# CONTENTS

About the Hepatitis C Coalition ........................................... 3

Executive Summary .......................................................... 4

1. **Background** .............................................................. 5
   - How Hepatitis Services are delivered .................. 6
   - Relevant policies ...................................................... 7
   - Project process and topics discussed ............... 8
   - List of ODN visits .................................................. 10

2. **Overview of findings** .................................................. 11
   - Run rates ............................................................. 11
   - Finances and CQUIN ................................................. 11
   - Delivering the clinical service and MDTs ........... 12
   - Data and sharing of information with NHS England ......................................................... 12
   - Prisons and outreach ............................................. 13
   - Diagnosis and referral ........................................... 13
   - Future of the ODNs ................................................. 14

Appendix – ODN visits discussion guide ............... 15
ABOUT THE HEPATITIS C COALITION

The Hepatitis C Coalition is an umbrella group of leading clinicians, patient organisations, professional groups, industry and other interested parties committed to the reduction of morbidity and mortality associated with hepatitis C and its eventual elimination. The Hepatitis C Coalition has funding from AbbVie, Gilead Sciences and Merck Sharp & Dohme. Lexington Communications provides the secretariat to the Coalition.

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair</td>
<td>Professor Steve Ryder, Consultant Hepatologist at Nottingham University Hospitals NHS Trust and Honorary Professor University of Nottingham, School of Medicine.</td>
</tr>
<tr>
<td>Vice-Chair (Clinical)</td>
<td>Dr Ashley Brown, Consultant Hepatologist at St Mary’s Hospital</td>
</tr>
<tr>
<td>Vice-Chair (Patient)</td>
<td>Charles Gore, Chief Executive, The Hepatitis C Trust</td>
</tr>
</tbody>
</table>

The Department of Health, NHS England and Public Health England are observers of the Coalition. They are able to attend its quarterly meetings.
EXECUTIVE SUMMARY

During 2016, the Hepatitis C Coalition embarked on a series of meetings with several of the 22 operational delivery networks (ODNs), the formal mechanisms for delivering hepatitis C services across England. They were set up by NHS England in April 2015 following the introduction of new direct-acting antiviral medicines (DAAs) in order to provide a mechanism for delivering uniform Hepatitis C services across the country. The aim of these meetings was to gather a sense of how the ODNs were working on the ground: what worked well and what challenges there were to overcome.

The implementation of the ODNs happened at a time of significant change in the treatment of hepatitis C, as the arrival of highly effective new medicines transformed the experience of most patients and the nature of hepatology services.

The Coalition continued its ODN meetings over the course of 2017, to try and understand how the networks were progressing and what had changed since the previous year.

The first ODN report found that across the ODNs there were many examples of good practice, with highly effective services and strong leadership, particularly in the administration of growing patient numbers by experienced nurse specialists and the management of new services by leading consultants. Owing to differences in local prevalence, the maturity of the hepatology service, or individual leadership, there were a range of operating models between ODNs and, as a result, varied patient experience. Some had short queues for treatment and limited outreach, operating reactively rather than proactively. Others were identifying more patients, and at earlier stages of disease, only to add them to a growing queue.

It was also clear that there were areas in which much more could be done. Local clinicians and health professionals were motivated and capable of seizing the opportunity of new treatment and delivering clinics in new community settings with local partners, but these ambitions were frustrated by the contradictory incentives set out in complex policies and payment schemes.

While the 2017 visits have reinforced much of this narrative, it has become clear that some of the current challenges now facing ODNs are different from those cited as being of most concern in 2016. There is still a mixed picture across the country in terms of how services are delivered. However, the attitudes of many of the consultants, managers and nurses we spoke with reflected a shift in concerns since 2016. The limiting nature of the run rates, for example, while previously a frequently-cited bugbear, had become less of a problem. Instead, many ODN leads and managers were concerned about how to find new patients to treat once they had worked through the already known patient ‘warehouse’. This did vary from network to network, however.

The one issue that remained consistent across each ODN was a frustration with the CQUIN. The single most problematic factor of the ODN system, the CQUIN has caused considerable consternation due to its complicated targets, data requirements, bureaucracy and the fact that it works as a levy rather than a reward. In some ODNs, the CQUIN has caused tension between the hub and spokes in the network. It is understood, however, that NHS England is in the process of revisiting the terms of the CQUIN at the time of writing this report.

