ordination with all stakeholders and partners, develop standards for IDUs to enter drug treatment services in GM. These standards should ensure that there is ease of access for IDUs into drug treatment services. 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. **D**
- 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. **D**
- Service providers should have a minimum dataset of service activity and service user information. **D**
- Routinely collected data must then be routinely analysed. This function should be coordinated by the GMHCVS Prevention sub-group. Annual reports should be produced to monitor progress and be disseminated locally and to the SHA and NTA. **D**

8. **Improve the coverage of NSP**
Increase NSP provider numbers:

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. Also, GM should generate greater NSP coverage by PCT areas through the recruitment of additional pharmacy services/drug services.

- 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/drug services to deliver NSP. **NICE**
- 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**

Approved 3rd December 2010
Increase NSP provision types:

- NSPs provision could also be delivered through more outreach/mobile services, police custody suites, walk-in centres and accident and emergency departments. NICE

Increase hours of NSP service delivery:

- Coordinate services to ensure injecting equipment is available throughout the PCT area for a significant time during any 24-hour period. Commissioners could also consider providing NSPs through community pharmacies that operate extended opening hours. Weekend coverage (particularly Sunday) needs to be extended both in terms of hours and number of services. This provision needs to provide equitable access across the PCT area with weekend coverage in a range of localities. This should include 24 hour access in key locations and new services in areas with low coverage. Meet the standards outlined in NICE guidance. NICE

Redistribution of NSP services:

- Areas of deprivation should be prioritised for drug-related services, but this should not be the sole consideration, transport and clustering of services needs to be taken into account as well as new emerging NSP user groups. NICE

All NSP services should provide injecting paraphernalia:

- There should be no arbitrary limit set on the number of syringes/packs distributed. NICE

- 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. D

9. **Improve the quality of NSP service**

Commission a mix of generic and targeted NSPs:

- NICE guidance recommends 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 HCV strategy\(^3\) and action plan\(^4\). NICE

- To meet local need within an PCT targeted services focusing on specific groups (for example, younger service users, women and BME) to increase the proportion of people from each group of injecting drug users who are in contact with NSPs need to be developed. This should incorporate work with user groups and pharmacy working group to develop strategies for improved overall levels and consistency of penetration into these populations. NICE

- Identify potential causes of, and address, the inequities for younger and female service users. More data at local levels is required to characterise the barriers for these populations not accessing NSP and to develop appropriate interventions and pathways for this group. NICE

Approved 3\(^{rd}\) December 2010
• Increase the range of services offered by NSP providers. **NICE**

• Ensure all services offering OST (SC pharmacies) also make needles and syringes available to their clients, in line with the NTA ‘Models of care’ (2006). **NICE**

• Ensure all NSP undertake health promotion and staff are trained in this aspect of provision. Ensure that harm reduction and treatment options information/advice are available to these clients to maximise the opportunity of signposting into structured treatment. **NICE**

• Increase access to free condoms. **C**

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

• Reduce barriers to accessing BBV testing and immunisation services, by making such services available through NSP were appropriate. **NICE**

• Encouraging IDUs in contact with services to take all the equipment they need and enable them to take extra to distribute to peers. All services working with IDUs should be promoting the message of ‘Break the cycle’, the campaign to utilise the skills of current IDUs to discourage new users by evidence based peer led interventions. **D**

• All NSPs should provide service users with the knowledge to bleach their injecting equipment using the evidence based approach recommended in the Harm Reduction Works campaign. PCTs, DAATs and harm reduction leads should review the available evidence and discuss the value of providing of ‘bleaching packs’ via NSP services. **D**

10. **NSP: Integration of services**

• NSP/drug services need to provide or ensure access to a range of other services including HBV vaccination, referral to OST and BBV testing. **NICE**

11. **Renegotiate service contracts/service level agreements to monitor performance**

• Services should monitor their performance through establishing a data collection system to measure testing, training, referral and client groups within NSP and drug services. **D**

12. **Training of NSP and SC staff**

• Workforce requires further training and development to ensure that staff are competent and confident in providing advice for HCV and other BBVs. As part of the service level agreement NSP and pharmacy staff must complete training. **D**

• Brief information packs, alongside training and support for general pharmacy staff may be important particularly in the high volume pharmacies. **D**

