HCVAction

HCV ACTION SOUTH EAST PRISONS HEPATITIS C GOOD PRACTICE ROADSHOW, 28 NOVEMBER 2019

SUMMARY REPORT

Introduction

On Thursday 28th November, HCV Action and NHS England Health and Justice held the latest in the long-running series of hepatitis C good practice roadshow events. The event brought together a range of health professionals to share best practice in prevention, testing, diagnosis and treatment of hepatitis C, focussing on services to support people in prison in the South East.

The morning of the roadshow featured presentations from a variety of experts and health professionals, from commissioners to nurses, peers to researchers, chaired by Rachel Halford, Chief Executive of The Hepatitis C Trust. Speakers presented from a range of perspectives about the barriers and solutions to providing hepatitis C care in prisons, and there were a number of good practice case studies presented.

Further presentations took place after lunch, followed by a panel discussion offering attendees the opportunity to ask questions. The audience then split into two groups to attend workshops on substance misuse teams in prisons and improving linkage to care in the community. The key points from these workshops were then fed back to the main group before Rachel Halford gave her closing comments and participants were able to network then depart.

Around 80 people attended the roadshow, including clinicians, nurses, drug service workers, prison healthcare staff and project managers. The full set of slides presented by each of the speakers can be found in the HCV Action resource library here.

Agenda

Chair's welcome
Rachel Halford, Chief Executive, The Hepatitis C Trust

Overview and setting the scene
Mark Gillyon-Powell, National Lead Public Health (Secure & Detained), NHS England and NHS Improvement

An ODN perspective
Professor Sumita Verma, Professor of Hepatology, Brighton and Sussex Medical School and Brighton and Sussex University Hospital; and Mucha Marufu, Hepatitis Nurse, Brighton and Sussex University Hospital

Good practice case study presentation 1: Improving opt-out testing
Michelle Storer, former Senior Commissioner and Project Manager, NHS England London Region

Peer support in prisons
Daren Caxton, South East Prison Peer Educator; Caragh Arthur, South East Region Prison Peer Coordinator; and Julia Sheehan, Women's Prisons Peer Coordinator, The Hepatitis C Trust

Good practice presentation 2: Treatment in prisons
Kate Jack, Research Associate and Advanced Virology Nurse Specialist, University of Nottingham and Nottingham University Hospitals NHS Trust

Lunch

HCV Action: Sharing best practice
Noah Froud, HCV Action Secretariat

Good practice presentation 3: Whole prison testing
Rachel Halford, Chief Executive, The Hepatitis C Trust; and Sean Cox, Director of Services, The Hepatitis C Trust

Panel discussion: Hepatitis C elimination in prisons
Q&A with the morning's speakers

Workshops

> **A. Hepatitis C and substance misuse teams in prisons**
> Francis Williams, Regional Head of Nursing (Prison Substance Misuse), Kent and Sheppey Prisons Cluster
>
> **B. Improving linkage to care in the community**
> Janet Catt, Nurse Consultant, King's College Hospital NHS Foundation Trust

Workshop feedback

Closing Comments
Rachel Halford, Chief Executive, The Hepatitis C Trust

Morning presentations

As the opening speaker at the event, Mark Gillyon-Powell, National Lead for Public Health (Secure and Detained) at NHS England / NHS Improvement, stressed the value of accelerated hepatitis C elimination and commented on the cost-effectiveness of initiatives to achieve this, such as incentives for patients to get tested. He emphasised the value of a 'whole team approach', with prison staff, healthcare providers, peers and nurses all working together seamlessly and aiming for an 80% take-up rate for opt-out testing. The talk ended with a call for prison teams to identify what they need and ask for the funds to deliver this.

Following this, Professor Sumita Verma, Sussex ODN Clinical Lead, and Hepatology Clinical Nurse Specialist Mucha Marufu presented on the work of the Sussex ODN to create a new model of care in Brighton. ITTREAT (Integrated Test-stage and TREAT) was developed as a community-based project where a specialist hepatitis nurse was appointed to lead a 'one-stop' holistic hepatitis C service including testing, assessment of liver scarring, education and treatment within a substance misuse service. Sumita and Mucha provided an overview of the challenges and outcomes. HCV Action has published a case study on ITTREAT, accessible here. This presentation also explored some other initiatives Sussex ODN has been piloting, such as the END C Study in Hastings and Eastbourne targeting the homeless population and the Vulnerable Adult Liver Disease (VALID) Study.

