Welcome and introduction and setting the scene

Charles Gore, Chief Executive, The Hepatitis C Trust

Tuesday 24 November 2015
Brighton
Local epidemiology

Paul Crook, Consultant Epidemiologist, Public Health England

Tuesday 24 November 2015
Brighton
Hepatitis C epidemiology in the South East

Dr Paul Crook
Consultant Epidemiologist
Field Epidemiology Services South East & London
National Infection Service, Public Health England
Rate of new hepatitis C reports

Rate of laboratory confirmed diagnoses of hepatitis C per 100,000 residents, by Region, 2014  Source: Laboratory reports PHE
Risk factors for hepatitis C

People who have ever injected drugs

People who received a blood transfusion before 1991 or blood products before 1986

People born or brought up in a country with an intermediate or high prevalence (2% or greater) of chronic hepatitis C.

Babies born to mothers infected with hepatitis C

Prisoners, including young offenders

Looked-after children and young people, including those living in care homes

People living in hostels for the homeless or sleeping on the streets

HIV-positive men who have sex with men

Close contacts of someone known to be chronically infected with hepatitis C
Men who have sex with men (MSM) with hepatitis C

75% - history of non-injecting recreational drug use
33% - injecting drug use
86% - sex under influence of drugs

High proportions – unprotected sex

Ethnicity

Proportion testing positive for anti-HCV by ethnicity in sentinel laboratories in the South East, 2010–2014.

Age and sex

Age-group and gender of individuals testing positive for anti-HCV in sentinel laboratories in the South East, 2014

Estimated burden in the South East

Of whom
60% estimated already diagnosed

17,500 HCV antibody positive

Of which

12,000 HCV RNA positive

41% current people who inject drugs

29% previously used drugs (no longer inject)

30% never injected drugs (1/3 of whom are from South Asia)

Crude hospital admission rate for hepatitis C related end-stage liver disease and hepatocellular carcinoma, persons per 100,000 population by South East local authority, 2012/3 (Source PHE Liver Disease Profiles).

(Medway, Bracknell Forest, West Berkshire, Reading, Slough, Windsor & Maidenhead, Portsmouth and Isle of Wight values suppressed for disclosure control due to small count)
Hospital admissions in South East residents (note different scales)

Diagnosis of **hepatitis C** (2008–2014)

Diagnosis of **HCV related ESLD (end stage liver disease)**, 2008–2014

Diagnosis of **HCV related HCC (hepatocellular carcinoma)**, 2008–2014

Source: Hospital Episode Statistics (HES), Health and Social Care Information Centre
First registrations with post-hepatitis C cirrhosis as primary, secondary or tertiary indication for transplant, South East residents, 1999–2014

Mortality

Map showing the rate of deaths from ESLD or HCC in individuals with HCV mentioned on their death certificate by PHE Centre (2008–14)

Source: Office of National Statistics. Death certification
Mortality

Crude mortality rate from hepatitis C related end-stage liver disease/hepatocellular carcinoma in persons less than 75 years per 100,000 population by South East local authority, 2011-13 (Source PHE Liver Disease Profiles).

[Graph showing mortality rates across different local authorities in the South East.]
Trends in testing

Number of individuals tested and the proportion testing positive for anti-HCV in sentinel laboratories in the South East, 2009 to 2014

Please note that the numbers relate to those tested in the sentinel laboratories, and do not represent all tests across the South East.

Service of testing

Number of individuals tested for anti-HCV and the proportion testing positive by service type in sentinel laboratories in the South East, 2009 to 2014. Please note that the numbers relate to those tested in the sentinel laboratories and do not represent all tests across London. Source: Public Health England. Sentinel Surveillance of Blood-borne Virus Testing
Testing of people who inject drugs (PWID)

Testing in drug treatment services

Proportion of clients of drug treatment services eligible and received a hepatitis C test by local authority in the South East 2013/4


Hepatitis C epidemiology in the South East

<table>
<thead>
<tr>
<th>Area</th>
<th>Proportion of clients eligible and received a hepatitis C test</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Sussex</td>
<td>95%</td>
</tr>
<tr>
<td>Hampshire</td>
<td>94%</td>
</tr>
<tr>
<td>Southend</td>
<td>93%</td>
</tr>
<tr>
<td>Isle of Wight</td>
<td>92%</td>
</tr>
<tr>
<td>Slough</td>
<td>86%</td>
</tr>
<tr>
<td>Portsmouth</td>
<td>86%</td>
</tr>
<tr>
<td>Wokingham</td>
<td>86%</td>
</tr>
<tr>
<td>Reading</td>
<td>86%</td>
</tr>
<tr>
<td>West Sussex</td>
<td>85%</td>
</tr>
<tr>
<td>West Berkshire</td>
<td>85%</td>
</tr>
<tr>
<td>Medway towns</td>
<td>85%</td>
</tr>
<tr>
<td>Buckinghamshire</td>
<td>85%</td>
</tr>
<tr>
<td>Kent</td>
<td>83%</td>
</tr>
<tr>
<td>Surrey</td>
<td>83%</td>
</tr>
<tr>
<td>Bracknell Forest</td>
<td>80%</td>
</tr>
<tr>
<td>Windsor and Maidenhead</td>
<td>72%</td>
</tr>
<tr>
<td>Oxfordshire</td>
<td>67%</td>
</tr>
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</table>
Testing in prisons

Hepatitis C testing in prisons in the South East, NHS Trust Development Authority, Prison Health Reporting System, 2013

Source: NHS Quality Observatory. Prison Health Performance & Quality Indicators (PHPQIs).

<table>
<thead>
<tr>
<th>Prison</th>
<th>% of receptions with a hepatitis C test performed within 31 days of reception</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aylesbury (HM/YOI)</td>
<td>0%</td>
</tr>
<tr>
<td>Blantyre House (HMP)</td>
<td>0%</td>
</tr>
<tr>
<td>Bronzefield (HMP)</td>
<td>16%</td>
</tr>
<tr>
<td>Bullingdon (HMP)</td>
<td>5%</td>
</tr>
<tr>
<td>Coldingley (HMP)</td>
<td>36%</td>
</tr>
<tr>
<td>Cookham Wood (HMP)</td>
<td>0%</td>
</tr>
<tr>
<td>Downview (HMP)</td>
<td>35%</td>
</tr>
<tr>
<td>East Sutton Park (HMP/YOI)</td>
<td>66%</td>
</tr>
<tr>
<td>Elmley (HMP/YOI)</td>
<td>5%</td>
</tr>
<tr>
<td>Ford (HMP)</td>
<td>7%</td>
</tr>
<tr>
<td>Grendon (HMP)</td>
<td>9%</td>
</tr>
<tr>
<td>High Down (HMP)</td>
<td>2%</td>
</tr>
<tr>
<td>Huntercombe (HMYOI)</td>
<td>9%</td>
</tr>
<tr>
<td>Isle of Wight (HMP)</td>
<td>3%</td>
</tr>
<tr>
<td>Lewes (HMP/YOI)</td>
<td>8%</td>
</tr>
<tr>
<td>Maidstone (HMP)</td>
<td>18%</td>
</tr>
<tr>
<td>Reading (HMP/YOI)</td>
<td>12%</td>
</tr>
<tr>
<td>Rochester (HMP/YOI)</td>
<td>26%</td>
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<tr>
<td>Send (HMP)</td>
<td>23%</td>
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<tr>
<td>Spring Hill (HMP)</td>
<td>1%</td>
</tr>
<tr>
<td>Standford Hill (HMP)</td>
<td>5%</td>
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<tr>
<td>Swaleside (HMP)</td>
<td>11%</td>
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<tr>
<td>Winchester (HMP)</td>
<td>2%</td>
</tr>
<tr>
<td><strong>South East</strong></td>
<td><strong>7.3%</strong></td>
</tr>
<tr>
<td><strong>England</strong></td>
<td><strong>7.9%</strong></td>
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</table>
Harm reduction

