Opportunity Knocks?

An Audit of hepatitis C services during the transition
## Contents

Foreword 4  
Executive summary 5  
Recommendations 6  
Background 7  
The case for improving hepatitis C services 7  
The problems with hepatitis C commissioning 7  
The opportunities presented by the NHS reforms and the National Liver Strategy 7  
Methodology 8  
Response rate 8  
Ensuring a strategic approach to hepatitis C commissioning 9  
Local leadership 9  
Local strategies 9  
Coordination between local NHS and public health services 11  
Joint working 11  
Clinical networks 11  
Health and wellbeing boards 11  
Estimating the extent of the burden of hepatitis C 12  
Prevention of hepatitis C 14  
Local campaigns 14  
Targeted prevention measures 15  
Auditing quality 15  
Hepatitis C testing and diagnosis 16  
Local testing campaigns 16  
Testing in general practice 17  
Local data on hepatitis C testing 17  
Hepatitis C treatment and care 18  
Estimates of service access, efficacy and cost 18  
Measures to increase treatment 18  
Looking ahead 19  
Public health 19  
Health commissioning 19  
Appendix 1 – List of NHS commissioners which responded to the audit 20  
Appendix 2 – List of local authorities which responded to the audit 21  
Appendix 3 – FOI requests made to NHS commissioners 22  
Appendix 4 – FOI requests made to local authorities 22  
References 23  

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There is no clearer test for the reforms to health and social care than whether outcomes from liver disease can be improved. Outcomes from liver disease in England are poor and getting worse\textsuperscript{1}. In most European countries deaths from liver disease are declining whereas in England they are increasing\textsuperscript{2}. This situation has been identified by the Chief Medical Officer as requiring urgent attention\textsuperscript{3}.

Hepatitis C is an infection which causes significant liver damage, potentially resulting in cancer, the need for a transplant, or death. Hepatitis C is preventable, but too many people are being infected\textsuperscript{4}. It can be easily diagnosed, but over a hundred thousand people remain unaware of their infection\textsuperscript{5}. And it is curable but only three per cent of people chronically infected receiving treatment each year\textsuperscript{6}.

Hepatitis C presents a unique opportunity to improve outcomes from liver disease. Treatment is NICE approved, cost effective and improving, and there are shining examples of good practice in preventing transmission, diagnosing people early and treating them effectively which could be emulated\textsuperscript{7}. Put simply, in a short space of time we could make a real difference to liver outcomes by improving hepatitis C services, saving lives and eradicating the disease within a generation.

The implementation of the Health and Social Care Act 2012 is a turning point for the NHS. With the correct action, it can also be a turning point for hepatitis C.

This is the choice the health services face: take action now to prevent infections and effectively treat people, reducing mortality, or continue to neglect hepatitis C, storing even greater health problems for the future.

The reforms will see the majority of responsibility for hepatitis C transferring from primary care trusts to local authorities and clinical commissioning groups. Some elements of hepatitis C treatment will be managed by the NHS Commissioning Board through specialised commissioning\textsuperscript{8}. In order to inform these reforms, we have undertaken an audit of current services. The findings identify good practice which should be shared and highlight challenges which should be addressed.

The Hepatitis C Trust is committed to supporting public health and NHS services in improving hepatitis C outcomes and the information in this report will provide an important starting point for this. We will also be holding public health and NHS services to account for delivery and so these findings will be used as the basis for measuring progress.

Charles Gore
Chief Executive, Hepatitis C Trust
Deaths from hepatitis C are increasing despite the fact that it is a preventable and curable disease. Without prompt and effective action, the virus will create a legacy of poor liver health, with increasing mortality and more people suffering from liver cancer, liver failure and requiring liver transplants. This has been recognised by the Chief Medical Officer who has called for liver disease to be tackled as a priority.

Addressing hepatitis C will require action from public health and NHS services. Both NHS commissioners and local authorities (as the future commissioners of many public health services) will have a key role to play in designing, purchasing and performance managing the services required to deliver improved outcomes for hepatitis C.

This report documents the findings from an audit of NHS commissioners in primary care trusts (PCTs) and local authorities. It reveals the scale of the task if outcomes are to be improved.

In researching this report, we sent Freedom of Information Act requests to NHS commissioners and local authorities to obtain information about the quality of services available for the prevention, testing, treatment and care for hepatitis C.

The key findings are:

• Lack of strategic oversight by local authorities: Local authorities are not yet demonstrating strategic oversight over hepatitis C, with only a fifth of those which responded to the audit currently having a lead for hepatitis C, and even fewer having a strategy in place for tackling hepatitis C.

• Urgent need for relationship building between local authority and NHS commissioners: Many local authorities do not appear to have forged essential relationships with local NHS commissioners to ensure coordinated working to tackle hepatitis C, with only 40 per cent of audit respondents saying that they have arrangements in place with the relevant local commissioner.

• Local authorities are not yet prepared for public health role: Only a quarter of local authorities which replied have assessed the current and future burden of hepatitis C in their local area, indicating a lack of preparation for taking on their new public health role.

