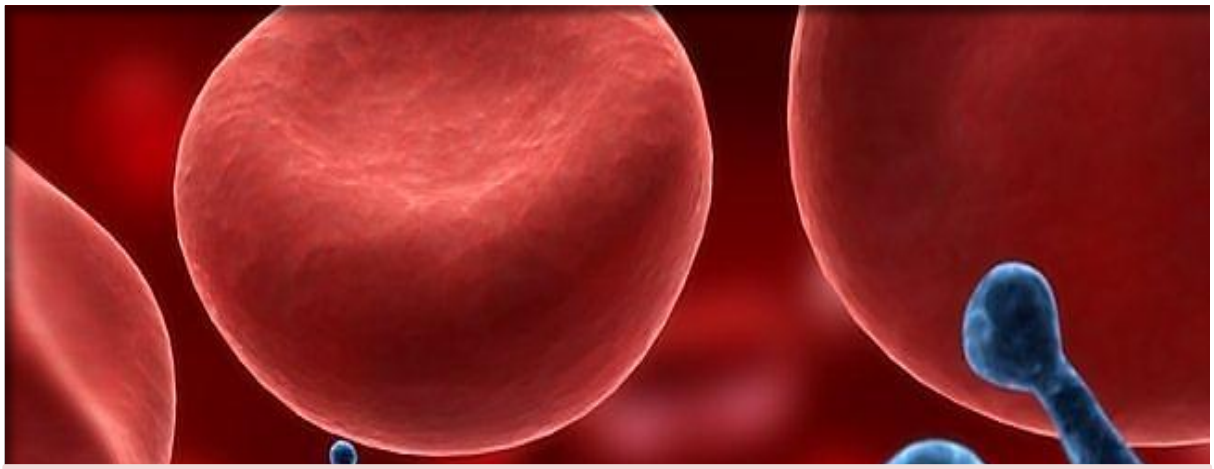
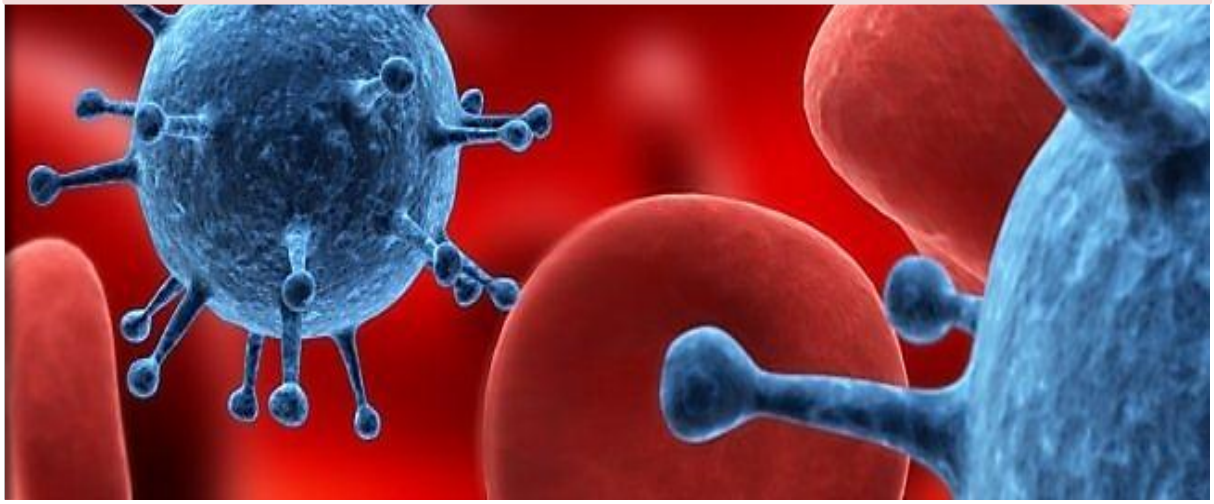


Substance Misuse and Sexual Health Blood Borne Virus Strategy 2014 – 2016



1.0 Executive Summary

A review and culture shift is required to address Blood Borne Viruses (BBVs) across the tri-borough of Hammersmith and Fulham (H&F), Royal Borough of Kensington and Chelsea (RBKC) and Westminster City Council (WCC) to ensure that prevention, diagnosis and treatment has an increased focus.