Another factor that was common to many of the ODNs was the concerted effort on the part of those involved to build their outreach service, particularly in prisons and drug and alcohol services. As the ODNs become more mature, it seems likely that
these services will give rise to more excellent examples of best practice from which other ODNs can learn.

**BACKGROUND**

Hepatitis C is a viral infection which damages the liver. Left untreated, it can cause liver scarring (cirrhosis), leading to liver disease, liver failure and liver cancer (hepatocellular carcinoma). Hepatitis C is one of the three main causes of liver disease, the only one of the five ‘big killers’ in the UK where mortality rates are rising.¹

Estimates suggest that around 160,000² people are chronically infected with the virus in England. Currently, only around 4.2% of people with the virus receive treatment each year and this, in combination with poor rates of diagnosis, contributes to rising mortality, high burden of disease and widening health inequalities, as hepatitis C disproportionately affects marginalised groups.³

Until recently, the only treatments available for people with hepatitis C involved a range of flu-like, unpleasant and often serious side effects. As a result, treatments that lasted for 48 weeks were difficult to tolerate and achieved significantly lower cure rates. This was the case even for those able to complete the course of treatment. New direct-acting antiviral medicines have been available, with much shorter treatment durations (8-24 weeks), very low side effect profiles and cure rates of around 95%.⁴

---

**Hepatitis C Coalition’s Mission Statement**

With curative treatment now available, there is an unprecedented opportunity to improve services and outcomes for people with the virus significantly. If advances in cost-effective treatments are matched by improvements in service delivery, the elimination of hepatitis C from the UK is achievable. In 2016, the World Health Assembly, to which the UK is a signatory, committed to the elimination of hepatitis C as a major public health concern by 2030. In order to hit the World Health Assembly targets, the Hepatitis C Coalition would like to see a more coordinated and effective approach to testing, treating and curing people with hepatitis C in the UK and greater emphasis on the prevention of new infections.

Our vision is to see hepatitis C-related liver cancers and deaths in the UK halved by 2020. Our ultimate goal is to see the virus eliminated by 2030, in line with the World Health Organisation’s (WHO’s) target and in solidarity with the World Hepatitis Alliance’s #NoHep campaign.
The NHS reforms of April 2013 saw the division of responsibilities for hepatitis C services between a number of different organisations:

» **Local Authorities** – responsible for prevention and awareness raising, including through commissioning **drug, alcohol and addiction services**

» **Clinical Commissioning Groups** – responsible for identification of disease (testing)

» **NHS England specialised commissioning** – responsible for costs of treatments and associated services

» **NHS England health and justice** – responsible for costs within prison services

» **Public Health England** – responsible for producing national guidance and an annual report, ‘Hepatitis C in the UK’.

Given the different points of entry to hepatitis C service pathways, the split between commissioners can be problematic. The below diagram seeks to demonstrate the different commissioners and providers involved in different hepatitis C service pathways.
RELEVANT POLICIES

Commissioners and providers of hepatitis C services are guided by a number of key policy documents:

Hepatitis C Operational Delivery Networks service specification

NHS England set out its requirements for Operational Delivery Networks in its service specification, published in April 2015. This document introduced Operational Delivery networks, with "centres that manage treatment decisions and prescribing but has a dispersed delivery model that will support partnership working and local access for patients in England. Network leadership will be provided through specialist centres with proven expertise in managing HCV, and prescribing decisions will be made through MDT meetings."

The aims set for the system include:

» providing a uniform standard, high quality service
» Reporting using a national standardised monitoring and outcomes dataset
» Establishing a network of services responsive to local epidemiology and working effectively in partnership with other health care providers and local organisations
» Contributing to tailored services to meet the needs of specific vulnerable groups
» Ensuring that people with hepatitis C are given sufficient, high quality information
» Allowing more people to have access to clinical trials of new drugs

The network service specification also sets out:

» The sources from which ODNs are to accept referrals
» The requirements of the network in terms of governance
» Outpatient service requirements
» Inpatient service requirements
» Required demonstrable links to other services and providers
» The number of networks required in each region
» The relevant quality standards and CQUIN goals

Commissioning for Quality and Innovation payment scheme

The Commissioning for Quality and Innovation (CQUIN) scheme is intended to allow commissioners to reward provider excellence, by linking a proportion of payment for services provided to the achievement of specific quality improvement goals. The impact of CQUIN payments on provider finances is often significant, and as such they are a major lever for guiding performance within the health system.

