Implementation of the hepatitis C guidelines in UK health care workers

Kirstie Gibson1 and Ioana Kennedy2

Background The UK Health Department circular HSC 2002/010 requires health care employers to test certain groups of health care workers (HCWs) for hepatitis C, without additional funding. Little is known about the consistency of implementation of such guidelines.

Aim This study audited the process, completeness and problems of implementation of circular HSC 2002/010 in acute and ambulance trusts in London and the Southeast of England.

Method Telephone questionnaire survey of 51 National Health Service trusts between July and October 2005.

Results The response rate was 92% (47/51). Eighty-five per cent (40/47) of the trusts reported partial or full implementation of the guidance. All compliant trusts reported testing HCWs entering exposure prone procedure specialities, although 40% (16/40) were testing more staff than specified in the guidance.

Conclusion Most trusts (85%) in this audit reported having implemented the guidance 3 years after publication and 90% claimed not to have needed additional funding. Implementation may be improved by greater clarity about which staff should be tested, frequency of testing and by raising HCWs awareness about hepatitis C infection and treatment. Newly published health clearance guidance addresses some of these points.

Key words Exposure prone procedure; health care worker; hepatitis C; policy implementation; professional to patient transmission.

Introduction

In August 2002, the UK Health Department (DH) issued a circular ‘Hepatitis C infected health care workers (HSC) 2002/010’ [1] advising employers to make arrangements to test certain groups of health care workers (HCWs) and prospective health care trainees for hepatitis C. Those with detectable hepatitis C RNA should be restricted from performing exposure prone procedures (EPPs). Previously hepatitis C-infected HCWs had only been restricted from EPP work where there was actual evidence of transmission of hepatitis C infection to patients. However, since 1995, five further confirmed episodes of transmission of hepatitis C from HCWs to patients had been reported in the UK [1].

Only one published study addresses consistency of implementation of such guidance in the UK [2]. Guidelines do not carry legislative status but National Health Service (NHS) trusts may have to justify non-compliance if challenged.

Method

This procedural audit used the recommendations in HSC 2002/010 as the standards in a telephone questionnaire (available as Supplementary data at Occupational Medicine Online) administered by an occupational physician.

Specifically, respondents were asked about their arrangements for informing relevant workers about testing requirements, testing the correctly specified groups of workers, processing samples, access to occupational health advice and any problems implementing the guidance.

Fifty-one NHS trusts (acute and ambulance) in London, Kent, Surrey and Sussex were contacted via their
occupational health department, with an explanation of the aims of the study. If there was no occupational health department then human resources were contacted.

The questionnaire was piloted at two NHS trusts outside the defined study area. Data was entered and analysed using a Microsoft Excel® 2000 database.

Results

The response rate was 92% (47 participating trusts out of 51 contacted). Seventy-two per cent (34/47) of respondents stated that their designation was an occupational health nurse or nurse manager. One respondent was a human resources manager.

By the end of the data collection period (October 2005), 40 of the 47 (85%) participating NHS trusts reported having implemented some or all of the requirements specified in the hepatitis C guidance. Figure 1 shows when trusts reported having implemented the guidance. Ninety per cent of compliant trusts claimed no additional funding had been necessary to implement the guidance.

Of the seven trusts (15%) that had not implemented the guidance, two believed it did not apply to them. The other five trusts reported difficulties with laboratory access, funding, persuading management of the business case and agreeing staff groups to be tested. Two trusts had no target date for implementation. Three planned to start early in 2006.

Of the 40 trusts that reported having implemented the guidance, all claimed to be testing new HCWs entering EPP specialities as required in the guidance. Table 1 shows the staff groups identified by respondents for testing.

However, 40% (16/40) of respondents reported testing all new staff employed for EPP work regardless of whether they were entering an EPP speciality for the first time. One of these trusts reported testing EPP workers already in post, which was not required by the guidance.

Sixty-three per cent (25/40) of respondents reported testing locum EPP workers. Thirty-three per cent (13/40) said that they had formally contacted EPP workers reminding them of their responsibility to seek advice if they believed they may have been exposed to hepatitis C.