• Ensure that all NSP providers receive appropriate training, particularly in relation to injecting techniques, prior to providing a NSP. This should be mandatory and enforced through contract monitoring processes. **D**

• Ensure that pharmacy NSP receive on-going training and support from a specialist harm reduction provider. **D**
• Provision of referral pathway information and pro-formas for staff including drug service and NSP staff for testing of BBVs. D

• Brief information packs, alongside training and support for general pharmacy staff may be important particularly in the high volume pharmacies. D

• Update Centre for Pharmacy Postgraduate Education course content on HCV. D

• Harmonisation of Accreditation Group accreditation should be applied to recommended BBV training. D

• Develop GM wide additional training on BBV/ HCV prevention training that is widely available across GM run several times a year with some training delivered out with normal pharmacy hours to enable attendance. This training should be for all pharmacy staff. D

• Ensure all PCTs have a service level agreement that requires mandatory training for all pharmacists (NSP and SC) and strongly recommends training for pharmacy technicians. D

• Services which commission NSP and SC and issue service level agreements should monitor that training has been undertaken and courses passed within a given time frame. D

• HBV vaccinations should be made available to all staff who may have contact with body fluids. A

13. Audit of OST provision against NTA guidance
• Monitor the number of clients being prescribed OST. Review which medications are being prescribed. Review the number of clients in supervised consumption and the duration which they remain in this service. D

• Introduce standards and guidelines to improve the volume/quality of data collected about service users and service provision. Currently it is not possible to accurately measure service provision in terms of capacity or effectiveness. D

• It is recommended that a system should be introduced where a minimum dataset of service activity and service user information Introduce standards and guidelines to improve the volume/quality of data collected about service users and service provision. Currently it is not possible to accurately measure service provision in terms of capacity or effectiveness. D

• Routinely collected data must then be routinely analysed. D

14. Increase OST treatment provider numbers
• In line with NICE guidance 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. NICE

• Increasing the number Locally Enhanced Service clinics/ GP practices offering shared care based on need within each PCT area. This provision should provide equitable access by been distributed across the PCT and associated with areas of high need (geographically – deprived areas). D
• Increase number of GP with Special Interest posts. These developments will enable drug users whose GPs do not participate in Shared Care services to be receive OST treatment in primary care and to provide support and peer supervision for those GPs providing Shared Care. \textbf{D}

• Improve unmet drug treatment (OST) need. \textbf{NICE}

\textbf{15. Increase hours of OST service delivery}
Coordinate services to ensure OST and SC is available throughout the PCT area for a significant time during any 24-hour period. Flexible opening times are required, alongside a range of “out of hours” availability. Commissioners could also consider providing OST SC through community pharmacies that operate extended opening hours. Weekend coverage (particularly Sunday) needs to be extended both in terms of hours and number of services. This provision needs to provide equitable access across the PCT area with weekend coverage in a range of localities. Evening shared care clinics should also be provided to enable greater access to this facility. \textbf{NICE}

\textbf{16. Redistribution of SC services}
Areas of deprivation should be prioritised for SC services, but this should not be the sole consideration, transport and clustering of services needs to be taken into account. \textbf{NICE}

\textbf{17. Improve the quality of OST service}
Commission a mix of generic and targeted OST to meet local need within PCT targeted services focusing on specific groups (for example, younger service users, men and BME, drugs of abuse) to increase the proportion of people from each group of injecting drug users who are ineffective treatment. This should incorporate work with user groups, pharmacy, drug services and LES/NES clinics to develop strategies for improved overall levels and consistency of penetration into these populations. This will include shared care provision, satellite, outreach and mobile models of working, as well as targeting specific groups and services such as prescribing clinics targeting younger groups/ drug types and “migrant worker” targeted outreach services.

