How to wipe out a growing killer

Hepatitis C is a growing problem in London but many sufferers are not getting the care they need. Kosh Agarwal and colleagues present a blueprint for treating the disease.

In London, an estimated 34,000 people with a history of injecting drugs have hepatitis C – yet only about 800 a year are treated. It is widely recognised that people who use drugs can find it difficult to navigate traditional referral pathways to specialist services. We believe people are simply falling through the gaps between services, and that this represents a major health inequality that must be addressed.

The London joint working group for substance misuse and hepatitis C formed in 2009. Its goal is to reduce liver-related mortality in drug users by developing a comprehensive London-wide service based on consensus recommendations, providing consistency and excellence in hepatitis C treatment for people who use drugs, resulting in improved care and outcomes.

These recommendations represent current best practice from opinion leaders and practitioners and should be considered as a blueprint to enable NHS London and successor agencies, commissioners, clinical commissioning groups, clinicians and providers to deliver effective, integrated services in London. They should also be considered as a template for service development in other areas.

It is not clear who will be responsible for delivery following the dissolution of NHS London. In the meantime, the chief executive of the NHS Commissioning Board should assume responsibility.

Rising mortality

In a radically changing healthcare environment with increasingly limited resources, mortality associated with liver disease is rising dramatically in the UK. The cost of liver disease is at least £500m a year, rising by 10 per cent annually. The main causes are alcohol abuse, obesity and viral hepatitis. Of these, hepatitis C is the factor most amenable to intervention, through prevention via education and awareness, and medical intervention.

Models show that large numbers need to be treated in order to prevent an epidemic of severe liver disease, which is extremely debilitating and potentially fatal, and enormously costly to the NHS.

It is clear that London faces a particular and sizeable challenge. Nearly 35,000 people accessed drug services in London last year – over 80 per cent related to heroin or crack cocaine use. People who inject drugs are the group most at risk of acquiring hepatitis C (50-80 per cent within five years of beginning to inject).

This represents a large pool of infected individuals capable of infecting others. Many will have stopped using drugs but may still be infected. London also houses more than 7,000 prisoners and young offenders. Studies from outside the UK suggest that up to a third of prisoners have hepatitis C. Half of England’s rough sleepers are in London. Many use drugs and alcohol, and have other mental and physical health problems, and very poor outcomes.

Hepatitis C can remain asymptomatic for years, so many people are unaware they have it. Left untreated, it can lead to cirrhosis, cancer, liver failure and the need for transplantation. A cost-effective treatment approved by the National Institute for Health and Clinical Excellence that can eradicate the virus in 40-80 per cent of patients, for a fraction of the cost of a liver transplant, is readily available. Treatment would prevent the long term clinical consequences and save at least £600m in London over 20 years.

Current service provision in London is disjointed and patchy, with many smaller local treatment centres.
so that even where individual services are performing well, gaps in the wider provision needed to treat and support drug users with hepatitis C can undermine their progress.

Antiviral treatment is a major undertaking. Side effects can impair day to day function and cause depression, and people who use drugs often lack a robust support network. Consideration should be given to psycho-social support, psychiatric assessment, alcohol use, housing, and appropriate opioid substitution therapy.

Treatment may positively affect a person’s recovery from
resource centre

THE LONDON BLUEPRINT

| Drug services | ★ Everyone attending a drug service in London should be tested for blood-borne viruses and vaccinated against hepatitis A and B. ★ Every hepatitis C ribonucleic acid (RNA) positive patient should be referred to a specialist treatment service for assessment. ★ Every drug worker should have a clear basic knowledge of hepatitis C and consistent harm reduction advice and should provide education. ★ Every centre should have a nominated person responsible for liaising with hepatitis treatment centres, prisons and primary care.

| Specialist hepatitis services | ★ Every hepatitis C treatment centre should have a nominated person responsible for liaising with local drug services, prisons and primary care. ★ Everyone referred to specialist services should be assessed for treatment. ★ Current substance misuse is not a barrier to treatment. ★ Nurse-led outreach services should be established wherever possible. ★ Data should be collected. ★ Patients should have access to mental health support before and during treatment.

| Directors of public health | ★ Every public health locality should have a multi-sector working group responsible for ensuring people who use drugs have access to a robust pathway from testing to specialist treatment services. ★ The use of dry blood spot testing or point of care (rapid) testing should be available in as many services as possible. ★ Data on prevalence and incidence – among both drug users and non-drug users – should be collected.

| Primary care | ★ Every clinical commissioning group should have a nominated lead for hepatitis C and substance misuse. ★ Every hepatitis C RNA-positive patient should be referred to a specialist treatment service for assessment. ★ At least one GP in every practice should have a basic knowledge of hepatitis C. ★ GP practices should have screening strategies.

| Prisons | ★ Test prisoners for blood-borne viruses at their initial health assessment and vaccinated against hepatitis A and B. ★ Every hepatitis C-positive patient should be referred to a specialist treatment service for assessment. ★ Prisoners on antiviral treatment should not have their therapy interrupted. ★ Every prison officer should have a clear, basic knowledge of hepatitis C and consistent harm reduction advice and education. ★ Every prison should have a nominated person responsible for liaising with primary care, public health, drug services and hepatitis treatment centres.

substance misuse, and is an effective way of reducing the spread of the virus. The first generation of directly acting antiviral agents are now licensed, improving treatment options, and adding complexity and specialisation to antiviral treatment. They may offer improved outcomes but there is an additional cost, increased side effects and drug-drug interactions. A clear set of guidelines should be in place to ensure the latest treatment can be delivered efficiently to all those likely to benefit. Our recommendations focus on prevention, diagnosis, treatment and data collection for each type of service. The emphasis is on education and training and on the need for integration and collaboration across drug and specialist hepatitis treatment services, public health, prisons and primary care (see box, above).

From consensus to action plan
Hepatitis C is a major public health issue facing the UK and London in particular.

‘Hepatitis C is a major public health issue facing the UK and London in particular’

patients fall through the net in London for want of effective planning and joined-up services. A multidisciplinary group of experts convened to explore ways to address this problem. A pan-London stakeholder conference developed a consensus, outlining a clear series of actions, each of which will have an individual effect on this problem, but which all together will provide a very significant impact on the seemingly inexorable rise in hepatitis C related liver disease. The consensus will now be turned into an action plan to enable this outcome. ★ Dr Kosh Agarwal is consultant hepatologist and transplant physician at the Institute of Liver Studies, King’s College Hospital Foundation Trust; David Badcock is head of research and development and blood-borne viruses for Addaction; Dr Owen Bowden-Jones is consultant in addiction psychiatry at the Chelsea and Westminster Hospital and honorary senior lecturer at Imperial College London; Dr Ashley Brown is consultant hepatologist at St Mary’s and Hammersmith Hospitals in London and honorary senior lecturer at Imperial College London; Charles Gore is chief executive of the Hepatitis C Trust; Professor David Nutt is director of the neuropsychopharmacology unit in the division of experimental medicine at Imperial College London. All authors are members of The London Joint Working Group for Substance Misuse and Hepatitis C.

FIND OUT MORE
London Joint Working Group for Substance Misuse and Hepatitis C.

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