Historically, all specialised providers have been offered a potential payment of 2.5% of their specialised budget as a CQUIN payment. The CQUIN scheme for hepatitis C is being revised by NHS England, but as it stands at the time of writing this report, the ODN lead providers for hepatitis C are offered up to 2.8% while other acute providers have seen their payments decline from 2.5% to 2.0%. For lead hepatitis C providers, 1.6% of the CQUIN payment will be related to their hepatitis C services, with an additional governance payment of £100,000 per network for the establishment of the ODNs.
The triggers for the CQUIN payment are:

<table>
<thead>
<tr>
<th>Trigger B1</th>
<th>Trigger B2</th>
<th>Trigger B3</th>
<th>Trigger B4</th>
<th>Trigger B5</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDT decisions aligned to NHS England published run rate</td>
<td>Cost per treatment relative to lowest acquisition cost</td>
<td>Prioritisation of patients with highest clinical need</td>
<td>Effectiveness in sustaining benefits of treatment</td>
<td>Completeness and data quality in the ODN registry</td>
</tr>
</tbody>
</table>

**Treatment run rates**

The most significant trigger identified in the Coalitions ODN visits has been Trigger B1, relating to the treatment ‘run rates’ which have been given to each ODN. These run rates, enclosed as appendix 1, confirm NHS England’s commitment to treat no more than 10,000 patients in 2016/17 and set out the allocation of these patients between ODNs. The run rate for 2017/18 is 12,500%.

To qualify for the full CQUIN payment, hep C ODNs must not treat less than 90% of their given run rate, nor more than 100%. Within this, the CQUIN provides stipulations on prioritising patients with greatest need.

**NICE Guidance on medicines**

NICE has published guidance on a range of new medicines for hepatitis C. Regarding implementation, the guidance states, ‘It is recommended that the decision to treat and prescribing decisions are made by multidisciplinary teams in the operational delivery networks put in place by NHS England, to prioritise treatment for people with the highest unmet clinical need.’

**PROJECT PROCESS DURING 2017 ODN VISITS**

The Coalition approached leads, clinicians and other health professionals involved in the ODNs and arranged visits to hubs and spokes.

Interviews were held using a discussion guide agreed by Coalition members. The meetings expressly prohibited discussion of individual treatments or tenders.

Draft notes of the interviews were sent to the individuals concerned to seek their comments and approval. The approved notes were then circulated to Coalition members and were used to inform this report about the experience of the ODNs, including by identifying any system barriers faced by the ODNs. These findings have led to the formation of the analysis and recommendations in this report.
TOPICS DISCUSSED WITH ODNS INCLUDED:

» The background to the ODN and its hepatology and outreach services
» Patient engagement with the ODN
» Diagnosis and referral, including any barriers
» Service delivery models
» Outreach activity and ambitions, including linkage with prisons, secure settings and drug and alcohol services
» National guidance and policies and other factors in MDT decision processes and prioritisation
» Treatment run-rates
» CQUIN schemes, including the financial context of the ODN and its provider Trusts
» Future outlook, challenges and opportunities
LIST OF ODN VISITS

1. **24TH MARCH | SURREY HEPATITIS SERVICES**
   Dr Michelle Gallagher, Consultant Hepatologist and ODN lead, Royal Surrey County Hospital

2. **30TH MARCH | EASTERN HEPATITIS NETWORK**
   Dr William Gelson, Consultant Hepatologist and ODN lead, Addenbrooke’s Hospital
   Kirsty McKibben, ODN manager, Addenbrooke’s Hospital

3. **28TH JUNE | SUSSEX HEPATOLOGY NETWORK**
   Dr Jeremy Tibble, Consultant Gastroenterologist, and ODN lead, Brighton & Sussex University Hospitals NHS Trust
   Ali McKinlay, ODN manager, Brighton & Sussex University Hospitals NHS Trust

4. **19TH JULY | WEST YORKSHIRE ODN**
   Dr Mark Aldersley, Consultant Hepatologist and ODN lead, Leeds Teaching Hospitals
   Tracey Stirrup, Clinical Nurse specialist, Leeds Teaching Hospitals

5. **27TH OCTOBER | SOUTH WEST PENINSULA ODN**
   Jayne Davies, Hepatology Network Co-ordinator, Plymouth Hospitals NHS Trust