• All SC pharmacies should be encouraged to offer NSP provision, health promotion and free condoms. Ensure all services offering OST (SC pharmacies) also make needles and syringes available to their clients, in line with the NTA 'Models of care' (2006). \textbf{NICE}

• Ensure all OST providers undertake health promotion and staff are trained in the BBV and harm reduction aspect of provision. \textbf{D}

• Increase number of outlets that provide condom distribution to this at risk group. \textbf{C}

\textbf{18. Testing}
• All services (especially specialist drug clinics, low threshold agencies and GPs) in regular contact with IDUs need to increase the frequency of BBV diagnostic testing of this group. \textbf{D}

• Dry blood spot testing (DBST) to be offered where appropriate. Where HCV diagnostic testing is offered through DBST methodology, testing for HIV and HBV should also be considered. \textbf{D}

• Introduce a validated, systematic methodology of enhanced case finding in all known high risk groups in line with current guidance. \textbf{C}
Training on risk assessment and indications for HCV testing for all major HCV testing providers (GPs, antenatal clinics, hospitals, drug service staff etc.). D

Increase drug service training of HCV across GM by:

- Providing a series evidence based training packages covering all aspects relating to HCV (referral, treatment, pre, post test discussion, testing, patient care, support). D
- Regular updates and refresher courses, monitor outcomes of training provided. D
- Ensure all staff (both voluntary and paid) have access to training around BBVs. D
- Input more about BBV in harm reduction courses. D
- Pre/post test discussion training for all staff who offer BBV testing. D
- Establish guidelines on frequency of test/re testing. D
- Increase number of outlets that supply/distribute health promotion and education (leaflets etc.) to this at risk group. D
- Increase number of service provides that provide condom distribution to this at risk group. C
- Highlight need for testing younger service users in drug services. D
- Offer testing through other services that at risk groups may access e.g. pharmacies, prisons, hostels and outreach homeless services. D

Performance and Image Enhancing Drug Users (PIEDs)

There are growing numbers of steroid users and other PIEDs 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. D
- Provide information or training where identified around the management and provision of injecting equipment and harm reduction advice for PIEDs. D
- Investigate funding sources for the provision of appropriate needles and syringes to PIEDs. D
- Encourage PIED specialist NSP workers and PIED users to become expert advisors and peer educators respectively. D

Active IDUs not accessing NSPs

- Outreach teams should target injectors including homeless, sex workers and PIEDS for BBV prevention interventions. This should include harm reduction, a referral system and condom provision where appropriate. D
- Offer testing in other services that at risk groups access. Outreach services to improve testing among prisoners/hostels and the homeless would also decrease age inequities in HCV testing that this group experience. D

Approved 3rd December 2010
**Former IDUs**
- **Introduce a systematic methodology of enhanced case finding in all known high risk groups (including former IDUs).** C
- **Training on risk assessment and indications for HCV testing for all major HCV testing providers (GPs, antenatal clinics, hospitals and drug services etc.).** D

Improvements specific to Primary Care training of HCV across GM by:
- Develop evidence based training course that is specific for GPs dealing with potential high risk groups (BME, IDUs and ex-IDUs). D

Educating other healthcare professionals:
- In order to improve awareness and management of HCV in the area it is essential to ensure other healthcare professionals, as well as key people such as, midwives, health visitors and social workers had adequate levels of knowledge so that they could pass on the correct information and help identify those at risk. D
- Use of expert patient models and PCT area ‘champions’ can prove to be effective and value for money when promoting the BBV agenda amongst competing priorities. D

**Non-injecting drug users**
- Very few drug users are likely to have commenced their drug use as injectors; it is most likely that they have been using drugs via other methods of administration. There is an opportunity to target non-injecting drug users with information on BBV risk and potentially deter them from injecting, or, at very least, prepare them better for injecting. D
- There is evidence of BBV transmission via shared use of equipment used for inhaled illegal drugs. The increased risk of bleeding caused by drugs such as cocaine requires a different approach to targeting information and health promotion. D

**Sexual Health**
- Greater efforts are required to identify undiagnosed HCV infections. Introduce a validated, systematic methodology of enhanced case finding in all known high risk groups including MSM, sex workers and their clients. C
- HBV vaccinations should be made available to all staff in contact with body fluids. A
- Training on risk assessment and indications for HCV testing for all HCV testing providers including maternity services, antenatal clinics, hospitals, voluntary sector. D
- Establish a locally relevant course that could be delivered to services to update their staff on HCV and enable them to train the public/clients about HCV. D
- Increase number of outlets that supply/distribute health promotion and education (leaflets etc.) to this at risk group. D
• Outreach teams should target homeless and sex workers for BBV prevention interventions. This should include harm reduction, a referral system and condom provision. Links should be established with where staff have experience of working with vulnerable groups including the homeless population. D

**Babies, children and young people**

Improve the awareness of HCV among all healthcare professionals, including those who come into contact with babies, children and young people. Training should be provided for healthcare professionals, including midwives, health visitors and social workers to ensure adequate levels of knowledge so that they can pass on the correct information and help identify those at risk.