Level of direct and indirect sharing amongst PWID in the South East, 2004–2014

HIV in Kent, Surrey and Sussex

Diagnosed HIV prevalence per 1,000 residents aged 15-59 years by local authority, Kent, Surrey and Sussex, 2013
HIV in Thames Valley

Diagnosed HIV prevalence per 1,000 residents aged 15-59 years by local authority, Thames Valley, 2013
HIV in Wessex

Diagnosed HIV prevalence per 1,000 residents aged 15-59 years by local authority, Wessex, 2013
### New HIV diagnosis rate / 100,000 aged 15+

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<thead>
<tr>
<th>Area</th>
<th>Count</th>
<th>Value</th>
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<tr>
<td>England</td>
<td>5,507</td>
<td>12.3</td>
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<tr>
<td>South East PHE centre</td>
<td>546</td>
<td>7.7</td>
</tr>
<tr>
<td>Brighton and Hove</td>
<td>77</td>
<td>32.3</td>
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<tr>
<td>Slough</td>
<td>20</td>
<td>18.2</td>
</tr>
<tr>
<td>Reading</td>
<td>22</td>
<td>16.9</td>
</tr>
<tr>
<td>Windsor and Maidenhead</td>
<td>13</td>
<td>10.8</td>
</tr>
<tr>
<td>Portsmouth</td>
<td>14</td>
<td>8.1</td>
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<tr>
<td>Southampton</td>
<td>14</td>
<td>6.9</td>
</tr>
<tr>
<td>Medway</td>
<td>15</td>
<td>6.8</td>
</tr>
<tr>
<td>West Sussex</td>
<td>44</td>
<td>6.4</td>
</tr>
<tr>
<td>Buckinghamshire</td>
<td>24</td>
<td>5.7</td>
</tr>
<tr>
<td>Bracknell Forest</td>
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<td>5.3</td>
</tr>
<tr>
<td>Wokingham</td>
<td>6</td>
<td>4.7</td>
</tr>
<tr>
<td>Surrey</td>
<td>43</td>
<td>4.5</td>
</tr>
<tr>
<td>Kent</td>
<td>53</td>
<td>4.3</td>
</tr>
<tr>
<td>Oxfordshire</td>
<td>19</td>
<td>3.4</td>
</tr>
<tr>
<td>Hampshire</td>
<td>33</td>
<td>3.0</td>
</tr>
<tr>
<td>East Sussex</td>
<td>13</td>
<td>2.9</td>
</tr>
<tr>
<td>West Berkshire</td>
<td>3</td>
<td>2.4</td>
</tr>
<tr>
<td>Isle of Wight</td>
<td>2</td>
<td>1.7</td>
</tr>
</tbody>
</table>

Source: Integrated HIV surveillance data: Survey Of Prevalent HIV Infections Diagnosed (SOPHID), HIV and AIDS New Diagnoses Database (HANDDD), and the new HIV and AIDS reporting and monitoring system held by the HIV & STI Department, National Infection Service, PHE. https://www.gov.uk/government/collections/hiv-surveillance-data-and-management
Co-author: Monique Pereboom

Acknowledgements:
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Lukasz Cieply & Sam Lattimore, PHE (Sentinel Surveillance of Blood-borne Virus Testing & oral fluid testing data provided by Concateno Plc.)
Vivian Hope and Katelyn Cullen, PHE (Data from Unlinked Anonymous Monitoring Survey of HIV and Hepatitis in PWID)
Annastella Costella, Helen Harris, Ross Harris, Vivian Hope, Sema Mandel, Mary Ramsay (Commissioning Template for Estimating Hepatitis C Prevalence by PCT and Numbers Eligible for Treatment)
Sam Lattimore (The Enhanced Surveillance of Newly Acquired Hepatitis C infection in men who have sex with men)
Annastella Costella, Philip Keel (Admissions, Deaths, Transplants)
Kevin Shelton, Jonathan Alderson (Drug services hepatitis C testing data)
Rachel Cloke
Piers Mook
John Hastings (Prison hepatitis C testing data)
The Office for National Statistics
The Health and Social Care Information Centre (HSCIC)
Treatment of hepatitis C and possibilities for elimination

Professor William Rosenberg, Consultant Hepatologist, Royal Free NHS Foundation Trust

Tuesday 24 November 2015
Brighton
The Going Viral project: Testing for BBVs in A&E - A good practice case study

Dr Stuart Flanagan, Clinical Research Fellow, Viral Hepatitis, Royal London Hospital

Tuesday 24 November 2015
Brighton
Non-targeted, HIV/HBV/HCV combined testing as routine in 9 UK A&Es: The ‘Going Viral’ campaign

Dr Stuart Flanagan
Specialist Registrar HIV Medicine
Clinical Research Fellow Viral Hepatitis
Background

The US Centre for Disease Control (CDC) recommends:

- Universal HIV testing in 15-65’s \(^\text{(1)}\)
- Birth cohort screening for HCV \(^\text{(2)}\)
- Targeted Screening for HBV \(^\text{(3)}\)

UK guidelines recommend:

- Routine HIV testing when the local prevalence is >0.2% \(^\text{(4)}\)
- Targeted HBV and HCV screening \(^\text{(5)}\)

Early diagnosis is key to better outcomes and reducing blood-borne virus (BBV) transmission. \(^\text{(1, 4, 5)}\)

1 in 4 people attend ED in England annually, 13% of attendees have bloods taken, making it a good place to test. \(^\text{(6)}\)

Combined blood-borne virus screening for HIV/HBV/HCV is not offered in UK Emergency Departments (EDs).

References:

1) CDC. Final Recommendation Statement Human Immunodeficiency Virus Infection
2) CDC. Recommendations for the Identification of Chronic Hepatitis C Infection Among Persons Born During 1945–1965
5) NICE. Hepatitis B and C: ways to promote and offer testing to people a increased risk of infection. 2013
6) NHS. Quality and Safety Programme Emergency departments ,Case for change. 2013
Unexpected high prevalence of HCV viraemia (HCV RNA+) in the Emergency Department (ED) of a London Hospital: Should we be screening for HCV in ED attendees?

Aim:

- To estimate the HCV prevalence and cost per diagnosis per viraemic infection in ED attendees.

Methods:

- Residual biochemistry samples from London ED attendees aged >18 years were collected
- Unlinked anonymised HCV testing done
- Data on age, gender and ethnicity were collected
- Samples were tested for HCV antibody (Ab). Reactive samples were further tested for HCV RNA

Results:

- 997 samples were tested for HCV Ab
- HCV Ab prevalence: 2.6% (26/997) of whom 1.2% (12/997) were also HCV RNA positive
- Median age of RNA+ was 47y, 66.7% (8/12) of RNA+ were male
- 75% (9/12) RNA+ individuals were aged 25-54yr (RNA+ 9/441; 2.0%)
- In males 35-44 years the RNA+ prevalence peaked at 4.8% (3/63)
- Although 31% (311/997) of attendees were white British, 58% (7/12) HCV+ were White British (2.3%) versus 0.3% viraemic Asian attendees (p= 0.0766)
Unexpected high prevalence of HCV viraemia (HCV RNA+) in the Emergency Department (ED) of a London Hospital: Should we be screening for HCV in ED attendees?