6. **9TH NOVEMBER | NOTTINGHAM ODN**
   Karen Murray, Hepatitis C Nurse Specialist, Lincoln County Hospital
   Breanne Dilks, ODN Manager, Nottingham University Hospitals NHS Trust
   Kathryn Jack, Advanced Virology Nurse Specialist, Nottingham University Hospitals NHS Trust

7. **17TH NOVEMBER | NOTTINGHAM ODN**
   Dr Adam Lawson, Consultant hepatologist and gastroenterologist, Royal Derby Hospital
OVERVIEW OF FINDINGS

RUN RATES

The first edition of the Hepatitis C Coalition’s Report on the Operational Delivery Networks found the introduction of run rates to be a particular cause for concern among ODNs. The run rates were viewed as a cap on treatment numbers that amounted to rationing. While some ODNs described the run rates as a hindrance during the 2017 visits, others were less concerned. Those who did think that it was a hindrance found that they were only stymied by a small margin, and thought that they could treat a few more patients than their run rate allowed, but not many.

At one ODN, run rates were viewed in a positive light for helping to provide a framework to access the new medicines in a more planned way. At another ODN, it was felt that the run rates help focus the use of resources. There were others who said they could treat slightly more than the numbers allocated, but none felt that they were severely impeded in their capacity to treat more patients by the run rate.

In fact, concern has now largely shifted in the opposite direction, with almost all ODNs stating that they were worried about finding enough patients to treat in the coming year as they had already worked through their ‘warehouse’ of patients.

The reason for this shift from 2016 to 2017 appears to be that the prioritisation of those with the greatest clinical need, primarily cirrhotic patients to begin with, meant that most known cases had been treated, so more had to be discovered. This would require an increase in testing in all settings. One way to achieve this would be to increase dry blood spot testing (DBST) – it was hoped that a funding source for improved case finding by blood spot testing could be identified.

There was also the problem of getting and keeping patients with chaotic lifestyles in treatment. One ODN stated that their does-not-attend (DNA) rate is quite high at around 20-25% due to patients often leading chaotic lifestyles. In many respects, this is not a failure of policy, but demonstrates the need for more education around the new medicines – as there was some perceived reluctance among patients to engage given fears over the side effects of interferon-based treatments – and the need for peer to peer support and patient engagement with the ODNs.

FINANCES AND CQUIN

The CQUIN was viewed as the principle negative aspect of the ODN system. There were many ODN representatives who stated that they were not against the principle of a CQUIN per se, and indeed they could be a useful incentive mechanism. However, in this instance, the terms of the CQUIN were seen as being punitive by the hubs and unfair by the spokes. Because the CQUIN for hepatitis C worked as a levy rather than a reward, lead providers found it very difficult having to carry all of the financial risk while also having to involve the spokes in meeting the terms of the scheme. This opinion was voiced by every hub that we spoke to. In the words of one representative, “CQUINs sound like you’re getting money, but you’re not. So whatever the Trust’s anticipated income for the year is, a proportion of that income is ‘top-sliced’ and taken away, so it doesn’t matter what size Trust you are because it’s proportional to your total income, so for a small Trust it’s a smaller sum but it’s still the same fraction”.

The spokes, conversely, felt pressure to meet the terms of the CQUIN but did not always get the advantage of the financial payoff. While some ODNs had a means of
sharing out the money amongst the ODN providers, this was discretionary and often involved considerable amounts of time and bureaucracy. One Trust described the CQUIN as ‘a logistical nightmare’.

There were some positive comments about the CQUIN, such as the fact that it provided a catalyst and some finances to move the hepatology service forward. For example, the Eastern Hepatitis Network had been able to use some of their CQUIN money for awareness-raising work, which it would otherwise have been unable to fund. It was also suggested that the CQUIN does help to focus minds in other parts of the lead provider on the work that hepatology is doing because there are financial implications for the whole hospital.

One Trust suggested that it might be more effective and provide a greater incentive for performance if the CQUIN payment was shared across the providers in the ODNs to stimulate activity.

There were other practical problems with the use of the CQUIN payments, such as it could be difficult to use the money to employ a nurse specialist or other member of staff as the payment was not a consistent form of funding. Certain triggers for the CQUIN were seen as especially difficult to meet, such as the requirement to retest at 12 months. It was also suggested that it seemed natural to be held accountable to NHS England, as opposed to another Trust.