• Shortage of measures to promote testing in GP practices: Not enough effort has been made by NHS commissioners to promote hepatitis C testing in GP practices, as shown by nearly half of audit respondents denying having measures in place to encourage testing in this setting.

• Monitoring of hepatitis C outcomes is not routine: Many NHS commissioners have not been effectively monitoring the uptake of hepatitis C treatment, with only just over half of those who replied to the audit holding information about the number of patients initiated on treatment and only a third knowing how many people have cleared the virus as a result of treatment.

To date, NHS commissioners have not done well enough in managing hepatitis C, and this has been shown in the rising mortality from liver disease and declining outcomes. In 2010, Extent and causes of international variation in drug usage, found that usage of hepatitis C drugs in the UK was significantly lower than in comparable countries, with the UK ranking 13th of 14 countries studied.

New NHS commissioners and local authorities now have the opportunity to reverse this trend. However, these findings show that serious work has to be done now to make this happen. New NHS commissioners must proactively learn from the mistakes of the past, local authorities must urgently prepare to take on public health responsibility, and the NHS and public health services must plan to work together effectively if the challenges ahead are to be met.
Recommendation 1:
Local authorities should have a designated liver health lead on their local health and wellbeing board, with hepatitis C designated as a clear part of their remit.

Recommendation 2:
Clinical commissioning groups should assess local oversight for hepatitis C and ensure that a lead for either liver disease, blood borne viruses or hepatitis C is in place.

Recommendation 3:
As part of their preparations for taking on full public health responsibilities, local authorities should ensure that they develop a comprehensive hepatitis C strategy which is jointly agreed with clinical commissioning groups and takes local need into account.

Recommendation 4:
The NHS Commissioning Board should support pilot clinical liver networks, with a view to their being hosted nationally in the future.

Recommendation 5:
Local authorities should ensure that health and wellbeing boards are equipped with relevant information about the burden of hepatitis C in the community.

Recommendation 6:
Public Health England should outline plans to establish a national liver intelligence network.

Recommendation 7:
Local authorities should ensure that measures to prevent hepatitis C transmission are targeted to all at risk groups within local communities.

Recommendation 8:
Local authorities must develop clear mechanisms to scrutinise their public health measures to tackle hepatitis C.

Recommendation 9:
Health Education England should raise awareness of the Royal College of General Practitioners’ training module on the detection, diagnosis and management of hepatitis B and C, and encourage GPs to undertake it as part of their professional development.

Recommendation 10:
Local authorities and clinical commissioning groups should regularly obtain information about hepatitis C testing uptake in community and acute settings.

Recommendation 11:
Clinical commissioning groups should regularly work with providers to gather data on how many patients with hepatitis C are initiated on treatment and how many achieve a sustained virological response.

Recommendation 12:
The NHS Commissioning Board should consider models that may improve the uptake of hepatitis C treatment.

Recommendation 13:
Local authorities should refer to the HCV Action commissioning toolkit to help inform the public health commissioning process.

Recommendation 14:
Clinical commissioning groups, in partnership with local authorities, should assess current and future local needs related to hepatitis C to inform the commissioning process.
The case for improving hepatitis C services

The Health Protection Agency (HPA) estimates that there are 216,000 people living with hepatitis C in the UK and more than half of them are undiagnosed. Due to the generic nature of its symptoms, or sometimes lack of them, hepatitis C can go undiagnosed for many years. Yet, if left untreated, it can cause liver cancer, liver failure, or even death. Viral hepatitis is one of the main causes of liver disease in England, along with alcohol and obesity.

Liver disease is a significant public health concern, and is the fifth biggest killer in England. Its incidence is rising and unlike the other of the five biggest killers, more people are dying each year, and people are dying younger than ever before. There was a 25% increase in liver disease deaths between 2001 and 2009, and deaths from hepatitis C have more than tripled since 1996. The situation in England is in sharp contrast to the rest of Europe where mortality rates from liver disease are actually decreasing. England will soon have higher death rates from liver disease than any similar EU country.

The importance of improving outcomes from liver disease has been recognised in the NHS Outcomes Framework, with mortality from liver disease designated as an improvement area in Domain 1. However, a challenge for the NHS Commissioning Board in delivering improved outcomes is the time-lag between measures being implemented to improve services and better outcomes for patients.

Hepatitis C, as one of the most common causes of liver disease in England, is the only cause of liver disease deemed both preventable and ‘amenable’ to intervention by the Office for National Statistics, i.e. it is possible to contain the spread of the virus through education and harm reduction measures, and drug treatment is available which can cure the disease. Therefore, focusing on hepatitis C will have considerable and more immediate benefit in improving liver disease outcomes than other measures.

Despite this, the latest status report on hepatitis C in the UK from the HPA suggests that, while diagnoses of hepatitis C are increasing, the treatment of hepatitis C is decreasing with only three per cent of people chronically infected receiving treatment each year. Their modelling suggests that if treatment was increased to ten per cent in those with moderate hepatitis C, and twenty per cent in those with more advanced hepatitis C, the number of people experiencing liver failure or liver cancer would fall by over 2,000 in the next ten years.