Conclusions:

• High levels of active HCV infection in screening ED attendees in this ethnically diverse large urban London hospital

• HCV prevalence 6-fold higher than the stated national prevalence of 0.4%

• Almost half (46%) of those HCV Ab+ were also HCV RNA positive and therefore infectious to others

• Further research exploring feasibility and acceptability of introducing targeted opt-out screening of ED attendees aged 25 – 54 years is needed

Assuming cost for HCV-Ab is £6 and HCV-RNA is £40/test, screening ED attendees aged 25-54 could identify 75% of RNA+ at a cost of £360 per viraemic infection

Orkin C, Epidemiol Infect. 2015 Feb 12:1-4
Aim

To determine the prevalence of HIV, HBV and HCV in nine EDs across the UK.
Methods

Logistics:
- 16 EDs high HIV prevalence EDs approached, 9 took part
- Offer opt-out testing for all adult ED pts having bloods as part of routine care
- Costs of HIV/Hep B/Hep C tests met by campaign, not ED.

Inclusion Criteria:
- Everyone >18yrs who attends EDs 13th-20th Oct 2014 and consents

Exclusion Criteria:
- Under 18s
- Patients who lack capacity/ language barrier
- Status known/recently tested (6 months)
Consent = like ANC No written consent needed

“As you’re having a blood test to look at how your liver and kidneys are working, this week we are also screening for infections including HIV and Hepatitis. Is that ok?”
Methods

- HIV Antibody (Ab), HBV Surface Antigen & HCV Ab were tested and confirmed by neutralisation (HBV) and with PCR (HIV/HCV).
- Testing uptake = \( \frac{\text{ED attendees tested for BBV}}{\text{ED attendees having bloods}} \)
- Demographic data were extracted from electronic records and analysed
- New positives were contacted and linked to care
Results

Figure 1: Flow Chart of Blood & BBV Testing During Campaign

<table>
<thead>
<tr>
<th>Hospital</th>
<th>No. with Bloods Taken</th>
<th>No. with BBV Bloods</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Royal London Hospital</td>
<td>2155</td>
<td>742</td>
</tr>
<tr>
<td>Newham University Hospital</td>
<td>711</td>
<td>279</td>
</tr>
<tr>
<td>St Thomas’ Hospital</td>
<td>810</td>
<td>276</td>
</tr>
<tr>
<td>St James University Hospital Leeds</td>
<td>642</td>
<td>170</td>
</tr>
<tr>
<td>Garnet Royal Hospital Glasgow</td>
<td>543</td>
<td>299</td>
</tr>
<tr>
<td>Whipps Cross Hospital</td>
<td>731</td>
<td>139</td>
</tr>
<tr>
<td>Homerton University Hospital</td>
<td>742</td>
<td>320</td>
</tr>
<tr>
<td>King George Hospital</td>
<td>627</td>
<td>262</td>
</tr>
<tr>
<td>Queens Hospital</td>
<td>498</td>
<td>90</td>
</tr>
</tbody>
</table>

Total No. with Blood taken (n=7,807)
- 47.6% Male
- 42.6% White
- Median age = 47 years

BBV testing not done* (n=5,689)
- 72.9%
- 46.8% Male
- 58.7% White
- Median age = 48 years
(* testing not offered or not accepted)

BBV testing done* (n=2,118)
- 27.1%
- 49.6% Male
- 46.7% White
- Median age = 45 years

HIV
- Total = 17, 0.80%
  New = 6, 0.28%

HBV
- Total = 15, 0.71%
  New = 11, 0.52%

HCV
- Total = 39, 2.04%
  New = 15, 1.84%

Barts Health NHS Trust
Results

- 7,807 patients had taken bloods during their ED visit
- 2,118 had BBV testing (bloods not taken vs tests refused not captured)
- Testing uptake was 27%, differing amongst EDs (range 9.5% - 60.5%)
- 71 BBV tests were positive (3.4%) with 32 (45.1%) new diagnoses:
  - HCV infections 39 (15 newly diagnosed)
  - HIV infections 17 (six new)
  - HBV 15 infections (11 new)
- Those aged 25-54 had the highest prevalence: HCV 2.46%, HIV 1.36% and HBV 1.09%
- Cost per new diagnosis (£7 for each virus) £988 for HCV, £1,351 for HBV and £2,478 for HIV
Conclusions

- Universal testing in the ED identified 32 new infections over seven days, 4.6 new infections per day.
- Testing for HIV alone would have missed 54 viral Hepatitis diagnosis (45% new).
- This week-long pilot strongly supports further evaluation of routine BBV testing in UK EDs.
Media Coverage...

[Images of social media icons (Twitter, Facebook, Radio), a news article from The Guardian titled 'Hepatitis C: Hunting the silent killer', and a photo of two people wearing shirts with the 'Going Viral' logo.]

Barts Health NHS Trust
Hootsuite, a social market research company, analysed social media activity and reach during the week of the campaign via #GoingViral3in1.

On Twitter the campaign hashtag achieved 1500 mentions, 1200 of which were re-tweets.

Tweeters were 70% female, tweets 98% in English, with 75% from the UK, 11% from the USA and 11% from South Africa.

These generated 5.8 million impressions (defined as delivery of a tweet to a twitter account), reaching the same number of potential users.
Funding secured for further opt-out HBV/HCV/HIV triple testing
- All ED attendees at the Royal London Hospital
- from 23\textsuperscript{rd} November 2015
- for 12 months!
Acknowledgements

Thanks to...

- Dr Chloe Orkin
- Dr Emma Wallis
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- Dr Monica Lascar
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- Dr Rak Nandwani
- Dr Joanne Bulman
- Dr Iain Reeves
- Dr Adrian Palfreeman
- Prof Graham Foster
- Dr Karim Ahmad
- Dr William Tong
- Dr Sam Lattimore
- Dr Georgina Ireland

Thanks to...

- Hep C Trust
- Charles Gore
- BHIVA
- BASHH
- BASL
- Gilead
- Abbvie
- Barts Health Charity
BBV opt-out testing in prisons: A progress report

Jane Cox, Policy and Public Affairs Adviser, The Hepatitis C Trust

Tuesday 24 November 2015
Brighton
BBV opt-out testing in prisons: a progress report

Jane Cox
Elimination as a serious public health concern
BBVs in prisons

Under-diagnosis is a huge issue with BBVs

Prevalence of BBVs in prisons is exceptionally high:
- Survey in 1998 showed 0.4% infected with HIV, 8% with hepatitis B and 7% with hepatitis C.
- Between 2008-12, 25% of female prisoners who were tested had a positive result, compared to 11% of male prisoners who were tested.

Historically low record of testing (7.8% new receptions in 2013)

Transmission within prisons

Community benefit
Progress!

NHS England, NOMS and PHE published their National Partnership Agreement in 2013

12 priorities for 2013/14, one of which was:

‘To work together to design and deliver an appropriate ‘opt-out’ model of testing for BBVs by April 2014, in collaboration with other non-statutory partners (e.g. National AIDS Trust and the Hepatitis C Trust)’.

http://www.justice.gov.uk/about/noms/working-with-partners/health-and-justice/partnershipagreement
An analysis of need towards full implementation

8 prison healthcare managers interviewed

<table>
<thead>
<tr>
<th>Prison</th>
<th>Region</th>
<th>Category</th>
<th>Capacity</th>
<th>Pathfinder involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMP Bristol</td>
<td>South West</td>
<td>B</td>
<td>614</td>
<td>Phase 3 pathfinder</td>
</tr>
<tr>
<td>HMP Brixton</td>
<td>London</td>
<td>C/D</td>
<td>798</td>
<td></td>
</tr>
<tr>
<td>HMP Haverigg</td>
<td>North West</td>
<td>C/D</td>
<td>644</td>
<td></td>
</tr>
<tr>
<td>HMP Holloway</td>
<td>London</td>
<td>YOI</td>
<td>501</td>
<td></td>
</tr>
<tr>
<td>HMP Lewes</td>
<td>Kent &amp; Sussex</td>
<td>Local male</td>
<td>742</td>
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<tr>
<td>HMP Pentonville</td>
<td>London</td>
<td>Local male</td>
<td>1310</td>
<td>Phase 3 pathfinder</td>
</tr>
<tr>
<td>HMP Stocken</td>
<td>East Midlands</td>
<td>C</td>
<td>842</td>
<td>Phase 2 pathfinder</td>
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<tr>
<td>HMP Wandsworth</td>
<td>London</td>
<td>Local male</td>
<td>1877</td>
<td></td>
</tr>
</tbody>
</table>

3 offering opt-out testing (2 DBST, one oral testing)
1 about to start (rolling out in substance misuse services initially to pilot)
4 not offering BBV testing yet
“So far we are in infancy but we are really quite excited about it [introducing opt-out BBV testing]. I think that it’s really good news that we are doing something much more organised and structured than before because it’s really well overdue in prisons I think.”

