Cynulliad Cenedlaethol Cymru
Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Ymchwiliad i Hepatitis C
HSCS(5) H02
Ymateb gan Fwrdd Iechyd Prifysgol Cwm Taf

National Assembly for Wales
Health, Social Care and Sport Committee
Inquiry into Hepatitis C

Evidence from Cwm Taf University Health Board

Targeting HCV with a view to eradication in Wales

There are number of factors which will affect our ability to eradicate HCV in Wales.

1) Baseline prevalence
2) Transmission rates
3) Detection of new and old cases
4) Engagement with the treatment services
5) Compliance with medication

1) And 2) As a HB CTUHB does not have pockets of very high prevalence in the same way that some large urban areas do but we know the prevalence of disease in our actively IV drug using community is moderate (18.6%) and that if we can make inroads into treating, particularly in the active IVDU group we can make a difference to rates of ongoing transmission. Data below is from the Harm Reduction Database 2017-18 and first two quarters of 2018/19. This shows that some HBs have particularly high levels (ABMU). Some HBs however have lower testing rates recorded on HRD and results therefore may not show prevalence accurately.

	Total individuals tested for anti-HCV	% Results Recorded (n=1,452)	% anti-HCV Reactive
ABMU	230	97.6	39.7
Aneurin Bevan	386	99.2	8.6
BCU	334	89.6	17.1
Cardiff and Vale*	38	73.2	22.2
Cwm Taf	471	93.5	18.6
Hywel Dda*	97	81.0	7.7
Powys Teaching	10	20.0	0.0
Wales	**1566**	**92.7**	**18.4**

2) As above

3) Detection of new and old cases:

In CTUHB since April 2018 we have had approx. 68 new referrals for patients with HCV.

35 referrals have come direct from GPs or hospital based services including GUM(2), these are people generally not actively using drugs but often being picked up due to screening for reasons for abnormal LFT.

22 are from the HB CDAT team. These people are generally people with complex MH and dependency issues who have not been able to be managed in the third sector community addiction services. Many of these patients have been seen in third sector commissioned addiction services prior to referral in to Health based CDAT services due to case complexity.

2 referrals have been from Barod, one of our community based addiction services. Given the prevalence of Hepatitis C positivity in our local IVDU population this is a very low number of referrals in the first 8 months of the financial year 18/19. Of those who are tested in community services there is a high number of HCV antibody positive people who are already know to have or have previously had HCV treated. On the HRD data base this is reflected by the high level (43%) of patients tested who are RNA negative: compared with ABMU where only 27% of the clients positive for anti HCV are RNA negative. This suggests that testing is focussing on those who have known previous disease which has been treated rather than on those who are likely to have new active disease. It is reassuring that the individuals are RNA negative and annual retesting for those continuing high transmission risk behaviours is recommended but it also suggests we are not targeting patients with risk taking behaviours who have no history of HCV.

6 referrals are through our self-referral pathway which enables friends, families and contacts of people already in our service to refer themselves in for testing and treatment.

3 were other routes including patients transferring into our HB from another HB.

Looking at the referral source it appears that we are picking up old cases opportunistically which is the majority of GP and consultant testing, the only downside of this approach is that these people are more likely to have established liver damage.

We fall down in the area of testing and referring people who are actively using drugs or are early in their engagement with community drug services. These are people who could be benefited most as not only could they be cured before they develop established liver disease from their hepatitis C. The people who are referred to the Viral hepatitis treatment services are those who have complex addictions, dual diagnosis or physical illness from their addictions who are managed by CDAT rather than community services such as Barod and whilst these patients do need to be seen they are often in a more difficult to treat category due to co-morbidities.

4) Engagement with treatment services is something we need to work on. Our service model of bring people to a hospital base for their first appointment results in a 50% DNA rate for first appointments and of those just over 50% DNA a second appointment which means only 74% are actually seen for a first appointment.

5) Compliance with treatment. Once patients are established in the service and they feel they are ready to embark on treatment compliance is good.

New treatments of short duration and many fewer side effects have meant that this is no longer the issue that it has been in years gone by. We have good arrangements with pharmacy and nationally agreed drug costs so that we can ensure there is no barrier to patients receiving the most appropriate treatment.

Our target in CTUHB is to treat 85 patients in each financial year. This target is set for our population taking into account population size, and prevalence rates, if we manage to hit this target we should start to have an impact on infection rates.

As we have not had enough referrals and our DNA rate is 26% we have not treated enough so far this year to be able to hit our target.

We have treated 29 patients in the first 8 months of the year, leaving 56 to treat in the last 4 months of the year. We have not had enough referrals to enable us treat another 56 even if all the patients we had been referred were treated we would not hit our target of 85 for 2018/19.

Actions we are looking to take:

1) We in the Health based services need to work more closely with our third sector community based third sector partners to understand the barriers they are experiencing to testing and referring patients for treatment. A new service provider is being commissioned and we need to ensure close partnership working form the start of the new service.

2) The new opt out testing as opposed to opt in may help increase testing rates but only if we ensure tests are offered and framed in a positive light. Ensuring those offering testing have up to date information on the new treatment options is essential as treatment has changed dramatically in the past 5 years becoming much simpler, moving from injections to oral and with reduced durations of treatment.

3) We need to look at the model of treatment services. Whilst services are provided in local community hospitals we could look at the treatment service going to the patient rather than the other way round. For patients already engaged with health services it may be less of an issue to come up to a local DGH or community hospital but if we can increase testing in community settings and this is the only point of contact for clients found to be positive, we may need to start looking at holding clinic consultations in community/third sector/local pharmacy/needle exchange premises. Visits to hospital bases should be kept for limited numbers of appointments where hospital based investigations are needed e.g. fixed fibroscan and only once a therapeutic relationship has been built between patient and treatment service..