The problems with hepatitis C commissioning

As highlighted by the All Party Parliamentary Hepatology Group (APPHG), the UK’s poor record on hepatitis C, and liver disease more generally, has been caused by a range of factors, including:

- Inadequate prevention strategies, with too many people adopting behaviours which put them at increased risk of liver disease
- Delayed diagnosis, resulting in liver disease only being identified at a stage when it has developed significantly, making management or cure more challenging
- Low treatment rates, with people not being offered timely access to interventions
- Poor support, with patients not being provided with the appropriate care

As the APPHG has stated: “Poor quality commissioning, often undertaken without access to the appropriate evidence, data or expertise, lies at the heart of all these problems.”

Public health, NHS and adult social care services need to work together to ensure an effective, coordinated approach to hepatitis C. Achieving this requires strong commissioning. Historically this has not been achieved with several audits in the past five years showing stark variations in the commissioning and management of hepatitis C services, with a consequent impact on performance and outcomes.

The opportunities presented by the NHS reforms and the National Liver Strategy

The Government has made clear its intention to focus on improving the outcomes which matter to patients, rather than on process measures which have mattered to managers. We warmly welcome this approach. To date, progress on hepatitis C services has been hindered by an absence of both process and outcome measures and this urgently needs addressing.

Designating mortality from liver disease as an improvement area in Domain 1 of the NHS Outcomes Framework and Domain 4 of the Public Health Framework represents excellent progress. However, hepatitis C goes wider than just mortality, impacting on many of the domains of the Public Health and NHS Outcomes frameworks. The NHS Commissioning Board should prioritise hepatitis C as a way to deliver against these domains.

The reforms will see responsibility for hepatitis C commissioning transferring from PCTs to local authorities (for the public health elements), clinical commissioning groups and the NHS Commissioning Board (for specialised types of hepatitis C treatment). This should be used as an opportunity to renew momentum on hepatitis C. New NHS commissioners and local authorities have the chance to strive for excellence in hepatitis C services, learn from the mistakes of the past, and to show that new structures can work together to improve outcomes in hepatitis C.

At the same time, the National Liver Strategy offers a strategic approach to improve hepatitis C services across the whole patient pathway from prevention and testing to treatment and care. However, the Strategy will only be effective if it is supported by collaborative working between the NHS, public health and social services. The Hepatitis C Trust is committed to working in partnership with these bodies to ensure that the National Liver Strategy is effectively implemented and leads to the improvement in services which is urgently needed.
This report evaluates current commissioning arrangements at NHS commissioner level and assesses the extent that local authorities are prepared to take on responsibility for the public health elements of hepatitis C commissioning. In order to inform the evaluation, an audit was undertaken using the Freedom of Information (FOI) Act 2000.

- The audit sought to assess the extent to which NHS commissioners and local authorities are:
  - Ensuring a strategic approach to hepatitis C commissioning
  - Working together to ensure coordination between local NHS and public health services
  - Estimating the extent of the burden of hepatitis C

It then explores the quality of services available for:

- Prevention of hepatitis C
- Hepatitis C testing and diagnosis
- Hepatitis C treatment and care

Response rate

Every NHS commissioner (primary care trust) and local authority in England was contacted as part of this process. Almost 80% of NHS commissioners and more than 70% of local authorities were able to provide some response to our audit. Figure 1 summarises the response rate for NHS commissioners and local authorities respectively.

Figure 1 – NHS commissioner and local authority response rate to Freedom of Information requests

The information collected allows a thorough assessment of measures to tackle hepatitis C in England. We are, however, disappointed that we did not receive responses from all PCTs and local authorities questioned given that it is their legal responsibility to respond to FOI requests.

Public bodies are not duty-bound to respond to FOI requests in a set format so the information that we received was not directly comparable. The analysis used in this report is therefore based on The Hepatitis C Trust’s own interpretation of the evidence received. Where relevant, an explanation is provided as to how the data have been interpreted.
Strategic leadership and oversight has to be at the heart of any approach to tackling hepatitis C. Historically, this has been lacking in commissioning bodies, which has led to inaction and complacency. Public health commissioning will soon be the responsibility of local authorities, and NHS commissioning will soon be the responsibility of clinical commissioning groups. Both of these bodies can learn from what PCTs have and have not done well and make sure that their approach to hepatitis C is strategic and well-led. These bodies should be getting ready now before they take on official responsibility later in 2013.

**Local leadership**

Figure 2 shows that of the 99 local authorities who responded to the audit, only 23 have a lead for hepatitis C. This is very concerning, given the fact that it is now just a few months until these bodies take on full responsibility for commissioning local public health services. Among those local authorities which do not have a lead for hepatitis C, around 5% stated that responsibility lies with the NHS and, although some suggested that this situation would change with the transfer of responsibility, many appeared to make no recognition of this.

**Figure 2 – Is there a lead for hepatitis C in the local authority?**

- **Yes** 21%
- **No** 79%

Around 5% of local authorities which did not have a designated lead for hepatitis C suggested that responsibility for hepatitis C lies with drug and alcohol treatment (DAAT) teams. Whilst it is encouraging that these groups are looking at hepatitis C, it is not possible to ascertain whether or not they are taking a holistic approach to hepatitis C in the area. For example, the DAAT team may come into direct contact with injecting drug users (IDUs) who are at risk of contracting hepatitis C and may teach them prevention messages, or encourage them to get tested, but it is not clear whether they also oversee links with the local NHS around follow up and treatment. There will also be local people who contracted hepatitis C through other means, or who are former IDUs who would not come into direct contact with DAAT services. Without proper oversight, a local approach could fail to address all the needs of local people with hepatitis C.