The move of Public Health into the tri-borough local authorities in April 2013 provided an opportunity for closer joint working with sexual health services. This strategy will build upon existing good practice and further develop joint working with sexual health services, homeless health, substance misuse and primary care to improve the identification and treatment of BBVs.

To reduce BBVs across the tri-borough, the BBV strategic partnership will deliver effective, equitable and value for money treatment options within National Institute for Clinical Excellence (NICE) guidance.

Prevention

The partnership will provide a consistent approach to harm reduction, publicity, educating professionals, joint working with sexual health and drug and alcohol services and building on the Hepatitis C Trust Peer to Peer Educator. Increase awareness of transmission with all partner agencies and develop training packages.

Diagnosis

The partnership will ensure clear pathways are in place and widely communicated to enable people to be tested and vaccinated. Partners of those who have been diagnosed with any one or a combination of BBVs will also be able to access these services. Services will be developed by building on experiences of peer groups, particularly those who are in drug and alcohol services. Improve the care pathway for those who require screening, vaccination and treatment and utilising the fast track clinic card for those who disclose their partners are at potential risk of infection

Treatment

The partnership will identify and roll out the best model of practice linking the specialist drug and alcohol and sexual health community based services with the most appropriate hepatology units. The model of a one stop shop approach to hepatology treatment consisting of a pre-treatment group, peer support and treatment led by a hepatology nurse and supported by a Consultant Hepatologist has been identified by the Hepatitis C Trust as best practice which the partnership will explore further.

2.0 Introduction

The strategy is to be used in conjunction with related local, regional and national policies and guidance. The tri-borough partnership work is critical to the success of full implementation of the strategy which is linked to National Standards and NICE guidelines. The alignment of the sexual health services and drug and alcohol services will bring harm reduction messages to the wider BBVs target groups including men who have sex with men (MSM), sex workers, black and minority ethnic groups (BAME), young people, Injecting Drug Users (IDUs) and users of Image and Performance Enhancing Drugs (IPEDs).

The long-term consequence of HBV and HCV are significant with up to 85% of people exposed to the HCV infection going on to develop chronic disease and are at high risk of liver disease. People infected with HIV who have access to appropriate specialist treatment can now expect to live 20 years longer and those with the HCV infection can access a range of treatments. Considerable developments have been made in establishing testing and vaccination in substance misuse services where there has been a positive movement in addressing BBVs as part of an individual's treatment.

Key objectives for substance misuse services, primary care services and sexual health services are to ensure that those who are injecting or have a history of injecting substances have access to:

- information on safer injecting practices, and prevention of BBVs especially those who inject image and performance enhancing and psychoactive drugs;
- accessible HBV screening and vaccination;
- testing and diagnosis for HIV and HCV;
- accessible pathways into treatment that are in line with NICE guidelines for antiviral treatments;
- regular health checks with service users and provision of regular harm reduction messages.

In order to achieve these objectives the partnership will identify and adopt best practice, drive implementation of research and new guidance to ensure the tri-borough is in the best position to continue to reduce and prevent the spread of BBVs. This will be achieved by:

- reducing infections rates by increasing the available harm minimisation advice;
- prevention of new BBVs infections amongst injecting drug users by continuation and expansion of the needle exchange programme;
- promotion of the HIV and HCV treatment pathways to ensure optimal outcomes for patients with these infections;
- ensuring access to treatment pathways designed to offer the most appropriate specialist health and social care interventions.

3.0 Prevalence of BBV and Sexual Health infections in the tri-borough area

3.1 Rates of Sexually Transmitted Infections

Hammersmith and Fulham

• Hammersmith and Fulham is ranked 4 (out of 326 local authorities, first in the rank has highest rates) in England for rates of STIs in 2011. 3,330 acute STIs were diagnosed in residents of Hammersmith and Fulham, a rate of 1962.2 per 100,000 residents.

Kensington and Chelsea

• Kensington and Chelsea is ranked 14 (out of 326 local authorities, first in the rank has highest rates) in England for rates of STIs in 2011. 2492 acute STIs were diagnosed in residents of Kensington and Chelsea, a rate of 1,470.3 per 100,000 residents.