There was concern that if case-finding was to be incorporated into the CQUIN, this would make the terms very difficult to meet, which would incur a financial penalty. The recent optional update to the CQUIN, which removed the upper cap for treatment numbers, was welcome in terms of driving the push for elimination, but could lead to problems with case-finding.

DELIVERING THE CLINICAL SERVICE AND THE MDTS

Most of the ODN representatives interviewed said that they operated a weekly or a fortnightly MDT, usually across all sites. There was only one exception to this, which operated one central MDT for difficult-to-treat cases, where they will not be using the lowest acquisition cost drug, but aside from this, each centre had their own MDT and they make their own decisions. This had been a conscious decision on the part of the ODN lead, in order to give the spoke providers greater autonomy over their clinical practice. The central MDT usually met twice a month.

Most ODN representatives thought that the MDT process was very helpful, though one spoke provider did not think that it had added much to their clinical practice, given that they had had a hepatology MDT at the spoke hospital long before the inception of the ODN system. Broadly, having an occasion to discuss cases with the hub and spokes together was viewed as a very helpful aspect of the ODN system. One Trust spoke very positively about how crucial it was to have pharmacists and nurse specialists present at MDTs, as this was important to being able to plan logistics like ordering medicines.

DATA AND SHARING OF INFORMATION WITH NHS ENGLAND

While most ODN representatives were happy to provide data to NHS England in order to meet the CQUIN and improve the hepatology service, there was a sense that much of the communication was ‘one way’ and that NHS England and the other arm’s length bodies could be more forthcoming in their communication. Many ODNs
would appreciate more reciprocal conversation with NHS England, for information and reassurance purposes.

PRISONS AND OUTREACH

There was a great deal of variation in the extent to which ODNs were embarking on outreach work in prisons and other care settings, but every one we spoke with was involved in some degree of work in this area. Every ODN had several prisons within their geographical boundaries; Nottingham had the most, including an immigration removal centre. This sort of institution epitomised one of the biggest problems facing ODNs in terms of their work in prisons, which is the difficulty in treating people who are only housed in a particular institution for a short period of time.

Delivering hepatology services in prisons was also highly dependent on the operational arrangements in each individual prison and the staffing levels. Most ODN representatives were working on developing in-reach services in prisons so that prison inmates did not have to leave the prison for treatment, which posed logistical problems.

Many thought that testing in prisons could be improved, despite the gradual roll-out of opt-out testing over the course of the year.

Many ODNs offered a good community service, though it was largely dependent on a nurse’s capacity to perform the work. The drug and alcohol centres in Cornwall were particularly active in this area and the South West Peninsula ODN worked closely with them.

There was general consensus that much more could be done, given the right time and resources. Of particular importance to diagnosing patients in prison was the availability of dry blood spot testing. Being able to offer this less invasive testing option would allow more patients to be tested in the prison setting, but some ODNs only had venous testing. **Consistent availability of DBST across all the ODNs, along with funding for this, would greatly help with diagnostics in prison and thus increase case-finding capability.**

DIAGNOSIS AND REFERRAL

Across all of the ODNs interviewed, the majority of referrals came from GPs, followed by drug and alcohol treatment centres and then prisons. One ODN mentioned their positive relationship with the local sexual health services, and received some referrals from them. Several ODNs stated that they took referrals from anywhere, and do not require a GP referral.

Some staff in drug and alcohol treatment centres and other care settings were labouring under the misapprehension that patients had to be referred to a GP in order to be referred into secondary care. It was felt that a greater knowledge of hepatitis C was necessary among GPs. One ODN had previously encountered problems getting referrals from drug and alcohol treatment centres, but this had since been resolved and the referral system was now working well.

The difficulty of treating patients with chaotic lifestyles remained a problem. Many ODNs had hepatitis C positive patients of whom they were aware of, but they were still unable to get them to engage with treatment services.
FUTURE OF THE ODN

All ODN representatives were asked what they would like to see for the future of the ODN system. A variety of answers were offered. One ODN stated that they would like to see more clinically driven decision making in the MDT rather than the rigidity of the rate card.

Several answers indicated that some flexibility around the run rate would be welcome so that Trusts were not scared of going over the limit by a single patient, and it would also provide greater autonomy over funding.