In areas where local leadership is in place, in the majority of instances (85%), this was the Director of Public Health, which is often a joint appointment between the NHS and local authority. It is difficult to ascertain the extent to which public health directors are directly engaged in tackling hepatitis C, or the resources which they have available to support them in this task. The significant public health pressures could limit their ability to address this in a coherent manner.

When local authorities take on public health commissioning, more priority needs to be given to hepatitis C and liver disease. Local authorities should have a designated liver health lead on their local health and wellbeing board which will oversee local needs assessments, health priorities and service co-ordination. Hepatitis C should be a key part of this person’s responsibilities.

**Recommendation 1: Local authorities should have a designated liver health lead on their local health and wellbeing board, with hepatitis C designated as a clear part of their remit.**

Figure 3 shows that three-quarters of NHS commissioners have a designated lead for hepatitis C. Given that NHS commissioners currently have a designated lead for infectious diseases, while a number explained that the lead number should be higher. It is clear that there is local variation as to where this role sits. Some commissioners said that responsibility for hepatitis C lies with the lead for blood-borne viruses or infectious diseases, while a number explained that the lead responsibility for hepatitis C sits with someone with general public health oversight.

> “There is a consultant in public health who leads on strategies to address blood borne viruses for high risk groups, and a lead commissioner who leads for commissioning hepatitis C services.”

**NHS Wiltshire**

> “The Primary Care Trust does have a public health lead for the control of infection and vaccination and immunisation. This would include an overview for the prevention and treatment of hepatitis C. They work closely with their commissioning colleagues for the agreement of appropriate care pathways, and the guidance of medicines management and clinical colleagues for appropriate management of patients with hepatitis.”

**NHS Warrington**

As with local authorities, most NHS commissioners who identified this role as sitting with public health stated that it was the Director of Public Health who had ultimate responsibility. As stated above, given competing public health priorities at a local level, it is difficult to assess how much priority hepatitis C is given on a daily basis by those with wide public health remits. It was particularly worrying that more than one NHS commissioner said that responsibility for hepatitis C sits with the commissioner of sexual health services. Hepatitis C is very rarely sexually transmitted so, therefore, local needs relating to hepatitis C will not be met by someone in this role, it also points to a lack of understanding of hepatitis C epidemiology within the PCT.

> “I have been advised that NHS Herefordshire does not have a specific lead for hepatitis C but does have a commissioner for sexual health services including hepatitis C.”

**NHS Herefordshire**

When clinical commissioning groups take on NHS commissioning, they must appoint someone to oversee local hepatitis C services. This person should lead on either hepatitis C, blood borne viruses or liver disease generally. Only with this level of priority will services for the condition be effectively managed at a local level.

**Recommendation 2: Clinical commissioning groups should assess local oversight for hepatitis C and ensure that a lead for either liver disease, blood borne viruses or hepatitis C is in place.**

**Local strategies**

In addition to leadership, local strategies have been seen to improve service configuration and outcomes. Figure 4 shows that less than 20% of local authorities have a strategy in place for managing hepatitis C. Some local authorities have suggested that they have strategies in development, but this is only a small number.
Figure 4 – Is there a strategy in place for managing hepatitis C in the local authority?

Some local authorities set out the mechanisms in place to tackle hepatitis C, without having a formal strategy.

“We do not have a standalone hepatitis C strategy. However we do have a wide range of interventions in place to address hepatitis C, taken forward through for example our wider borough healthcare, substance misuse and homelessness strategies.”

Lambeth Council

In the majority of cases, however, it is hard to imagine that local authorities will be in a position to assess the needs of the local population, and identify the most appropriate health promotion and prevention methods without having a formal strategy in place.

A significant proportion of local authorities referred to NHS strategies or processes without referencing how this would change in 2013. Some local authorities did appear to be looking ahead to their public health responsibilities but we would urge those local authorities that reference NHS strategies to ensure that they take full ownership of these policies when they take on public health responsibilities.

“As the PCT has overall responsibility currently for control of infection, the local authority does not have a separate strategy for hepatitis C.”

Warrington Council

“There is no strategy at this time, it is led through health systems but will be reviewed as part of the transitions process.”

Middlesbrough Council

Figure 5 shows that of the 118 NHS commissioners that responded to our audit, only 48 have a strategy in place for tackling hepatitis C. Most of these strategies appear to be PCT-specific, but NHS commissioners in Greater Manchester and the East Midlands said that they have adopted regional hepatitis C strategies. The overall number of commissioners which have a strategy, whether local or regional, is too low given the increasing health burden of hepatitis C. An additional 19 NHS commissioners claimed that they currently have a strategy in development. For example, NHS commissioners in Merseyside and Lancashire stated that region-wide strategies are in development, while others are tackling this at a local level.