“I have met with some prisons that are about to start and I think the anxiety is often the cost and the numbers. But actually in reality we haven’t really, other than thinking about where you’re going to dry them and to think about how it best works for individual prisons, I don’t think we’ve really experienced any problems. So I think there’s more anxiety about doing it than there is in reality the process of actually doing it.”
Issues raised…

1. Care pathway guidance required
2. Clarity of funding
3. Continuity of care
4. Guidance on training
5. Tailored information for prisoners
6. General complexities of delivering healthcare in prisons
7. Delivery of negative results
Expert roundtable: What does ‘good’ look like?

- **Commissioning**: incorporate a good service into contracts
- **Practical guidelines for providers**: what happens on the shop floor?

Testing → Diagnosis → Support → Treatment → Continuity of care
### January 2016: Guidance on hepatitis C prevention, diagnosis and treatment in prisons to complement PHE resources

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<td>1</td>
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<td>3</td>
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<td>Treatment</td>
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<td>Information, support and health promotion</td>
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<td>Harm minimisation</td>
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<td>Staff training and education</td>
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<td>11</td>
<td>Reporting and information governance</td>
</tr>
<tr>
<td>12</td>
<td>Links to substance misuse and mental health services</td>
</tr>
<tr>
<td>13</td>
<td>Approval, ratification and review process</td>
</tr>
<tr>
<td>14</td>
<td>Dissemination and implementation</td>
</tr>
<tr>
<td>15</td>
<td>Monitoring, compliance and effectiveness</td>
</tr>
<tr>
<td>16</td>
<td>References</td>
</tr>
</tbody>
</table>

**Appendices**
1) Example BBV testing pathway
2) Example hepatitis C treatment pathway
3) Example alternation to regime pathway
4) Example continuation of care pathway
Key aspects…

- Testing normalised: expectation at second reception, continuous offer throughout stay
- DBST optimises opportunity
- PCR automatically performed when antibody positive
- On-going training for healthcare staff, also substance misuse, mental health, governors – culture change
- In-reach service, regular clinics run by specialist nurse / consultant; linked to ODN
- Nurse with special interest inside the prison
- Practicalities: drugs, diagnostic testing, use of SystmOne
- How to ensure continuity of care
- Who pays for what?

Workshop at 2.10: Increasing testing and improving treatment pathways for BBVs in prisons
*Natalie Robinson and Leigh Wilkinson, HMP Kirkham*
“We have successfully treated quite a lot of people over the past few years which is great but we’ve also seen quite a lot of people with decompensated liver and who have liver cancer because it hasn’t been picked up.”
Hepatitis C Good Practice Roadshow

Tuesday 24 November 2015
Brighton
Hepatitis C and HIV (co-infection) patient perspective

Robert James

Tuesday 24 November 2015
Brighton
Commissioning landscape for hepatitis C

Bill Gillespie, Regional Director for Specialised Commissioning, South, NHS England

Tuesday 24 November 2015
Brighton
Commissioning landscape for hepatitis C

Bill Gillespie,
Interim Regional Director Specialised Commissioning (South)

24 November 2015
Overview

• NHS England – commissioner of services

• Commissioning of Hepatitis C services

• Treatment

• Achievements

• Challenges

• Ambitions
Specialised Commissioning NHS England

- Five Year Forward view - vision for transformation in prevention
- Integrated and networked care models to improve patient experience
- Collaborative commissioning approaches in specialised commissioning to improve commissioning
- Care pathways in partnership with CCGS and LA’s
- Strong national support implemented locally
- 6 programs of care, over 70 CRGs, 200+ service specifications - £13bn
Commissioning Hep C Services

- Complex pathway: variance in settings, infectious diseases, substance misuse and liver services
- Drug costs – NHS England specialised services
- Attendance – falls to different commissioning bodies
- Improve access to treatment in view of the current model of care delivery
Treatment for patients with Hep C in England

Who makes treatment decisions?

- Health and Justice: Prison health services
- LAs
- NHS England: Infectious Dis / Gastro / Liver services
- Clinical Commissioning Groups: DGH / Community Services
- All via HEP C ODNs (hubs and spokes)

Cost of drug treatment – NHS England
Challenges

- Patient populations
- Engaging users – designing the service
- Diagnosis
- Pattern of disease progression
- Treatment
- Service impact – prevalence, new diagnosis rate, treatment options
- The ambition – to reduce liver cancer, cirrhosis and end stage liver disease
MDT support in treating HCV – Model of Care

- Establishment of Operational Delivery Networks – working in partnership with care services to combine access to medical expertise locally
- Effective treatment targeted within pathway
- MDT decision making on treatment by clinicians with Hepatology expertise
- Patient treatment historically low – 3% (new treatments to improve this)
### Hepatitis-C Operational Delivery Network lead provider map

<table>
<thead>
<tr>
<th>Network name</th>
<th>Lead provider</th>
<th>Region covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surrey Hepatitis Services</td>
<td>Royal Surrey County Hospital NHS FT</td>
<td>Surrey</td>
</tr>
<tr>
<td>Sussex Hepatology Network</td>
<td>Brighton &amp; Sussex University Hospitals-Royal Sussex County Hospital</td>
<td>Sussex</td>
</tr>
<tr>
<td>Thames Valley Hep C ODN</td>
<td>Oxford</td>
<td>Oxfordshire, Berkshire, Bucks, Swindon &amp;North Wiltshire</td>
</tr>
<tr>
<td>Wessex Hep C ODN</td>
<td>University Hospital Southampton NHS FT</td>
<td>Dorset, Hampshire, &amp; IOW, South Wiltshire</td>
</tr>
<tr>
<td>Bristol and Severn Hep C ODN</td>
<td>University Hospital Bristol NHS FT</td>
<td>Bristol, North Somerset &amp; Gloucestershire, Gloucestershire, Somerset</td>
</tr>
<tr>
<td>SW Peninsula Hep C ODN</td>
<td>Plymouth Hospital NHS Trust</td>
<td>South west Peninsula and Somerset</td>
</tr>
<tr>
<td>Kent Network via Kings ODN</td>
<td>Kings College Hospital NHS FT</td>
<td>Kent</td>
</tr>
</tbody>
</table>
Specification Overview

Service Model
• The service model proposed is a formal network (Operational Delivery Network (ODN))

• The mature service will be provided as a network with a host organisation (prime contractor model) responsible for delivering the service via a variety of joint ventures, which will include (but not be restricted to) other hospitals, clinics, specialist addiction services, and secure environments.

Service provided
• Full patient pathway management will be in accordance with NICE and national guidelines.

Models of care
• Not defined as it is unlikely that a single model of service delivery will be optimal in all locations.
• Specific local models may be needed to provide a service to prisons and other secure environments.
Where are we?