Westminster

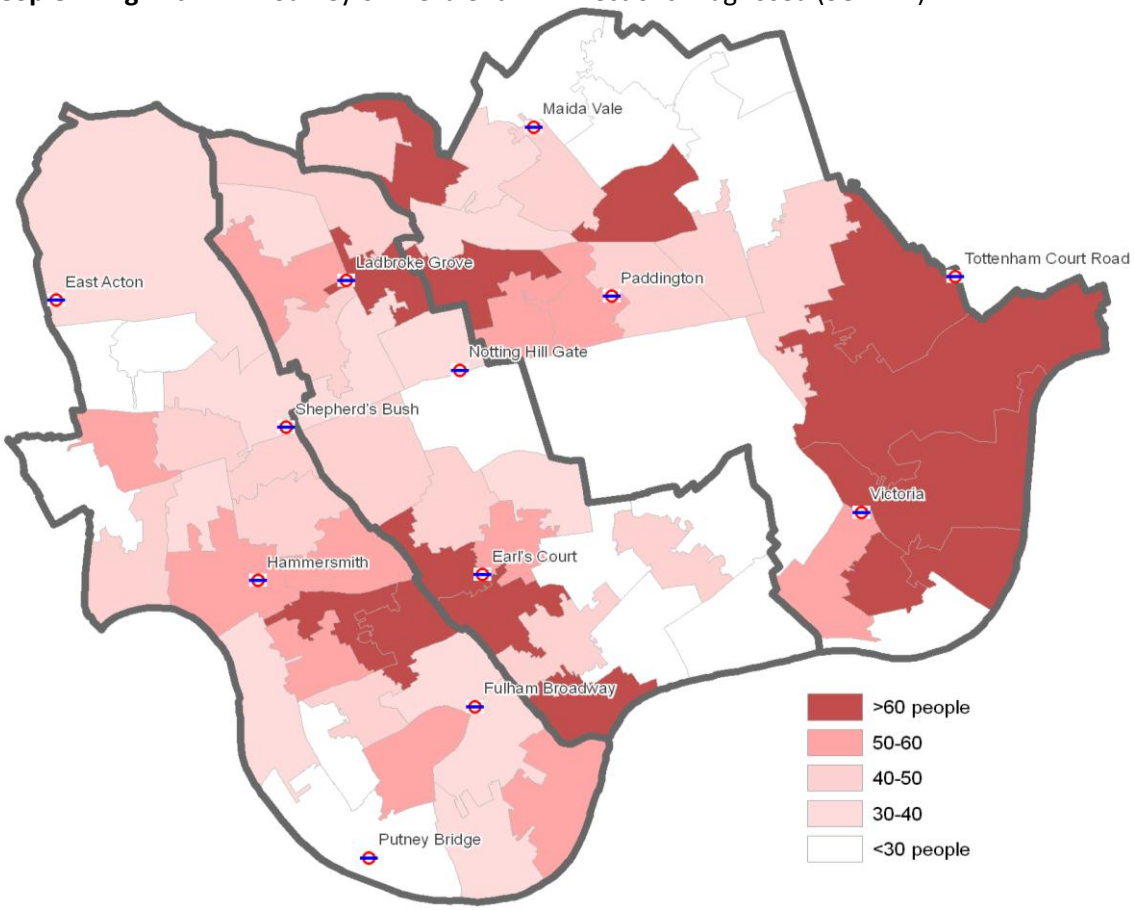
• Westminster is ranked 10 (out of 326 local authorities, first in the rank has highest rates) in England for rates of STIs in 2011. 4,154 acute STIs were diagnosed in residents of Westminster, a rate of 1641.2 per 100,000 residents.

3.2 HIV

Recent years have seen a rise in the annual number of newly diagnosed HIV cases. The rise can be attributed to the increased numbers of infected heterosexual males and females from high prevalence countries coming to London coupled with the increase of testing. The number of men who have sex with men (MSM) diagnosed with HIV has also risen in recent years. Factors include increased HIV testing in the genitourinary medicine setting and continued transmission of HIV. Anecdotal evidence has suggested the number of diagnoses among injecting drug users has decreased following introduction of comprehensive harm reduction strategies in the late 1980s and early 1990s.

- 3,604 people in tri-borough (1,076 in H&F, 1,053 in K&C, 1,475 in Westminster) have been diagnosed with HIV and are accessing care – this is equivalent to 689 per 100,000 population aged 15 and over;
- In the tri-borough area, HIV infection is predominantly concentrated in MSM and Black African ethnic groups particularly amongst persons aged 35-54 years old;
- Men who have sex with men is the most common mode of transmission in the tri-borough
- The population of persons living with HIV is ageing - persons aged 45 and over now account for 45% of persons diagnosed and accessing care during 2011, compared with 38% in 2007;
- There has been little change in the overall incidence of HIV, however, an increasing number of new diagnoses are in older persons and MSM, with a decreasing number of new diagnoses in African born heterosexual contacts

People living with HIV - Survey of Prevalent HIV Infections Diagnosed (SOPHID)



Greatest concentration of people living with HIV was observed in Soho/ West End area of Westminster and Earl's court areas. High numbers were observed in West Kensington and Notting Hill/ Bayswater areas in Inner North West London.