“There is a draft Lancashire-wide Hepatitis C Strategy which is led by Cumbria and Lancashire Health Protection Unit.”

NHS North Lancashire

“The PCT has a strategy for blood borne viruses such as HIV and is currently developing and agreeing a strategy for hepatitis B and C through a new multidisciplinary control group.”

NHS Berkshire East

Figure 5 - Does the commissioner have a strategy in place for managing hepatitis C?

A few NHS commissioners stated that hepatitis C is covered by their drug and alcohol strategy. Although addressing the needs of IDUs is clearly an important element of tackling hepatitis C, this is only one part of the comprehensive approach needed to effectively manage hepatitis C at a local level and may not cover the needs every person who has contracted hepatitis C in a particular area. In addition, harm reduction and prevention strategies are unlikely to incorporate treatment, care and support for people living with hepatitis C which means that an opportunity is being missed.

“There is currently a Drug Harm Reduction Strategy in the early stages of development across all related work streams of the Cheshire Drug partnership which encompasses managing hepatitis C.”

NHS Western Cheshire

Two NHS commissioners stated that although they do not have a strategy for hepatitis C, they had identified specific actions to manage hepatitis C in the local area. It is positive that NHS commissioners are highlighting actions specific to hepatitis C, but this is not a substitute for a clearly thought-out strategy based on local need which provides a defined focus and outcomes.

“It does not have a strategy but does have a series of actions identified through the needs assessment completed Feb 2012.”

NHS Suffolk

Again, it is particularly concerning that two NHS commissioners stated that hepatitis C is covered by their sexual health strategy, given that hepatitis C is very rarely sexually transmitted. At the very least, hepatitis C should be included in a blood-borne virus or infectious disease strategy, although having its own individual strategy is preferable.

“There is no specific hepatitis C strategy but strategic actions are contained within both the drugs and alcohol strategy and sexual health strategy.”

NHS Tower Hamlets

The transition to clinical commissioning is an opportunity for NHS commissioners to develop comprehensive strategies for hepatitis C. Ideally, these would be hepatitis C specific, but could be part of a wider blood-borne virus or infectious disease strategy if necessary. Encompassing hepatitis C within a drug and alcohol or sexual health strategy will not be adequate and could result in the needs of people living with hepatitis C being negated.

Recommendation 3: As part of their preparations for taking on full public health responsibilities, local authorities should ensure that they develop a comprehensive hepatitis C strategy which is jointly agreed with clinical commissioning groups and takes local need into account.
Within the new health structures, coordination between the NHS and public health services will be vital to ensure joined up care and improved outcomes for patients with hepatitis C. National leadership is required to ensure coordination across the NHS Commissioning Board, Public Health England and the Department of Health’s adult social care services team and all of these bodies will need to identify designated leads for hepatitis C to ensure accountability.

On a local level, this kind of coordination should be replicated to ensure the needs of people affected by hepatitis C are taken into account. This could be via informal commissioning arrangements, strategic clinical networks or health and wellbeing boards.

Joint working

Figure 6 shows that 60% of the local authorities which responded to the audit said that they do not yet have arrangements in place with the relevant NHS commissioner to ensure coordination on hepatitis C.

**Figure 6 – Are there arrangements in place with the relevant local commissioner to ensure coordination on hepatitis C?**

There are some examples of good practice which should be expanded and continued. For example, the Director of Public Health for Bedford Borough Council and NHS Bedfordshire has responsibility for the coordination of hepatitis C services. This includes implementation and oversight of the following arrangements:

- Commissioning leads at NHS Bedfordshire sit on the Bedfordshire Hepatitis Network
- A dedicated public health manager acts on behalf of the Director of Public Health to work jointly with NHS Bedfordshire commissioners to coordinate the local commissioning of services

“The Director of Public Health is a joint appointment with the local authority and ensures the co-ordination of services which are commissioned for the prevention and treatment of hepatitis C”

**NHS Oxfordshire**

“There is a public health team have recently relocated to the local authority and are currently being hosted by them until April 2013 when there will be a formal transfer of public health to the local authority. We currently jointly commission drug and alcohol services in the community (including prisons) and incorporate hepatitis testing.”

**NHS Milton Keynes**

Among those local authorities that do not currently have arrangements in place, there are indications that these organisations plan to take a greater interest in ensuring coordination going forward when they take on public health responsibility. This must happen as a matter of urgency.

“...as the borough looks to integrate health and social care commissioning it is likely that there will be increased co-ordination across all levels of commissioning, including care pathways for blood borne viruses.”

**Brent Council**

“Liverpool’s Health and Wellbeing Board will enable coordination of commissioning across NHS Commissioning Board, CCGs and Local Authority as required.”

**NHS Liverpool**

**Clinical networks**

Strategic clinical networks will be developed in condition areas where a whole system, integrated approach is needed to drive improvements in the quality and outcomes of care for patients. These networks will be designed to reduce variations in the quality of services and encourage innovation. The NHS Commissioning Board has set out plans to develop strategic clinical networks for cancer, cardiovascular disease, maternity and children’s services and mental health, dementia and neurological conditions.