- Lead providers are at varying stages of developing their Operational Delivery Networks (ODN).
- Monies have been allocated for extra resources required by both lead provider and partner organizations.
- King’s (Kent) have produced their operational delivery network agreement to share with their partner organizations.
- All lead providers have been asked to provide updates on the progress of their ODN’s.
- Regular meeting are / have been set up with lead providers to gauge and monitor progress.
- New antivirals being prescribed appropriately (Blueteq).
Ambitions

• Step change in treatment of HCV related liver disease
• Ensure patients with cirrhosis are identified
• Treatment of cirrhosis
• New treatment technologies: improving side effect profile (will lead to increased demand)
Questions
Hepatitis C Good Practice Roadshow

Tuesday 24 November 2015
Brighton
Panel discussion: Problems and solutions for tackling hepatitis C locally

Tuesday 24 November 2015
Brighton
Good practice: Community-based testing and treatment for hepatitis C

Magaret O'Sullivan, Community Hepatitis Nurse, Viral Hepatitis, Brighton and Sussex University Hospitals NHS Trust

Tuesday 24 November 2015
Brighton
PROJECT ITTREAT-Community based service for Hepatitis C Infection

Mags O’Sullivan, Dr Hugh Williams, Dr Sumita Verma
PHE 2015

- 214,000 Adults with HCV (Hepatitis C virus) in UK
- 90% - PWID
- <5% Treated

**Strategy**

- Prevention
- Increase testing and Awareness
- Increase treatment and Care
- Treatment alone is not enough
Background

- High prevalence of HCV in Brighton
- High levels of on-going high risk behaviour
- Low numbers in treatment
- 2012 six month research at the SMS (substance misuse services)
- <5% of hospital referrals attended
- Recognition of need for a community clinic to extend to vulnerable group.
Funding

- Dr Verma Academic Hepatologist

- Gilead fellowship programme/Gilead Investigator Sponsored Research and Brighton and Hove commissioners

- Partnership between BSUH/BSMS and SMS

- Funding for a specialist nurse/fibro scan/phone/laptop

- VALID Homeless project funded by Dunhill medical trust
Aim of research

- Establish and evaluate the viability of a community HCV service (integrated test, stratify and treat)

- Collection of
  - Clinical data data (demographics, drug and alcohol use, acceptance of DBST, HBV vaccination and HCV treatment
  - Outcomes
    - Patient reported outcomes (SF12, SFLDQOL)
    - Health Economics

- Conduct of qualitative interviews with SMS attendees and two focus groups with staff members to assess their views about the service.

- Timeline December 2013 to Nov 2017
Complexity of this vulnerable group

- Addiction
- Mental health
- Learning difficulties
- Homelessness
- Domestic abuse
- Sexual abuse
- Poor nutrition

- Multiple bereavements
- Physical health issues
- PTSD
- Learned associated behaviour
- Socially isolated
- Lack of core coping strategies
Management of HCV is complex

Patient
- Asymptomatic
- Competing priorities
- Poor venous access
- Stigma
- Treatment side effects
- Continued alcohol and drug use
- Mental health
- Co-morbidities

Services
- Lack of awareness and education
- Low testing rates
- Resources
- Competing priorities
- Rigid hospital appointment times
Integrated model of care

- Accessibility of specialist HCV care under one roof
- Familiar, non judgemental environment
- Flexible appointments
- Care co-ordinators onsite
- Psychiatrist onsite
- Needle exchange onsite
- Opiate substitute prescribing onsite
- Access to practical help
- Recovery community
- Peer mentors
- Volunteers
- Support group
- GP support
Role of specialist nurse

- Establish the clinic at the SMS
- Education and raising awareness sessions
- Intensive onsite support to staff and clients
- DBST/vaccinations/phlebotomy/Liver assessment including onsite fibro scanning to measure liver stiffness (LSM)
- Liaising with all multidisciplinary team members
- Co-ordination and close monitoring of clients on HCV treatment
Present: 310 recruited

- Mean age 39.7 yrs.
- 81.6% Male
- 30% currently injecting
- 74.5% ever injecting
- 19.4% alcohol >21iu weekly
- 45.5% psychiatric diagnosis

- HBcAb 18.7% (n=58)
- 56.0% HCV Ab (n=168)
- 79.2% HCV PCR positive (n=133)
- 111 community fibro scan
  - 41 (35.7%) > LSM 7.5kPa
  - 24 (18%) cirrhosis (LSM 12kPa)
36 treatment clients

- 36 Started treatment
- 22 (61%) completed
- 13 on treatment
- 1 stopped - mental health
- 12 SVR to date
- 6 waiting SVR results
- 4 Responder Relapser
- 5 treated in EAP - decompensated cirrhosis
- 13 interim policy
- Total 14 cirrhotic clients
- 4 non cirrhotic G1 started on Sof/Peg/Riba at the SMS
Case study

- Male 58yrs, drinking 20iu daily, diagnosed with cirrhosis during hospital admission. DNA follow up. Seen at SMS, did not feel unwell and very reluctant to stop drinking. Seen by Dr Verma and I at SMS.

Package of care:
- Inpatient alcohol detox pre treatment
- G3a on Sofosbuvir/Pegylated Interferon/Ribavirin for 3 months
- Weekly appointments due to neutropenia and anaemia needing weekly GCSF injections and monitoring
- RVR at treatment week 4, continues on treatment
Case study

- Male 59yrs, lives alone and socially isolated, diagnosis of anxiety and depression. Nil illicit use but drinking 1 bottle of wine daily. Refused to attend hospital setting, guarded and fearful of services. Seen at SMS and diagnosed with decompensated cirrhosis.

Package of care:
- Increased input by key staff, established trusted relationship with peer mentor.
- Alcohol intake addressed, EAP funding of treatment, shared care of client between hospital and SMS for close monitoring. Peer mentor KEY to engagement.
97 remaining not on treatment

- Mental health issues
- Significant alcohol/drug use
- Ongoing social issues
- Rehab/early recovery
- Moved away/prison
- 75 Waiting
New treatment regimes

- Dramatically increase uptake within this population.
- Shorter duration/reduced side effects
- Increase SVR’s
- Benefits to the client’s physical and mental health
- Reduced hospital admissions for ESLD/HCC
- Reduce prevalence and interrupt transmission
- Benefit to society
Shared responsibility

- Continue to raise awareness and provide teaching sessions to services in Brighton
- BBV champion training for hostel/primary care/secondary care staff
- Peer mentor development
- Volunteer/buddy system
- Recovery café/recovery community
- HIP group-Hepatitis Information Point
Any Questions?

Thank you
Margaret O’Sullivan
margaret.o’sullivan@bsuh.nhs.net
07768355937

This project has been supported by an educational grant via the Gilead and Ireland fellowship programme
References

- Hepatitis C in the UK 2014: Public Health England (PHE) annual report
- Shooting up: Infections among people who inject drugs in the UK 2012. PHE
- Unlinked anonymous HIV and viral hepatitis monitoring among PWID:2013 report. HPA
- Barriers and Facilitators for Assessment and Treatment of Hepatitis C Virus Infection in Opioid Substitution Treatment Setting. 2014 Treloar et al. Journal Viral hepatitis
Workshops

1. Awareness and prevention: ChemSex and BBVs (This room)

2. Improving treatment pathways through ODNs (Fecamp Lounge)

3. Increasing testing and improving treatment pathways for BBVs in prisons (Regency Suite)
Workshops

1. Awareness and prevention: ChemSex and BBVs (This room)
Chemsex, Trends & Interventions

Jamie Willis
Training & Outreach Manager
Antidote @ London Friend
London Friend

- Small charity working to promote health & well-being of lesbian, gay, bisexual and trans (LGBT) people
- Identity, self esteem, mental health, sexual health, well-being
- Drug and alcohol service – Antidote
- Almost exclusively club drug use
Antidote experience

- Established 2002 at Turning Point
- Moved to London Friend 2011
- Community support service – psycho-social interventions, complementary therapies
- Late 2000s increased crystal and G
- Medical pathways
- Club Drug Clinic and GUM satellites
- SWAP - Structured Weekend Antidote Programme
Why are we concerned?