ODNs generally agreed that a reduction in onerous bureaucracy would be appreciated, as would greater thought being given to which laboratories were designated to each provider in order to process tests, as this was not always practical.

Since the recent optional update to the CQUIN which removed the upper cap on patient numbers, it would now be possible for those who had signed up to this updated CQUIN to treat more patients, which will be important for moving towards elimination. However, it would still leave ODNs with the difficulty of case-finding. It was suggested that if case-finding was a joint responsibility with local authorities, it would alleviate some of the pressure on the providers to find patients.

Getting patients with chaotic lifestyles to engage with services was a perennial problem that could possibly not be overcome by policy levers. However, peer to peer support and education, as well as making access to treatment as wide as possible, could help.

Several ODN representatives expressed support for the idea that primary care providers and different community providers could be empowered to give out the treatment. It would be possible for community pharmacists to dispense it, because the simplicity of the way in which it is administered. One ODN suggested a model whereby a patient can access testing and treatment wherever they are most comfortable – for example, a drug and alcohol treatment centre, hospital or pharmacy. It could be approached like a course of antibiotics and, while there would be some potential medical risk, this is likely to be minimal.
APPENDIX

DISCUSSION GUIDE

The topics being discussed by the ODNs include:

- The background to the ODN and its hepatology and outreach services
- Patient engagement with the ODN
- Diagnosis and referral, including any barriers
- Service delivery models
- Outreach activity and ambitions, including linkage with prisons, secure settings and drug and alcohol services
- National guidance and policies and other factors in MDT decision processes and prioritisation
- Treatment run-rates
- CQUIN schemes, including the financial context of the ODN and its provider Trusts
- Future outlook, challenges and opportunities

The meetings expressly prohibit discussion of individual treatments or tenders

Outline discussion guide

The preliminary list of topics for the ODN interviews is set out below. This is intended to provide a framework for the discussions which aim to consider the effectiveness of ODNs and how their potential can be maximised.

Introduction

Interviewees will be asked to talk in brief about their role and experience to date with the hepatitis C ODN. Other questions may include: How many patients with hepatitis C does the ODN treat per month? What proportion of those are (i) referred to specialist care? (ii) receiving NICE/NHS England approved antiviral therapies for HCV?

Diagnosis and referral

Interviewees will be asked to outline the local referral routes for hepatitis C – e.g. primary care and sexual health clinics – and describe the opportunities and challenges arising from each route. Factors preventing earlier referral into specialist care will be discussed, and interviewees invited to consider how these barriers are being addressed at a local level. Consideration around testing and patient preference will also be raised, as potential factors affecting time to treatment.

Service delivery model

Interviewees will be asked to outline the specific organisations involved in the ODN and to describe how the different partners work together to enable joined-up
delivery of hepatitis C services. Interviewees will be invited to comment on the pros and cons of the ODN approach compared to the previous arrangement, and to provide case studies of demonstrating the relevant improvements. Treatment adherence and the role of patients in the design and functioning of the network will be discussed.

Questions will be also be raised about the impact of collaborative commissioning and the national network of ODN leads. Interviewees will also be asked to comment on the specific models of delivery for e.g. prisons and localised immigrant populations.

National guidelines/ policies

The interviews are a good opportunity to assess local understanding of the national guidance such as the relevant NICE guidelines and NHS England’s service specification of hepatitis C ODNs. Interviewees will be invited to provide their views on the guidance and assess whether the relevant recommendations are being followed at a local level. The aim will be assess whether local incentives are aligned with the delivery of national policy recommendations. Questions will also be raised about the ODN’s audit and research programmes, as well as how the network intends the findings to be used to influence future commissioning policies.

Future outlook

Interviewees will be asked to reflect on the opportunities and challenges facing their ODN and provide an indication of the anticipated future direction of travel. System barriers which are hindering the progress of ODNs will be discussed, and interviewees will be asked to provide a view on how these could be addressed. Interviewees will be invited to indicate what additional support is required to improve the coordination and operation of ODNs. Interviewees will be asked whether there is anything else they would like to discuss.

1 Public Health England Liver Disease Profiles: https://fingertips.phe.org.uk/profile/liver-disease
5 NHS Choices, Hepatitis C – Treatment: http://www.nhs.uk/Conditions/Hepatitis-C/Pages/Treatment.aspx
6 http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2017-03-06/66762/