It is disappointing that liver networks will not initially be hosted by the NHS Commissioning Board. It is one of the only areas with improvement indicators of Domain 1 in the NHS Outcomes Framework that does not have a designated strategic clinical network.

The All-Party Parliamentary Hepatology Group has underlined that the potential role of liver networks is significant and its functions could include:

- Promoting coordination in the commissioning of liver services across public health, NHS and adult social care and enabling integration of services where this is appropriate
- Ensuring effective working between different tiers of liver service commissioning
- Delivering the commissioning of some liver services on behalf of clinical commissioning groups
- Planning capacity to ensure that patients can be treated in a safe and effective way
- Advising on the appropriate level of specialisation required to deliver effective treatment
- Developing ‘hub and spoke’ models of care where these are appropriate
- Identifying challenges and areas for improvement to clinical commissioning groups, local authorities and the NHS Commissioning Board
- Championing and spreading good practice, promoting high quality and efficient care
In order to develop a greater understanding of the extent of existing networks on a local level, our audit asked NHS commissioners and local authorities whether they sat on a hepatitis C clinical network.

As shown in Figure 8, just 10% of local authorities sit on a hepatitis C clinical network.

Figure 8 – Does the local authority sit on a hepatitis C clinical network?

It is clear that the understanding of ‘clinical network’ varies amongst NHS commissioners, from informal local groupings to bigger regional networks.

“Greater Manchester Hepatitis C Network has led on needs assessment and the establishment of training and improved care pathways.”

Manchester Metropolitan Council

The number of NHS commissioners which responded that they sit on a clinical network was greater, but still accounted for just over half of respondents. Figure 9 shows the breakdown.

Figure 9 – Does the commissioner sit on a hepatitis C clinical network?

Although only a small proportion of local authorities currently sit on a clinical network, the work that is being undertaken in some areas is encouraging. We urge other local authorities to follow this example and work with NHS commissioners to establish clinical networks when they take on public health responsibilities. Participation in these networks encourages a joined-up, holistic approach to hepatitis C services locally.

“The Bedfordshire and Luton Hepatitis Network oversees the local Hepatitis C Strategy and the Hepatitis Action Plan. The Director of Public Health is accountable for leadership of the Network and the delivery of the strategy, on behalf of Bedford Borough Council and NHS Bedfordshire.”

Bedford Council

“This clinical network is essentially hosted by the hepatitis B/C strategy group [and] includes microbiologists, gastroenterologists, GUM physicians, public health and the Health Protection Agency.”

NHS Warwickshire

“The PCT participates with other partner organisations such as the acute trusts and Health Protection Agency in a local blood borne virus network which has needs assessment, strategy formulation, clinical pathway design and service commissioning for hepatitis C on its agenda.”

NHS Berkshire West

Several NHS commissioners highlighted that they used to sit on a clinical network but that they have since stopped operating, which is worrying. Others said that they are in the process of exploring the establishment of a clinical network for hepatitis C.

“There was a South East London Hepatitis Group (clinical and primary care) but this has not met for one to two years.”

NHS Bromley

“Work has commenced to scope what this means for the area including an initial meeting of the PCT with stakeholders including a provider trust, the Health Protection Agency, and a local authority and links have been made with the regional groups on this agenda.”

NHS North Yorkshire and York

We call on the NHS Commissioning Board to support pilot clinical liver networks, with a view to their being hosted nationally in the future. This will create the structures to support the good practice in this area that is already ongoing, but also promote the participation of bodies which have yet to be active in clinical networks to date.

Recommendation 4: The NHS Commissioning Board should support pilot clinical liver networks, with a view to their being hosted nationally in the future.

Health and wellbeing boards

Health and wellbeing boards are currently in shadow form but will take on significant, statutory responsibilities in April 2013. Health and wellbeing boards will:

• Have strategic influence over commissioning decisions
• Involve democratically-elected representatives
• Bring together clinical commissioning groups and local authorities to assess local health and wellbeing needs of the community and undertake the Joint Strategic Needs Assessment (JSNA)
• Drive local commissioning of health care, social care and public health

These bodies will be hosted by local authorities. It is concerning therefore that, to date, only 8 of 106 local authorities that we audited have provided any guidance to local health and wellbeing boards on hepatitis C, as shown in Figure 10.

This is a key opportunity to ensure that health and wellbeing boards are fully aware of the impact of hepatitis C on the local community. Local authorities should provide them with this information as a priority.
Many local authorities stated that the reason for the lack of communication with health and wellbeing boards is a result of their being in shadow form. We know that the development of health and wellbeing boards has not been consistent across the country and that the baseline for coordination across health and local authorities varies greatly between regions. However, engagement needs to begin now if health and wellbeing boards are to be properly equipped to start operating formally.

In Nottinghamshire, the health and wellbeing board has already assessed issues around health protection and the specific need to develop hepatitis C services, which is excellent progress. In order for health and wellbeing boards to improve hepatitis C commissioning, it is vital that they undertake an assessment of current policies and the burden of disease so that they can make a positive impact as soon as they take on additional responsibilities.