Numbers of HIV diagnosed persons by probable route of HIV infection during 2011

Local authority	Sex between men	Injecting drug use	Sex between men and women	Mother-to-child transmission
WCC	1,045	30	322	13
K&C	776	10	203	7
H&F	697	35	288	15

3.3 Hepatitis C

Current NICE guidance recommends anti-viral treatments, which can cure the virus in over 70% of patients. However, only 3% of people living with the virus receive treatment each year.[1] While new treatments are being developed, there is still pressing need for greater numbers to be accessing the current treatments which are effective in the majority of patients and highly cost-effective.

[1] Health protection Agency, Hepatitis C in the UK 2012 report (July 2012)

London has a quarter of all those living with HCV in England. It is estimated that failure to detect the virus means that each drug-user with HCV spreads the virus to twenty others.[2]

The two main routes of infection in the UK have been identified as the sharing of drug injecting equipment and the transfusion of infected blood or blood products. Up to two thirds of people infected with HCV are unaware of being carriers and many show no symptoms over a long period of time. HCV infection can be adversely affected by factors such as alcohol consumption, obesity, age and co-infection with HIV or HBV.

Routes of Hepatitis C transmission in England:

- prevalence of HCV is highest amongst IDUs (Injecting Drug Users);
- the majority of people diagnosed with HCV in the tri-borough area are men from White ethnic groups, however, a relatively large proportion of persons diagnosed in originate from Europe and South East Asia;
- persons with HCV often have co-morbidities such as mental health problems and addiction problems and some may be co-infected with HIV and/or HBV.

Number of people infected with hepatitis C in the tri borough by infection group

	Hammersmith and Fulham	Kensington and Chelsea	Westminster	Tri-Borough
Hepatitis C positive IDU	638	663	1039	**2,340**
Hepatitis C positive ex-IDU	688	743	961	**2,392**
Hepatitis C positive non-IDU	**101**	**109**	**141**	**351**

- Source: HPA

3.4 Hepatitis B

The prevalence rate of HBV estimated as between 0.1% to 0.5% of the UK population. HBV infections are usually acquired in adulthood, principally resulting from sexual activity or injecting drug use. Reports of acute HBV infection have fallen sharply, which is thought to be mainly due to a decline in cases of intravenous drug misuse and possibly changes in behaviour in response to the risks from HIV/AIDS.[3]

National HBV surveillance has identified that London has an incidence rate of acute HBV of 2.02 per 100,000 populations, which is nearly twice the national rate (England rate 1.04 per 100,000)[4]. Within the tri-borough it shows that the rate of acute HBV infection per 100,000 residents is lower than the English average. Westminster has a rate of 1.01 per 100,000, Hammersmith and Fulham has a rate of 0.8 and Kensington and Chelsea have the lowest of all London boroughs with a rate of 0.24 per 100,000.[5]

[2] London Drug & Alcohol Policy Forum, The Hepatitis C Trust, Reducing health inequalities in London by addressing hepatitis C, July 2013
[3] Health and Safety Executive
[4] Public Health England: Hepatitis B epidemiology in London 2012 data
[5] Public Health England: Hepatitis B epidemiology in London 2012 data

4.0 The Public Health Challenge

People can be infected with one of the three viruses or any combination. HBV carries a high risk of infection while HCV and HIV carry low risk except for those individuals considered at high risk such as MSM, IDUs who share injecting equipment and individuals coming from an endemic high risk area.

The cost effectiveness of different approaches to HCV screening was subject to health technology assessment by Health Protection Scotland, the findings from these assessments are indicated below.

Health setting	Hep C test offered to	Hep C prevalence	£QALY	Cost Effective
GUM	ALL	1.5%	£85,000	No
	Past IDU	49%	£27,000	Yes
Prison	New inmates	16%	£20,000	Yes
GP	IDU	49%	£16,500	Yes
Drug and Alcohol Service	IDU	68%	£17,500	Yes

A recent publication developed by the Hepatitis C Trust and the London Drug and alcohol policy forum,' recommended and identified increasing diagnosis, testing and treatment rates will not only effectively address HCV but will also ensure progress on achieving the following public health outcomes:

- reducing premature death from liver disease;
- reducing death from cancer;
- improving early diagnosis;
- reducing death from communicable disease and preventable causes;
- reducing health inequalities;
- improve the quality of life for individuals.