• Evidence of users presenting for treatment
• Small number experiencing significant harms
• Numbers in treatment increasing
• Concern of ‘time-lag’ between using and problematic use
• ‘Legal highs’ – no evidence base
How many seek treatment for club drugs?

Club Drug use among new presentations to treatment (18+) in 2005 – 2014

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>GHB/GBL</td>
<td>18</td>
<td>46</td>
<td>66</td>
<td>80</td>
<td>142</td>
<td>135</td>
<td>190</td>
<td>231</td>
<td>249</td>
</tr>
<tr>
<td>Ketamine</td>
<td>114</td>
<td>235</td>
<td>392</td>
<td>558</td>
<td>675</td>
<td>845</td>
<td>751</td>
<td>868</td>
<td>944</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>1,872</td>
<td>2,138</td>
<td>2,102</td>
<td>1,694</td>
<td>1,467</td>
<td>1,067</td>
<td>1,018</td>
<td>1,089</td>
<td>964</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>22</td>
<td>27</td>
<td>52</td>
<td>42</td>
<td>75</td>
<td>78</td>
<td>116</td>
<td>208</td>
<td>240</td>
</tr>
<tr>
<td>Mephedrone*</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>839</td>
<td>900</td>
<td>1,630</td>
<td>1,641</td>
</tr>
<tr>
<td>Any club drug cited</td>
<td>1,991</td>
<td>2,371</td>
<td>2,503</td>
<td>2,246</td>
<td>2,280</td>
<td>2,692</td>
<td>2,675</td>
<td>3,536</td>
<td>3,543</td>
</tr>
<tr>
<td>Percentage of all new presentations citing a club drug</td>
<td>2%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
<td>4%</td>
<td>4%</td>
<td>5%</td>
<td>5%</td>
</tr>
</tbody>
</table>

*A code for mephedrone was added to the NDTMS Core Data Set in 2010-11. Any clients reporting mephedrone prior to this are counted in the ‘Any club drug cited’ total but no separate total is given for mephedrone.*
Who seeks treatment?

- Typically different profile to traditional drug services
- Higher functioning
- Less likely to have criminal record
- Respond well to treatment – ‘recovery capital’
- Triggers include arrest & negative experience whilst using
What’s new?

- Mephedrone
- Bladder issues from ketamine use
- Sexualised using
- Dependence (GBL)
- Significant mental health concerns (mephedrone, crystal meth)
- Injecting (8% of adult club drug users, up to 75% in Antidote amongst MSM)
What’s being used in London?

• Info from Club Drug Clinic at Chelsea & Westminster hospital
• Different and distinct patterns of use in LGBT and non-LGBT communities
Heterosexual use

- Cocaine
- Ketamine
- Alcohol
- MDMA
- GBL
- Mephedrone
LGBT use

- GBL
- Crystal Meth
- Mephedrone
- Alcohol
- Cocaine
- Ketamine
Drug use by LGBT people

- Part Of The Picture research by Lesbian & Gay Foundation
- Up to seven times more likely to be using drugs (LGF)
- UK Drug Policy Commission report 2010
- All reports consistently higher levels
- Stonewall research higher in BME LGB people
- Evidence of “early adoption” e.g. ‘legal highs’
- Increased sexual risk behavior particularly associated with some drugs
- Uptake of services low and perceived not to meet needs
- Little evidence of LGBT interaction with criminal justice system
Why higher levels of LGBT use?

Internalised homophobia/transphobia - a feeling of personal unease about sexual orientation or gender identity

• Growing up “different”
• Hyper-vigilant about judgment, rejection
• Bullying at school
• Lack of positive role models
• “Abomination” “Unnatural” “Sinful”
• Sexual shame/ intimacy anxiety/ vulnerability issues
• HIV stigma/reality
• ‘Normalised’ drug use and other behaviours within the LGB & T communities
## Recent trends

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>130 – 73%</td>
<td>79 – 11%</td>
</tr>
<tr>
<td>Cocaine</td>
<td>46 – 26%</td>
<td>86 – 11%</td>
</tr>
<tr>
<td>Ecstasy/MDMA</td>
<td>37 – 21%</td>
<td>9 – 1%</td>
</tr>
<tr>
<td>Ketamine</td>
<td>23 – 13%</td>
<td>44 – 6%</td>
</tr>
<tr>
<td>GHB/GBL</td>
<td>3 – 2%</td>
<td>334 – 46%</td>
</tr>
<tr>
<td>Crystal meth</td>
<td>0 – 0%</td>
<td>373 – 51%</td>
</tr>
<tr>
<td>Mephedrone</td>
<td>0 – 0%</td>
<td>461 – 64%</td>
</tr>
<tr>
<td>Heroin</td>
<td>5 – 3%</td>
<td>2 – &gt;1%</td>
</tr>
<tr>
<td>Crack</td>
<td>14 – 8%</td>
<td>6 – 1%</td>
</tr>
<tr>
<td>Referrals from GUM, A&amp;E, statutory drug services</td>
<td>8%</td>
<td>63%</td>
</tr>
</tbody>
</table>
Mephedrone (Meow Meow) Class B

- Approx £20 per gram
- Snorted, dabbed, swallowed, injected
- Stimulant; a cathinone, similar to amphetamine
- Vascular constrictor
- Used for dancing, sex
- Increasingly responsible for psychotic presentations
Crystal Methamphetamine (Class A)

- “Crystal”, “Tina”, “Ice”, “Crank”, “Yabba”
- £80 -£100 per half gram
- Powerful amphetamine, crystalline form (occasionally powdered)
- Used widely by MSM in sexual contexts. (Low incidence of non MSM use in UK)
- Smoked, injected (snorted, booty-bumped)
- Powerful high, compulsive behaviour, increased libido, users awake for days
- Psychological dependence very common
- Increasingly responsible for psychotic presentations/sexual health consequences
**GBL (GHB) Class C**

Gammabutyrolactone/Gammahydroxybutyrate

- “G”, “Gina”
- A solvent, used industrially
- Liquid (ingested orally)
- 2 principal dangers; **toxicity** (overdose) and **physical dependence**
- 30ml bottle = (approx) £15
- Sedative (though with stimulant-like effects)
- Euphoria; used to dance, sleep; for sex, confidence, as an anti-depressant
- Used widely by LGB communities
Recent trends in MSM

Of G and crystal users:
• 95% using to facilitate sex
• 75% injecting
• Prefer to use ‘bareback’ sites to find sex
• Average 5 partners per episode
• 52% HIV positive
• 48% with HIV attribute diagnosis to drugs
• 60% non-adherence to ARVs whilst ‘high’
• >50% of HIV negative men had at least one course of PEP in past year (max 8 in 2 years)
A survey of 874 MSM who reported chem use found:

- 98% had never previously accessed drug use support
- 45% reported average of between four and 10 partners per episode
- 70% reported no ‘chem-free’ sex in previous 6 months (Zero Sober Sex)

- Of the HIV - cohort, 40% reported using condoms less than 50% of the time. 55% had done 1 or more courses of Pep
- Of the HIV + cohort 64 % not on ARV reported zero condom use of those on ARV, 25 % reported zero condom use 64% reported good ARV adherence
Let’s talk about sex, baby...
The popularity of “BareBacking”
Chems online
New challenges

• New drugs, with less information
• Different (greater) harms
• Dependence
•Injecting practices
• Sexual risk behaviour
Working in GUM settings

- People present much earlier than they would to a drug service
- Treatment of STIs or PEP
- Perfect opportunity to deliver motivational & preventative interventions
Interventions with LGB & T clients