Mucha then gave an overview of the project in HMP Lewes, a Category B prison in East Sussex with a population of around 700 men. A hepatology clinic was established in 2010,

holding one three-and-a-half-hour clinic every other week. In 2019, the number of patients treated with DAAs nearly doubled from the year before, from seven in 2018 to 12 in 2019. This has been helped by introducing opt-out DBST at second reception and the governor of the prison agreeing to put patients 'on hold' to restrict transfers while on treatment. The hepatology nurse has also developed good relationships with the prison substance misuse service (provided by the Forward Trust) and sexual health services, both of whom identify and refer new patients to the clinic. The value of training for staff, delivered by The Hepatitis C Trust, and testing and awareness-raising days was also emphasised. To counter the ODN not knowing when patients are being released or transferred, the hepatology team invited the ODN to their monthly Healthcare Operational Meeting and created the role of a 'Hepatitis C Link Nurse'. The aim of the Link Nurse was to improve communication, reduce the burden on prison officers by escorting hepatology nurses on wings, manage patients and clinic lists, act as a direct contact for queries, and reduce did not attends (DNAs) by providing appointment reminders.

Michelle Storer, former NHS England Senior Commissioner and Project Manager in the London region, then presented on the processes that have led to an increase in the take-up of opt-out testing in London. This has included introducing peers, ensuring there are dedicated blood-borne virus nurses in all sites (except Feltham YOI), putting a CQUIN on secondary screening within seven days, collecting data on the number of people not tested, training substance misuse teams to test, and establishing a steering group to manage the programme.

Caragh Arthur, Daren Caxton and Julia Sheehan from The Hepatitis C Trust's prison team talked from their own lived experience of the value of treatment. In particular, they demonstrated the importance of peer support in engaging people in prisons and encouraging them to get tested and treated.

Kate Jack PhD, Advanced Virology Nurse Specialist at Nottingham University Hospitals NHS Trust, spoke about treatment in prisons in the Nottingham area. Nottingham ODN set out various pathways to make it easy for nurses to see what they should be doing with patients and to what timeline. She raised that while the HITT approach of testing whole prison populations intensively had merits, it is also important to adopt a "whole prison approach" if we are to sustain elimination in prisons.

Afternoon presentations

Following an overview of HCV Action's work by Noah Froud, HCV Action Secretariat, there was a panel discussion for all speakers. This focused on testing, specifically on how frequently people should be retested, which Mark Gillyon-Powell stipulated as being around every 12 months unless the clinician suspects the patient has been exposed to risk factors in the meantime. The panel also stressed the importance of language when asking people whether they would like a test on first screening: Mark suggested that clinicians put forward the question as "we are going to do this" rather than "is this ok" (which is more of an opt-in than an opt-out approach). Rachel Halford highlighted that even when prisons have micro-eliminated there will still be a need to maintain testing for HIV and hepatitis B as well. There were also questions about access to prisons for peers, which Mark said he would work hard to remove as a barrier if informed of specific issues.

Rachel Halford, Chief Executive, and Sean Cox, Director of Prison Services, both from The Hepatitis C Trust, then described the lessons that had been learnt from recent whole-prison testing days. Specifically, these included the importance of communication and good relationships with governors and prison officers; HITT working groups being very useful; the effectiveness of incentives to receive testing such as fruit or chocolate; and the value of nurses in supporting events.

Finally, attendees split up into two separate interactive workshops. Francis Williams, Regional Head of Nursing at Kent and Sheppey Prisons Cluster, ran a breakout session specifically focused on how substance misuse teams in prisons can work to promote testing, while Janet Catt, Nurse Consultant at King's College Hospital, ran a session on achieving sustained virologic response (SVR) if a resident is released part way through treatment.

Workshop A: Hepatitis C and substance misuse in prisons

Francis presented on barriers and solutions to providing hepatitis C care in substance misuse teams in prisons. In particular, Francis outlined problems such as staffing shortages and short sentences, but also issues around patient engagement. He noted that people might be reluctant to get tested because, for most people linked into substance misuse teams, getting opioid substitution therapy (OST) takes precedence over screening in the very busy first few days in prison. Possible solutions might involve booking people onto secondary screening if they are unable to attend initial testing.

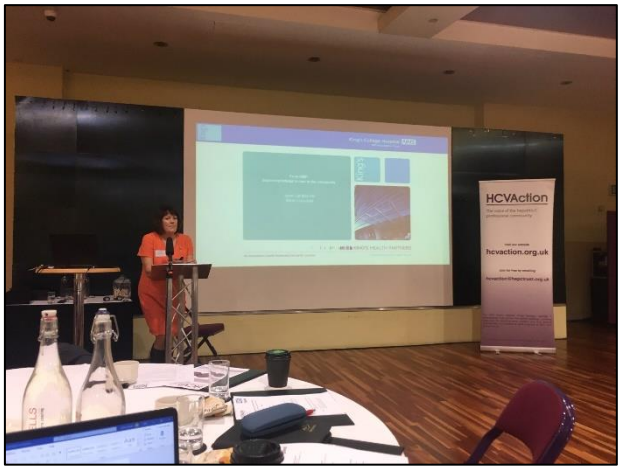
Francis raised that people may have been tested or treated previously and so either not want to go through the process again or think that they cannot get re-infected with hepatitis C. The workshop group discussed the importance of putting the case forward for people to take agency over their health and the role peers can play in engaging patients. The way treatment was offered was seen to be crucial, and there was some debate over the importance of being honest about the possible symptoms of DAA treatment while making it clear that they work in a completely different way to interferon-based treatment and many people have no adverse side-effects.