**Recommendation 5: Local authorities should ensure that health and wellbeing boards are equipped with relevant information about the burden of hepatitis C in the community.**
In order for NHS commissioners and local authorities to improve outcomes in hepatitis C, it is essential that they have an understanding of the burden of hepatitis C within their local population so that they can design and resource services appropriately.

Figure 11 shows that almost three quarters of local authorities have not undertaken an estimate of the number of people diagnosed with hepatitis C in their area. Of those local authorities that had undertaken an assessment of the number of people diagnosed with hepatitis C, 87% had also assessed the current and future burden of disease.

In total, more than three quarters (76%) of local authorities failed to undertake an assessment of the current and future burden of hepatitis C. This is worrying, given that local authorities will have such a major role in terms of the prevention and identification of hepatitis C in the new health care system. Local authorities should be preparing now to fully understand the public health needs of their local population so that they are ready to take on the tasks required to meet these needs.

**Figure 11 – Has an estimate of the number of people diagnosed with hepatitis C been undertaken by the local authority?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>27%</td>
<td>73%</td>
</tr>
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In contrast, three-quarters of NHS commissioners have estimated the prevalence of hepatitis C in their area, as show in Figure 12. This figure, although considerably better than that for local authorities, is still not good enough. Estimating the prevalence of hepatitis C should be baseline activity required of the NHS commissioner, and should already be happening as part of the Joint Strategic Needs Assessment (JSNA).

**Figure 12 - Has an estimate of the number of people diagnosed with hepatitis C been undertaken by the commissioner?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
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<tbody>
<tr>
<td>76%</td>
<td>24%</td>
</tr>
</tbody>
</table>

Both local authorities and NHS commissioners have used the tools provided by the HPA to enable a local assessment of the burden of hepatitis C. Under reforms to public health information, the HPA’s functions and powers will be transferred to Public Health England. It is crucial that this public health expertise is not lost in the transition. Traditionally, the data around hepatitis C have been poor compared to other condition areas such as HIV. The NHS reforms present an opportunity to improve the information collected on hepatitis C.

In cancer, the establishment of a National Cancer Intelligence Network (NCIN) significantly improved the information collected about cancer services and outcomes for analysis, publication and research. The data collected and published by the NCIN are now extensive and this continues to grow. Making relevant data available for liver disease and hepatitis C would allow effective benchmarking of performance between commissioners and providers, facilitate patient choice and drive improvements in patient experience and outcomes. We therefore call on Public Health England to establish a similar network for liver disease as a priority.

**Recommendation 6: Public Health England should outline plans to establish a national liver intelligence network.**

The focus of Domain 4 of the Public Health Outcomes Framework, Improving outcomes and supporting transparency, is on reducing the numbers of people living with preventable ill health and people dying prematurely, while reducing the outcomes gap between communities. Much of the responsibility for delivering against this aim will fall with local authorities, although it should be noted that this is a shared indicator with the NHS.

**Local campaigns**

Raising awareness of hepatitis C is an important way to prevent infection and to cut transmission rates in the long-term. The symptoms of hepatitis C can often be attributed to other illnesses, for example, fatigue, skin problems, pain and digestive disorders could all have other causes. For these reasons, hepatitis C often goes undiagnosed and so is referred to as the ‘Silent Epidemic’.

Guidance from the National Institute for Health and Clinical Excellence (NICE) on promoting and offering testing of hepatitis B and C underlines the importance of awareness-raising in order to encourage people to get tested. Figure 13 shows that only 30% of local authorities currently have local awareness campaigns in place. These range from awareness raising activities via substance misuse and homelessness services, work with people in prisons who are injecting drug users, and awareness activities with providers of services. It is disappointing that such a large proportion is yet to undertake any sort of awareness campaign.

**Figure 13 - Have local awareness campaigns been developed by the local authority?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>71%</td>
<td>29%</td>
</tr>
</tbody>
</table>
Prevention of hepatitis C

Targeted prevention measures

Given the nature of the condition, many local authorities may have already come into contact with hepatitis C as an issue through drug, alcohol and treatment teams in the community. As shown in Figure 14, almost half of local authorities have targeted measures in place to prevent hepatitis C transmission among at risk groups.

**Figure 14 - Are targeted measures in place to prevent hepatitis C transmission among at risk groups?**

- **Yes:** 49%
- **No:** 51%

Among those local authorities that provided detail on the measures in place, the majority were focused on injecting drug users and those using harm reduction services. It is, however, not only injecting drug users who are at increased risk of contracting hepatitis C. Other groups that are at increased risk of having the disease are:

- People born or brought up in a country with an increased prevalence of hepatitis C
- People who have injected drugs in the past (no matter how rarely)
- Prisoners and young offenders
- Close contacts of someone known to be chronically infected with hepatitis C
- Babies born to mothers infected with hepatitis C

Local authorities should review their policies on preventing hepatitis C transmission to ensure that the needs of the whole local population are taken into account. This could form part of the JSNA.

**Recommendation 7:** Local authorities should ensure that measures to prevent hepatitis C transmission are targeted to all at risk groups within local communities.