• Same principles: MI, CBT, relapse prevention
• But with cultural adaptations: e.g. relapse prevention through management of online sexual-social profiles
• Tackle sexual health and drug use together
• Only 12% of Antidote clients would feel comfortable accessing ‘mainstream’ treatment
Chemsex clients in your services

• What are your experiences of working with chemsex clients?
• Have there been any noticeable trends?
• Have you experienced any differences working with them? Any difficulties?
• If no direct experience, what are your concerns about supporting this group?
• How do you think services can best respond?
Contact details

• [www.londonfriend.org.uk](http://www.londonfriend.org.uk)
• [www.londonfriend.org.uk/antidote](http://www.londonfriend.org.uk/antidote)
• [antidote@londonfriend.org.uk](mailto:antidote@londonfriend.org.uk)
• [www.facebook.com/londonfriend](http://www.facebook.com/londonfriend)
• Twitter: [@lgbtfriend @JamieWillis71](http://twitter.com/lgbtfriend @JamieWillis71)
• 020 7833 1674
2. Improving treatment pathways through ODNs
IMPROVING TREATMENT PATHWAYS THROUGH ODNS

Clare Phillips and Alex File
Hepatology Clinical Nurse Specialists
Brighton
Introductions

• **Alexandra File**
  • Hepatology Clinical Nurse Specialist at Royal Sussex County Hospital and soon to cover Worthing Hospital

• **Clare Phillips**
  • Hepatology Clinical Nurse Specialist at Royal Sussex County Hospital and East Sussex Healthcare Trust (Eastbourne and Hastings)

• **Majella Keller** (Absent today)
  • Hepatology Clinical Nurse Specialist at Royal Sussex County Hospital and Lewes Prison
We will cover

• What are ODNs and why have they been established?
• Sussex Hepatology ODN
• How you can contribute
• Discussion: Patients with HCV - Improving access to care
• Discussion: Undiagnosed patients - how do we target those at risk?
What is an ODN?

• Operational Delivery Network

• Initially set up to administer ‘Treatment of chronic Hepatitis C in patients with cirrhosis’ policy – often referred to as the ‘interim policy’

• Now oversees all patients going onto treatment in the region

• ‘ODNs will provide clinical leadership over a given geography, co-ordinating high quality patient care through a specialist multidisciplinary team (MDT) and delivering oral therapies in line with this policy in largely outpatient (including outreach) settings’ NHS England
Why have ODNs been established?

• To oversee treatment of HCV within a region

• To ensure appropriate treatment options are prescribed

• To ensure access is available in all areas of the country (equitable access) but with specialist support and advice available within the local region
  • Improve treatment success and patient engagement
  • Reduce need for patients to travel long distances for treatment

• The lead site takes responsibility for feeding back data from the region to NHS England

• Puts onus on each region to responsibly prescribe cost effective treatments and to work within the policies.
The ODN application process

- Prior to the ODNs being established EAP centres administered access to newer treatments

- EAP (early access programme) was launched in summer 2014 to treat patients with decompensated cirrhosis only

- Brighton applied and became EAP site **BUT** all patients from within Sussex had to travel to Brighton for treatment – the EAP sites seen as the expert centres to treat these patients

- BSUH had to reapply to become an ODN and was granted ODN status in August 2015.
ODN requirements

- Hepatology Consultant
- HIV Consultant
- Virology Consultant
- Pharmacists
- Clinical Nurse Specialists
- Administrator

- Multi-disciplinary Team Meetings (weekly)
- Fibroscanner
- HCV UK research membership
- Inreach & Outreach clinics
- HCV UK research
Sussex Hepatology ODN

- Lead site – BSUH
- Partner sites – ESHT, WSHT, Drug and Alcohol Services, Lewes Prison – Sussex Partnership
- 210 GP practices within the network area
ODN members

- Hepatology Consultants – Lead Dr Jerry Tibble
- HIV Consultants
- Clinical Nurse Specialists
- Pharmacists
- Network Administrator
- Virology Consultant available
The MDT

• MDT held every Friday morning
• Cases brought from all sites – typically 5 or 6 cases discussed per week
• Unusually for an ODN we have nurses working on all sites (or soon will have) so cases are rapidly presented and follow-up is rapid
• Current focus on treating the cirrhotic cohort
Sussex Hep C ODN – Patient pathway

- GP Services / Primary Care
- Social Health Clinics
- HIV Specialist Centres
- Community Substance Misuse Service
- Prison Healthcare Teams

- Refer to Sussex Hepatology ODN
- To generate and secure email address (Sussexhepc@doctors.net)
- Referring Centre to receive acknowledgement within 48 working hours (excluding confirmed date of MDT review)

- Network MDT (weekly) review of treatment
- Within 2 weeks of receiving referral from the Referring Centre

- Start Treatment
  - Treatment Plan documented sent to the Referring Centre
  - Prescriptions done locally by the Referring Centre
  - Referring Centre informs GP of the treatment plan
  - Local follow-up arranged (4-6 weeks from discharge)
  - Treatment start 4.6 weeks from initial referral to the ODN
  - Patient invited to give feedback
    - Including Friends and Family Test plus local ODN survey (if appropriate)

- Delay Treatment
  - Watch & Wait
    - Ongoing referral (Substance Misuse, UAP, etc.)
    - Referral to Tertiary Centre (e.g. for transplant)
Sussex Hep C ODN – Patient pathway - times

1. Patient Assessed in Referring Centre: Max 1 week
2. Referral to Sussex Hepatology ODN: Max 2 weeks
3. Network MDT Review: Max 1 week
4. Treatment Plan back to Referring Centre & Prescription arranged: Max 2 weeks

TOTAL of 6 weeks

TREATMENT STARTED
# Sussex Hepatology ODN MDT Referral Form

## Patient Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
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<tbody>
<tr>
<td>Patient Name</td>
<td></td>
</tr>
<tr>
<td>Phone Number</td>
<td></td>
</tr>
<tr>
<td>NHS Number</td>
<td></td>
</tr>
<tr>
<td>Trust ID</td>
<td></td>
</tr>
<tr>
<td>DOB</td>
<td></td>
</tr>
</tbody>
</table>

## Clinical Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fibroscan (kpa)</td>
<td>Genotype (+ subtype)</td>
</tr>
<tr>
<td>Coinfections</td>
<td></td>
</tr>
<tr>
<td>Imaging evidence (USS, MRI or CT)</td>
<td>Treatment Experienced/Naïve?</td>
</tr>
<tr>
<td>Evidence of PHTN (cirrhotic)</td>
<td>Previous drug regimen</td>
</tr>
<tr>
<td>Liver biopsy</td>
<td>Previous treatment response</td>
</tr>
<tr>
<td>APRI</td>
<td>Interferon intolerant?</td>
</tr>
<tr>
<td>Child-pugh score</td>
<td>Reason for interferon intolerance?</td>
</tr>
<tr>
<td>MELD score</td>
<td></td>
</tr>
<tr>
<td>Previous OLT?</td>
<td>Ribavirin intolerant?</td>
</tr>
<tr>
<td>Listed for transplant?</td>
<td>Current weight (kg)</td>
</tr>
</tbody>
</table>

## Current bloods (last 3 months)

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>AST</td>
<td>GGT</td>
</tr>
<tr>
<td>ALT</td>
<td>BILI</td>
</tr>
<tr>
<td>ALP</td>
<td>ALB</td>
</tr>
<tr>
<td>AST:ALT</td>
<td>AFP</td>
</tr>
</tbody>
</table>

## Patient History

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past Medical History</td>
<td></td>
</tr>
<tr>
<td>Current Medications</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergies</td>
<td></td>
</tr>
<tr>
<td>Alcohol (unit/week)</td>
<td></td>
</tr>
<tr>
<td>Recreational drug use</td>
<td></td>
</tr>
</tbody>
</table>

## MDT Outcome

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy Advice (DDIs)</td>
<td></td>
</tr>
<tr>
<td>Drug Regimen</td>
<td></td>
</tr>
<tr>
<td>Clinicians present</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinicians present</th>
</tr>
</thead>
<tbody>
<tr>
<td>A St Clair Jones, A Parmar, C Wood, C Phillips, A File, Dr S Verma, Dr N Parnell, Dr K Jamil, Dr J Tickle, Dr M Austin, Dr Y Gileece, M O’Sullivan, M Keller</td>
</tr>
</tbody>
</table>
Reasons for declining a referral

- High alcohol intake
- Chaotic drug/alcohol use – no engagement with services
- Other co-morbidities which may preclude treatment
- Poor prognosis e.g. palliative cancer (could unrelated to HCV)
How you can contribute?