The group discussed the relationship between healthcare and substance misuse teams and the importance of linking the latter in to the former, particularly if substance misuse teams were aware of behaviours that might put patients at risk of contracting blood-borne viruses, necessitating additional testing. Substance misuse teams are in a good position to engage patients who might not have a good relationship with healthcare (for example, healthcare might have taken away their OST script). It was suggested that supporting healthcare should

even be a part of substance misuse services' commissioning. As Mark Gillyon-Powell had spoken about in his presentation at the start of the day, having a 'whole team approach' is key, with all staff giving out the same information. To achieve this, it was suggested that substance misuse teams be given access to the same information and training resources as healthcare. Attendees expressed concern that some members of staff in prisons still believe hepatitis C is passed on through spit and are in need of training.

Harm minimisation was also discussed, with attendees raising issues around keeping needles clean in the absence of needle and syringe exchanges in prisons. It was suggested that people should be made aware of the risks of sharing and informed about harm reduction behaviours.

Workshop B: Improving linkage to care in the community



Janet began by providing an overview of statistics around prisons and hepatitis C. There are over 150,000 individual admissions to prison in the UK each year. Public Health England estimates the prevalence of hepatitis C among the prison population to be above 9% with a Scottish study putting the estimate at 19%.

Attendees were then asked for ideas of how patients could be supported to complete treatment and get confirmation of SVR when they have been released with a significant amount of medication still to go. It was suggested that people could be given their full course of treatment on release, and if they were on remand that they should be given this in the sealed bag that goes with them to court and they receive back if they are released.

However, confirming SVR had been achieved and treatment had been completed was the key challenge. It was highlighted that follow-up is particularly important for those patients with decompensated livers as they require regular reviews.

Attendees identified the following services or points of contact that prison-based staff could use to ensure SVR has been achieved after release, or make contact to arrange SVR testing:

- Probation, who should have a contact and address.
- Homeless services.
- Substance misuse services, particularly as those in the community may already work closely with prison-based services.
- Relatives of the patient.

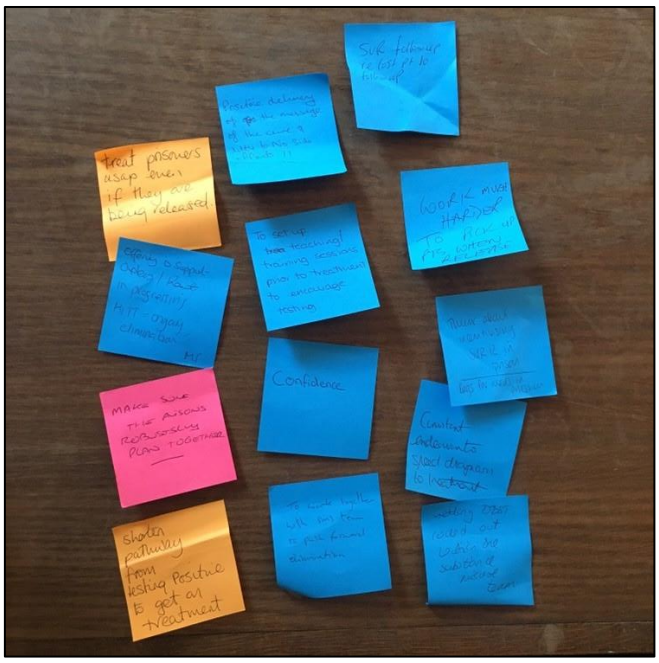
- Outreach services like The Hepatitis C Trust testing van, commissioned by King's College Hospital.
- Given some residents may re-offend and return to the same prison, prisons should be ready to follow-up if someone does re-enter the prisons system.

Attendees noted they had been able to successfully refer patients onto other ODNs when a patient had moved to another area and that ODNs' shared national agenda was helpful, though this relies on knowing the location the person is moving to upon release. Some prison-based teams give cards with contact details to those being released so they can at the very least re-establish contact with the prison healthcare team. The group discussed a new pilot in Kent called 'Reconnect' which focusses specifically on supporting high-risk patients to maintain the healthcare gains they made in prison on release.

Attendees were also told about a toolkit published by Public Health England on continuity of care for substance misuse patients leaving prison which may be of use to those working to improve follow-up. The toolkit can be accessed here.

Pledges by attendees

At the close of the roadshow, attendees were asked to note an action point they would take forward to their services or in their practice as a result of things they had heard discussed during the day. Contributions included:



"To work together with the substance misuse team to push forward elimination"

"Make sure the prisons robustly plan together"

"Think about incentivising SVR 12 in prison"

"Work much harder to pick up prisoners when released"

"Getting DBST rolled out within the substance misuse team"

"Shorten the pathway from testing positive to getting treatment"

"Treat prisoners ASAP, even if they are being released"

"Positive delivery of the message of the cure and few side effects"

Acknowledgements

HCV Action would like to thank all the speakers and attendees for making the roadshow a success.