In addition to this publication, the World Health Organisation recommends screening for alcohol use for those who have been diagnosed with HCV.

5.0 Priority Themes

There are three main themes required to deliver and achieve the public health outcomes they are prevention, diagnosis and treatment. BBVs cut across different domains of commissioning including specialist sexual health, substance misuse, homeless health, community safety, public health and infectious diseases. There is clear need for an integrated strategic approach.

5.1 Prevention

The partnership advocates early screening and testing for BBVs, alongside the referrals and uptake of treatment. The local picture on prevalence is not clear and the role of the strategic partnership is to ensure a performance framework is used to monitor the effectiveness of raising awareness, pathways to treatment.

There are no obvious gaps identified in prevention, however the partnership wants to ensure consistency. There is a need to target health promotion amongst asylum seekers from high risk regions, young people and those who are injecting drugs more than the traditional heroin and crack users. Sexual health services and other service providers within the wider substance misuse partnership will deliver BBVs prevention through:

- condom distribution;
- ensuring access to HIV and hepatitis testing with rapid results and referral to an evidence-based patient pathway;
- delivery of effective HBV vaccination programmes targeting those who are identified as at risk;
- young people remaining a priority for broad based risk reduction programmes developing life skills and the ability to make informed choices;
- the needs of vulnerable groups such as the homeless and looked after children met through tailored interventions.

5.2 Diagnosis

The main rationale for testing is to:

- reduce the transmission rate through immunisation and reduce risky behaviours;
- provide a route into treatment which can prevent life threatening complications;
- identify prevalence amongst former injecting drug users and the partners of former and current drug users.

There is a need to increase access to testing across the tri-borough and to have a framework in place that will gather data that informs local prevalence. The needle exchange programmes offer a point of contact for IDUs. This service could accelerated testing for HIV and HCV. Vaccinations could be offered as part of the needle exchange programme to improve completion rates and accessibility to the active injecting cohort.

Infection with HBV is preventable using a vaccine. The tri-borough already offers HBV vaccines within some substance misuse services. However, not all individuals take up the offer of vaccinations or complete the full course. This is an area of improvement to be addressed across the partnership.

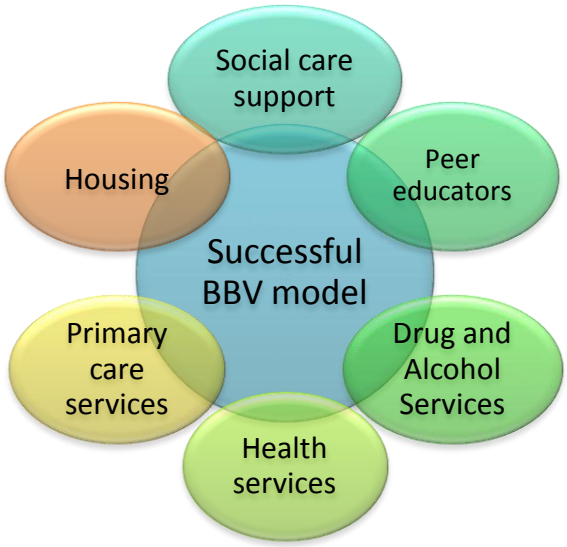
5.3 Treatment

Clinical services for people infected with HIV, HBV and HCV have developed across a variety of settings. However, there are overlaps in the client groups and shared risk factors. The partnership provides an opportunity to streamline the pathways into services and create capacity within specialist teams.

The model of a one stop shop approach to hepatology treatment. The model will consist of a pre-treatment group, peer support and treatment led by a hepatology nurse and supported by a Consultant Hepatologist. The model has been identified by the Hepatitis C Trust as best practice which the partnership will explore further.

6.0 Moving Forward

A consistent model that addresses the three domains of the strategy is needed in order to deliver on the objectives illustrated below.



