HOW COMMUNITY SERVICES ARE WORKING TO ERADICATE HEPATITIS C IN HOMELESS COMMUNITIES

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Study of targeted screening, prevalence, risks and treatment outcomes amongst 109 residents in two homeless hostels in Lambeth.

WHAT IS HEPATITIS C?

Hepatitis C is a slow, progressive disease of the liver caused by infection with the blood-borne Hepatitis C virus (HCV)

50–80% will develop chronic HCV leading to liver disease

About **25–50%** of people will spontaneously clear the virus without treatment (but are not immune to future infection)

HOW DO YOU GET THE INFECTION?

Intravenous drug use accounts for 90% of new infections. Prevalence among current users is estimated to be 50% in England. Evidence suggests two in five people who inject drugs have HCV, and about 50% of these people remain undiagnosed.

BACKGROUND

Public Health England want to eliminate HCV as a public health threat by 2030. The Health Inclusion Team (HIT) is a specialist nurse-led team providing primary care to marginalised groups across Lambeth, Southwark and Lewisham. Screening for HCV and referring to specialist services has always been part of the team's remit, but uptake for treatment has always been low. A specialist nurse working in Lambeth measured the rates of screening, referral and uptake of treatment in order to evaluate service provision.

Case study - Persistence is key

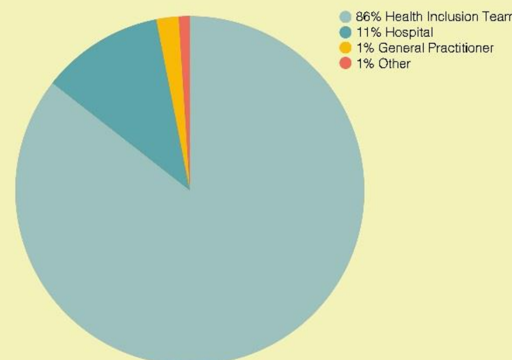
Amy had her HCV diagnosed nearly 30 years ago after starting injecting at age 17. The HIT had offered her referral on multiple occasions since the first contact in 2009. Even after direct contact by a HCV team, she was still unable to make any hospital appointments due to her alcoholism and chaotic lifestyle. It was not until March 2018, after a visit to the Emergency Department and referral for urgent investigation of a shadow on her liver, that she attended a follow up at an outpatient appointment. Investigations ruled out malignancy, and follow-up for HCV treatment was arranged. Unfortunately, again, despite verbalising a wish to start treatment, she did not attend this follow-up. It was unlikely she would access treatment via outpatient care, so arrangements were made for remote consultation with the hospital HCV nurse specialist, with all physical monitoring and investigations performed by the HIT. Twelve weeks of treatment with Ribovirin and Epclusa were delivered to the hostel, and monitoring was carried out by the HIT.

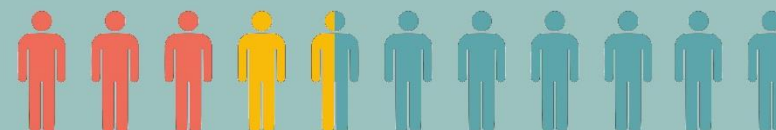
Amy was engaging poorly despite weekly outreach by the HIT nurse, and her monitoring and concordance was varied with 12 weeks treatment lasting 17 weeks. She was seen at the hostel 11 times, on all other outreach occasions she was out of the hostel or did not answer her door. Bloods were monitored at the start of treatment, then at 2, 16 and 29 weeks. Despite this, Amy's blood test at 29 weeks showed a sustained virological response (SVR).

Screening surveillance

Screening uptake (population of 109)	
Documented screening results	97
Declined	12
Who undertook screening? (population of 97)	
Health Inclusion Team	83
General Practitioner	2
Hospital	11
Other	1
Where did screening take place? (population of 97)	
Hostel of study	65
Other hostel with HIT clinic	8
Drug and Alcohol Service with HIT clinic	13
Emergency Department	2
Hospital (other than ED)	5
Day Centre with HIT clinic	3
GP Surgery	1

Who undertook screening?

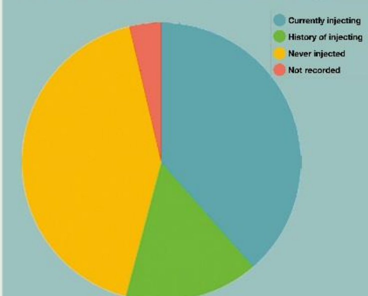




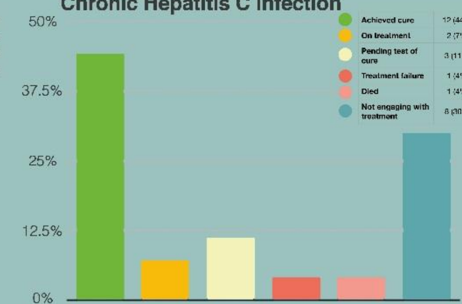
Screening outcome of 97 residents	
Chronic Hepatitis C	27
Previous exposure to Hepatitis C, spontaneously cleared	14
No exposure to Hepatitis C	56

	Currently Injecting	History of Injecting	Never Injected	Not recorded
Chronic Hepatitis C	19	6	1	1
Previous exposure to Hepatitis C, spontaneously cleared	22	2	0	0
No exposure to Hepatitis C	10	9	37	0

Prevalence of intravenous drug use



Outcomes of those with Chronic Hepatitis C Infection



FINDINGS

1. Just over half of the homeless hostel populations had injected drugs at least once, with almost 40% currently injecting.

2. Two thirds of those who had ever injected drugs came into contact with HCV.

3. Nearly half of those who had ever injected drugs had chronic HCV.

4. Almost half of those with chronic HCV successfully completed treatment with a confirmed sustained viral response.

5. The Health Inclusion Team was central to both the screening and treatment outcomes for these 'hard to reach' individuals.

RECOMMENDATIONS

1. Mainstream primary care, specialist screening services and emergency departments should collect audit data on the prevalence of risk factors (such as people who inject drugs), as well as the offer and uptake of screening.

2. As almost 40% of the homeless hostel population are currently injecting drugs, there needs to be a review of in-reach harm minimisation provision (such as needle exchange) to prevent the clear risk of new and re-infection.

3. HCV specialist in-reach services, along with primary and secondary care need to improve communication and information sharing to reduce duplication, pool resources, spend money more efficiently and learn from each other's successes.

To contact the HIT please email: gst-tr.referralsHIT@nhs.net