• Identify cases and refer into your local service who will refer to ODN MDT
  • Given the future landscape of treatment we need to know who has HCV
  • Now is the time to be finding cases, assessing patients and starting the process of engagement

• Supporting patients on treatment

• Education
  • HCV treatments
  • Fibroscanner
  • Infection prevention
Discussion: Patients with HCV - Improving access to care

• What are the barriers to people accessing care?
• What can we put in place to ensure a smoother transition into treatment services?
• How can we ensure greater link-up between community services (GP, SMS etc) and treatment services/ODN?
• What additional support do people need to access treatment and whilst on treatment? How can this be provided?
Brighton and Sussex University Hospitals NHS Trust
Hepatitis C patient referral form

Anti-HCV antibody positive patients

Surname: ..................................................................................
Forename: .............................................................................

DOB: .................................. Sex: .................................. NHS number: .............................................

Home/Contact Address: ..........................................................
.........................................................................................
.........................................................................................
.........................................................................................
.........................................................................................
.........................................................................................
.........................................................................................
.........................................................................................

Postcode: ..............................................................................

Tel No Home: ............................................................. Mobile: ..........................................................

Consent to send text reminder Yes ☐ No ☐

General Practitioner’s Name: ............................................................

Address: ..................................................................................
.........................................................................................
.........................................................................................
.........................................................................................
.........................................................................................
.........................................................................................

Postcode: ..............................................................................

Key Worker: ..............................................................................

Reason for testing / Risk factors (please tick all relevant):

Injecting Drug Use ☐ Current use (past month) ☐ Past use ☐
Abnormal LFTs ☐
Unexplained Jaundice ☐
Chronic Hepatitis/Cirrhosis ☐
Blood Transfusion Pre-1991 ☐
Contact with case ☐ Sexual ☐ Household ☐ Other ☐
Tattoo/Piercing ☐
Born/lived in a high prevalence country (SE Asia, Middle East, Africa) ☐
Other ☐ Specify: ..............................................................

Test results: Result – please enclose all copies of results

Copy (tick)

Hepatitis C antibody Pos ☐ Neg ☐
Hepatitis C PCR Pos ☐ Neg ☐
Genotype: ..............................................................................

Hep A IgG Pos ☐ Neg ☐
Hep B serology (tick if +ve) HBsAg ☐ HBsAb ☐ HBsAg ☐ HBsAb ☐
HIV status Pos ☐ Neg ☐
Liver Function Tests AbNorm ☐ Norm ☐
FBC AbNorm ☐ Norm ☐
Substance Misuse:
Recent history of substance misuse: Yes = No = Specify ..........................................................

Immunisation History:

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Already Immune</th>
<th>Course Completed</th>
<th>Doses Remaining</th>
<th>Dose Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hep A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hep B</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

History of Alcohol Consumption:
Current alcohol intake ............................................................................................................
Previous alcohol history ...........................................................................................................

Current Medication:

Mental Health History/Diagnosis
Previous psychiatric history No = Yes = details ........................................................................
...........................................................................................................................

Referral made by:
Signature: ..............................................................................................................................
Name: .................................................................................................................................
Designation: .........................................................................................................................
Contact Telephone: ...............................................................................................................
Fax: ......................................................................................................................................
Date: .....................................................................................................................................
Email: ...................................................................................................................................

I wish to be seen by the viral hepatitis team and agree to attend out patient appointments (please be aware that if NA no further appointments will be sent and referral process starts again). Please sign and send to L9 A DDC.

Patient Signature
Referree Signature
Date

I do not wish to be engaged in the viral hepatitis service at present but am aware that I can request referral at any point in the future. File in patient records.

Patient Signature
Referree Signature
Date
Discussion: Undiagnosed patients - how do we identify those at risk?

• How can we increase testing?
• How do we identify those outside of the substance misuse/prison setting?
• How do we get the message out about HCV and the changing landscape of treatment?
• Local initiatives/practices
Acknowledgements

• Thanks to Robert Szymanski who developed the ODN flowcharts and maps.
3. Increasing testing and improving treatment pathways for BBVs in prisons
Introduction To Opt-Out Testing and Good Practice

By Natalie Robinson
Healthcare Support Worker

If you have any questions about any of the aspects of the branding guidelines please contact communications@lancashirecare.nhs.uk

Supporting Health and Wellbeing
What Do I do?

My main role is to support nursing staff throughout the day, but will also see all new receptions that come to HMP Kirkham and will offer Blood born virus screening. To hold regular HCV clinics and to monitor any patient on treatment and to liaise with nursing lead. To organise clinics for the visiting specialist.
What is Opt-out Testing?

An instance where we presume that the patient will be partaking in BBV screening, unless otherwise stated by the patient.
The Challenge

- Re education for Healthcare staff and prison officers.
- Education for patients.
- Increased workload.
- Cost implications increased work load at path lab.
- Understanding of best practice.
Staff Opinions and Barriers

• “What about pre and post test counselling”? 

• “Are we giving patients the opportunity to refuse treatment”?

• “I refuse to force someone the have a test when we have not counselled the patient.”

• “We are testing patients that may not want it.”

• “Are we really gaining consent if we adopt this method”? 

Supporting Health and Wellbeing
Key Lessons

• Learned how staff felt.
• Adapting to a new way of working.
• True understanding of consent.

THE DEFINITION: Permission for something to happen or agreement to do something. English National dictionary

For consent to be valid, it must be voluntary and informed, and the person must have capacity to make the decision. NHS Choices
See the Difference

Number of Admissions to HMP Kirkham

% screened

Jun-15
Jul-15
Aug-15

Supporting Health and Wellbeing

Lancashire Care
NHS Foundation Trust
Practical Steps

• We have introduced opt-out as a routine standard of best practice to other clinics such as NHS Health checks, and Chlamydia Screening.

• Community midwives also use opt-out testing for screening expectant mothers for HIV.
Discussion Time

What are the perceived barriers to introducing opt-out testing in prisons?
What practical steps can be taken to ensure that these barriers are removed?
What additional support may prisoners require in order to participate in the testing process?
Feedback
Treatment pathways In Your Area?
What additional support may prisoners require when undergoing treatment?
How can we ensure a greater link up between prisons and primary/secondary care in order to ensure continuity of support
Feedback and conclusion
REFERENCES

• An audit of hepatitis c services in a representative sample of English prisons 2013 May 2013

• Department of Health Strategy for England August 2002

• Department of Health National Survey of Hepatitis C services in prisons in England July 2012

• Frequently Asked Questions to support the opt-out BBV testing policy May 2014

• Opt-out blood borne virus testing algorithm guidance notes May 20014

• The Hepatitis C Trust Addressing hepatitis C in prisons and other places of detention.
Closing comments

Tuesday 24 November 2015
Brighton
Hepatitis C Good Practice Roadshow

Tuesday 24 November 2015
Brighton