6.1 Social care and support

Social care support is a crucial part of BBV treatment and an integrated approach to delivery ensures the needs of the most vulnerable are met. This will be influenced by the stage they are in their treatment and includes:

- one to one support and counselling;
- stress management and life skills;
- signposting and referrals to other services;
- benefits advice;
- care management;
- peer support;
- family and carer support;

6.2 Substance misuse services

The Substance Misuse and Offender Health Commissioning Team commission a number of services across the tri-borough to deliver on a number of health interventions. The key outcomes are health protection and preventing premature mortality. People with substance misuse conditions are considered socially excluded and a vulnerable group of people who are at a high risk of BBVs and preventable infections. Evidence has indicated that substance misuse service user engagement with tertiary treatment service is poor.

To build upon good practice within the commissioned drug and alcohol services. Particularly the recommendation made by the PREVENT project are implemented and that where necessary BBV treatment is initiated within substance misuse services.

6.3 Sexual Health Services

Within sexual health services, awareness needs to be raised and staff trained about problematic and recreational drug use. This has been evidenced in the joint work carried out within the “club drug clinic”. The developing project in the sexual health service at 56 Dean St has demonstrated a clear link between risky behaviours of drug use and sexual health.

6.4 Needle Exchange Programmes

Injecting behaviour has been associated with opiate users, however there is a trend amongst drug users towards injecting new psychotropic substances and image and performance enhancing drugs. This has resulted in a hidden market for injecting equipment.

Typically in the UK anabolic steroids are injected however it has been difficult to engage these groups in addressing their drug taking behaviours and to provide appropriate harm reduction advice and information. NICE guidelines have been updated for the needle and syringe programmes stating the programmes ‘should support the growing number of image and performance enhancing drug users so they can access sterile equipment to prevent the spread of blood-borne viruses and infections from contaminated needles’.

The existing needle and syringe services in the tri-borough areas were established to help IDUs, such as those who use heroin or crack during the height of the concerns about the spread of HIV. Therefore, there will need to be a cultural shift in this service area to accommodate the different needs of this cohort of service users.

6.5 Primary Care

Across primary care, particularly GP surgeries, there is disparity in the way in which individuals are screened for BBVs. Those GPs that participate in the shared care schemes are more likely to offer the screening and vaccination. However, this is not monitored consistently and it is difficult to determine if all patients on the scheme have been offered this intervention. Guidance has been developed for GPs especially for those who have the RGCP certificate. These guidelines need to be embedded in practice.

7.0 Conclusion

The integrated partnership model aims to improve prevention, diagnosis, and treatment and achieve the following key outcomes:

- reduction in the numbers of people becoming infected with HCV;
- reduction in the proportion of infected people who are undiagnosed;
- increased numbers of people infected with a BBV accessing treatment services.

The management of BBVs needs to remain a shared priority to ensure it receives system wide support.

With the emerging patterns of psychoactive drug injecting and the higher level of risk associated with people who inject these drugs, a consistent approach to harm reduction and up skilling the workforce is essential.

Within the tri-borough models of best practice need to be consistently adopted to guarantee all residents have access to prevention, BBV screening and treatment. This needs to be supported by a framework which allows local need to be better identified so treatment options can be tailored and treatment options effectively evaluated.

8.0 Recommendations

A number of recommendations have been considered for the partnership to champion and implement

Prevention

- Training staff in substance misuse on addressing the changing needs in sexual health interventions.
- Training of staff within sexual health services in the changing drug trends and providing appropriate interventions and screening.
- To increase the awareness of transmission and infection of BBVs across a broader range of primary care services.
- Development of peer educators across all services and peer mentors in sexual health services.
- Review of the literature available in needle exchange packs in pharmacies highlighting injecting practices.
- Training hostel staff and clients on sexual health services and interventions.
- Further development of the partnership to include BBV screening and TB to reduce the prevalence of BBVs and TB in the homeless population.

Diagnosis

- Adopting a performance framework that captures the prevalence across the tri-borough of BBVs and how resources should be distributed.
- Increase the completion of immunisation of HBV vaccination.

- Develop protocols for partner disclosure and traceable contact working with PHE to develop this agenda.
- Implement the fast track clinic card for partners of substance misuse service users.
- Recommendation of testing across the tri-borough of all MSM within sexual health services.

Treatment

- Integrate substance misuse and hepatology treatment into a one stop shop to increase the number of those that require treatment for HCV to appropriate services.
- Develop the care pathway and increase the numbers of infected individuals into treatment and improve integration across all services for people affected by BBVs.
- Develop further joint working with sexual health services and substance misuse services including co-location on services and development of best practice.