**Ethnic minorities**

• All services (low threshold agencies GPs) in regular contact with those at high risk ethnic status need to increase the frequency of BBV diagnostic testing among their at risk service users. D

• Case finding strategies should be employed in line with current guidance including the Department of Health guidance for hepatitis C testing in primary care.11-14 C

• Increase number of outlets that supply/distribute health promotion and education (leaflets etc.) to this at risk group. D

• Training on risk assessment and indications for HCV testing for all major HCV testing providers including GPs, antenatal clinics, hospitals, voluntary sector. D

• Educating other healthcare professionals: In order to improve awareness and management of HCV in the area it is essential to ensure other healthcare professionals, as well as key people such as, midwives, health visitors and social workers had adequate levels of knowledge so that they could pass on the correct information and help identify those at risk. D

**Occupational groups**

Increase the availability of training for:

• Non-specialised hospital nurses, student nurses and staff/emergency service staff. D

• Including HCV training into the mandatory infection control training. D

• Provide annual more detailed training on HCV as required. D

Develop and introduce a standardised blood borne virus component to training on infection control and the handling of sharps based on a generic template. Ensure this includes a series of key points on BBV to be delivered to any staff member undertaking any exposure prone activity regardless of frequency. This should include:

• Training for all local authority trainers on the developed blood borne virus component and HCV information points. D
• Training for managers on assessing the risk behaviours and relative risks of individuals of being exposed to different types of BBVs. D

• Incorporation of the developed blood borne virus component and key HCV information points within any infection control or sharps training course and materials delivered by councils. D

• An audit of local authority risk assessments for blood borne viruses to assess their quality and consistency between councils. This should include a comparison of those being immunized for HBV and those receiving training for HCV to ensure no discrepancies in risk assessment. D

• An agreed schedule of training updates for existing staff on infection control and the handling of sharps to ensure currency and revision. D

• Develop and introduce a more in depth training course on HCV for housing workers/services. D

• HBV vaccinations should be made available to all staff in contact with high risk groups or potentially contaminated equipment. The PCT immunisation lead should work with the BBV prevention lead to coordinate allocation of resources and develop a strategy. D

Prisoners
• All services in regular contact with IDUs and high risk groups need to increase the frequency of BBV diagnostic testing among their service users. In prisons all prisoners should be assessed and if considered to have been at risk should be tested for BBVs. NICE

• Provide BBV testing for all prisoners at risk. NICE

• Dry blood spot testing to be offered for individuals with poor venous access. C

• Develop and introduce training for all prison staff across GM using the training provided by Buckley Hall Prison as a basis/template. This should include training on risk assessment and indications for HCV testing. D

• Increase the provision of health promotion and education (leaflets etc.) to prisoners. D

• Ensure HBV vaccination is available to all prisoners. B

Contact sports
In some sports there may be a risk that some players or officials could come into contact to with blood. Recommendations for this reflect the low risk and are not intended to dissuade people from participating in these sports but provide information on how to limit risk. The relevant HPA guidance in relation to individuals at risk of exposure to blood spillages will be followed for all at risk through contact sports. This will include, where appropriate, the provision of HBV vaccination.
**All service providers**

Recommendations applicable to all service providers across GM are detailed in the following three subsections: data and monitoring; training of staff; and commissioning.

**Data and Monitoring**

19. **Review data collection methods and improve the usability of recording systems**
   - Provide services with training and systems to improve the consistency of data collection between services and PCTs. This process should be driven and coordinated by GMHCVS. D
   - Ensure all service providers have access to a monitoring/data collection tool that meets PCT and their own requirements. D
   - Training for staff on data collection processes/requirements within their service. D
   - Regular audits should be completed in all services. To facilitate this training for service managers/leads should be provided.
   - **Collation of HCV-related data at a PCT level to assist both PCTs and future audits in identifying inequities and effective commissioning and recommissioning strategies. D**
     - Development of a GM HCV Database for all professionals working with high risk groups, in line with the recommendations of the GMHCVS database scoping report. D

20. **Encourage service providers to collect all relevant demographic data on service users**

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.