Three-quarters (30/40) of trusts reporting having implemented the guidance said that the hepatitis C antibody assays were available on site. Four respondents (10%) reported the availability of on site hepatitis C virus RNA testing, 18 (45%) used external laboratories and 18 (45%) were not sure.

Discussion

Most trusts (85%) in this survey reported having implemented the requirements of circular HSC 2002/010, 3 years after its publication. All of these reported testing staff new to EPP specialities, 63% reported testing locum EPP staff and 40% (16/40) reported testing more staff than specified in the guidance. Of the seven trusts that reported not having implemented the guidance, two specified financial reasons as the main obstacle. The area of poorest compliance (33%) was informing EPP workers about the guidance and their responsibility to seek advice if they believed they may have been exposed to hepatitis C.

The study was small but the response rate was high. As a procedural audit it represents the first stage of the audit cycle.

Reported overall compliance appears reasonably good and the reasons for poor compliance with informing staff of their responsibilities were not clear. The guidance is not prescriptive about how this should be done. The General Medical Council (GMC) [3] recently suspended a locum surgeon for 3 months for not informing his employers of his hepatitis C-infected status. Regulatory bodies including the GMC, General Dental Council and the Nursing and Midwifery council have a role in reminding health care professionals of their responsibilities. It is also important to raise awareness of the availability and

![Figure 1. Cumulative percentage of trusts implementing guidance per year.](image)

| Table 1. Summary table showing compliance with testing specified groups of EPP workers |
|---------------------------------|-----------------------------------|-----------------|-----------------|
| Aspect of practice audited      | Number of respondents             | Yes (%)         | No (%)          |
| Testing previously known Hep C positive workers for RNA | 37 | 36 (97%) | 1 (3%) |
| Testing staff starting career as EPP worker | 40 | 40 (100%) | 0 (0%) |
| Testing all EPP staff joining the trust regardless of experience | 40 | 16 (40%) | 24 (60%) |
| Testing EPP workers who may have been exposed to Hep C infection | 40 | 30 (75%) | 10 (25%) |
| Testing all existing EPP workers | 40 | 1 (3%) | 39 (97%) |
| Testing locum EPP workers       | 40 | 25 (63%) | 15 (38%) |
efficacy of treatment for hepatitis C, particularly if detected early [4], which balances the adverse career implications of a positive test.

Although most respondents claimed that additional funding had not been needed to implement the guidance, two trusts cited funding as the main obstacle to implementation. Forty per cent claimed to be doing more testing than required by the guidance, which could incur further cost and effort and possible legal challenge from staff restricted from EPP work after being unnecessarily tested. The circulation by the UK Health Department of similar draft guidance called ‘Health Clearance for Serious Communicable diseases: New health care workers’ for consultation in January 2003 may have led to some confusion and misinterpretation. However, this document now renamed ‘Health clearance for tuberculosis, hepatitis B, hepatitis C and HIV: New HCWs’ has only recently been finalized for implementation in March 2007 [5]. Some respondents believed that the responsibility for testing locum EPP workers rests with the agencies. However, NHS trusts do have responsibility for locum and agency staff as defined in the briefing document ‘Safer Recruitment—a guide for NHS employers’ [6].

Twelve respondents commented that the advice on frequency of testing needed review and 17 wanted more clarity on which junior doctors to test in light of changes to post-graduate training called ‘Modernising Medical Careers’ [7]. The new guidance issued in March 2007 [5] goes some way to addressing these issues.

The circular HSC 2002/010 [1] did not specify a deadline for implementation and indeed seven trusts were non-compliant 3 years after publication for a variety of reasons. The new UK Health Department guidance recommends implementation ‘as soon as reasonably practicable’. Some trusts may need more help and support when implementing such guidance and the DH could consider additional sources of advice and support.

To complete the audit cycle, it would be useful to audit compliance with the newly published guidance ‘Health clearance for tuberculosis, hepatitis B, hepatitis C and HIV: New HCWs’ which supersedes the requirements of circular HSC 2002/010 after a further period.

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Conflicts of interest

None declared.

References