   - Minimum data set defined for all HCV service providers. D
   - Commissioners should make it a target or requirement of recommissioning that basic annual audits are undertaken across against standards, practice and guidance should be encouraged for all services by all service providers. D

**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. D

- 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. D
21. **NHS and Community Training Provision**

Development and implementation of a GM coordinated and funded HCV training programme to ensure quality, consistency and access to HCV training for professionals working with individuals living with HCV across sectors and settings in GM. Ideally this should comprise:

- GM training project management ‘Hub’- to ensure full validation and evaluation of courses delivered and that all courses use current evidence based material. D

- Delivery by GM trainers with local trainer involvement. Experienced professional trainers working across GM with a local professional in each PCT/service ‘spoke’. The local trainer would to be agreed and identified by the NHS PCT according to their skill, capacity and links to any local care pathway. Each GM trainer may cover a range of services depending on need. D

- Individualised courses designed around each service need/role to encourage the application of the training received, that are based on professional need. D

- A generic education component on HCV and a local component regarding local epidemiology, care pathway (treatment centres and referral) and patient experience. Including an online core education package for HCV as part of an overall programme of training to widen access across sectors and professions. This package would contain locally relevant information (epidemiology, care pathways and contacts). D

- Courses should be designed to take into account preferred learning styles of participants (visual learners, auditory learners, reading/writing-preference learners or tactile learners). D

- All courses should have links to professional competencies for health care, social care, pharmacy and addiction staff primarily to encourage uptake by a range of professionals and equally to involve professional societies and associations. D

- Effective promotion and advertising across Greater Manchester to encourage uptake. D

- All courses should include evaluation for the application of knowledge gained to determine effectiveness and retention of knowledge. D

- An agreed schedule of training updates to ensure staff knowledge remains current. D

- Regular evaluations, updates and accreditation of the training programme. D

**Commissioning**

An integrated approach to commissioning of services relating to BBV prevention will be developed further in the implementation plan. However, the three following recommendations will be central when drafting the implementation plan:

- Centralised funding for the GM coordinated training programme recommended for NHS and Community staff. D
• Ensure each PCT has sufficient funds has in place to ensure that a Public Health/PCT employee is in place to act as local lead /local trainer with sufficient capacity and skills to support the GM training programme recommended for NHS and Community staff. 

• Provide centralised funding for a Greater Manchester coordinated project to a) standardize risk assessments in relation to BBVs and b) the BBV education provided within infection control and sharps training delivered by councils across GM.

Horizon Scanning

The next five years will have the most unprecedented cuts in the health and social care budgets. Horizon scanning will be difficult due to the current and future changes in the political, health and social care settings.

References


Appendices

*Levels of evidence and grades of recommendations*

**Levels of evidence**

1++ High quality meta-analyses, systematic reviews of RCTs, or RCTs with a very low risk of bias.

1+ Well conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias.

1- Meta-analyses, systematic reviews or RCTs, or RCTs with a high risk of bias.

2++ High quality systematic reviews of case-control or cohort studies or High quality case-control or cohort studies with a very low risk of confounding, bias, or chance and a high probability that the relationship is causal.

2+ Well conducted case-control or cohort studies with a low risk of confounding, bias, or chance and a moderate probability that the relationship is causal.

2- Case-control or cohort studies with a high risk of confounding, bias, or chance and a significant risk that the relationship is not causal.

3 Non-analytic studies, e.g. case reports, case series.

4 Expert opinion.

**Grades of recommendations**

A At least one meta-analysis, systematic review, or RCT rated as 1++ and directly applicable to the target population or A systematic review of RCTs or a body of evidence consisting principally of studies rated as 1+ directly applicable to the target population and demonstrating overall consistency of results.

B A body of evidence including studies rated as 2++ directly applicable to the target population and demonstrating overall consistency of results or Extrapolated evidence from studies rated as 1++ or 1+.

C A body of evidence including studies rated as 2+ directly applicable to the target population and demonstrating overall consistency of results or Extrapolated evidence from studies rated as 2++.

D Evidence level 3 or 4 or Extrapolated evidence from studies rated as 2+.
For further information please contact
Siobhan Fahey, Programme Manager,
The Greater Manchester Hepatitis C Strategy
siobhan.fahey@hmr.nhs.uk

www.gmhepc.com

Approved 3rd December 2010