Auditing quality

In order to assess the effectiveness of prevention and awareness campaigns and interventions, local authorities should be auditing the quality and outcomes of their programmes as standard. This will give them the information they require to evaluate their measures to tackle hepatitis C, identify areas for improvement and examples of good practice. However, only six local authorities out of 107 that responded to our request have undertaken an audit of the quality of their public health measures to tackle hepatitis C, as shown in Figure 15.

“I can confirm that the local authority is currently undertaking an audit of all public health services that are provided by City and Hackney PCT, in preparation for the transfer of public health responsibilities in 2013.”

**City of London Council**

“The Council has undertaken an audit of the quality of public health measures to tackle hepatitis C in the area. The results are regularly analysed to understand expected prevalence. A service user involvement exercise was recently undertaken that involved mystery shopping exercises at pharmacy needle exchanges and a case file audit to scrutinise activity in relation to all areas of drug and alcohol service provision, including hepatitis C.”

**Coventry Council**

**Figure 15 - Has an audit of the quality of public health measures to tackle hepatitis C been undertaken by the local authority?**

- **Yes:** 94%
- **No:** 6%

Given the imminent handover of public health powers, the lack of scrutiny over public health measures to tackle hepatitis C is concerning. Local authorities will need to extend these measures, as well as ensure that they achieve the desired outcome (reducing hepatitis C transmission) when they become responsible for public health. They will need to have clear mechanisms in place through which to comprehensively measure these.

**Recommendation 8:** Local authorities must develop clear mechanisms to scrutinise their public health measures to tackle hepatitis C.
Hepatitis C testing and diagnosis

Despite the high prevalence of hepatitis C in England, public awareness of how the disease can be diagnosed, treated and cured remains very low. The central issue in England is that the majority of people with the condition do not know that they have been at risk and are infected, and only a very small proportion of people who are diagnosed are actually receiving treatment. Testing, diagnosing and treating hepatitis C as early as possible is crucial to boosting patient outcomes and also to preventing its further spread. Since IDUs are at increased risk of contracting hepatitis C, there needs to be targeted interventions to increase the uptake of testing among this group. However, hepatitis C testing should not just be focused on this group; it should be increased for all at-risk groups, including people born or brought up in a country with an increased prevalence of hepatitis C, such as those from South-East Asia.

Local testing campaigns

As part of health promotion efforts, local organisations should be developing hepatitis C awareness and testing campaigns to increase the uptake of testing. The Hepatitis C: are you at risk campaign run by the Department of Health could prove a useful model for how campaigns could be run at a local level. However, as shown in Figure 16, only two-fifths of local authorities who responded to the audit have worked with the NHS to develop testing campaigns for hepatitis C so far.

Figure 16 – Has the local authority undertaken work with the local NHS to develop testing campaigns?

Testing in general practice

Alongside general testing campaigns, there need to be concerted efforts to increase hepatitis C testing in general practice. GPs are the first healthcare professionals that people tend to come into contact with, and are therefore in an important position to identify those who might be, or have been, at risk of hepatitis C infection and should be offered a test. Figure 17 shows that only just over half of NHS commissioners who responded to the audit currently have measures in place to encourage hepatitis testing C in local GP practices.

Several of the NHS commissioners which responded that they do have measures in place said that this was particularly targeted at IDUs. This group should, of course, be a major focus for hepatitis C testing but they need to be mindful of the other at-risk groups too. Some NHS commissioners had clearly taken a strategic approach to encouraging GP hepatitis C testing which is excellent.

The Royal College of General Practitioners has a training module on the detection, diagnosis and management of hepatitis B and C which has been well received by the hepatitis C community. This course supports GPs in detecting and diagnosing hepatitis B and C, and advising people about reducing risk of infection. It describes the clinical management of viral hepatitis and explains how to reduce morbidity and mortality in people with hepatitis through early identification. It also discusses the identification and ways of...
addressing the needs of different population groups and explains how other factors can impact on liver health in combination with hepatitis infection.

**Recommendation 9: Health Education England should raise awareness of the Royal College of General Practitioners’ training module on the detection, diagnosis and management of hepatitis B and C, and encourage GPs to undertake it as part of their professional development.**

**Local data on hepatitis C testing**

The ability to evaluate the effectiveness and sustainability of testing campaigns is dependent on being able to measure how many people are actually tested for hepatitis C. This information should be the bare minimum that commissioners obtain in order to assess the level of testing within their area and to see whether campaigns have made a difference to the overall numbers being tested.

Despite this, Figure 18 shows that only a third of local authorities which responded to the audit said that they hold data on the number of people tested for hepatitis C. A couple of local authorities stated that this information already forms part of the local needs assessment. It was clear from their responses that most of the local authorities hold the information in relation to people being tested in drug treatment services but not in community or secondary services more broadly.

“**The local authority is required to meet performance targets relating to HCV testing of past and current injecting drug users. Every drug user who falls into this category is offered a HCV test. Testing rates currently stand at 82%.”**

**City of London Council**

“The Community Safety and Substance Misuse Team have data on the number of service users in treatment with the commissioned drug and alcohol service who have had a hepatitis C test. However this only applies to this client group. The local authority does not have data on the numbers tested in the wider community.”

**Warwickshire Council**

When local authorities take on public health responsibilities, they will need to obtain information on how many people are being tested for hepatitis C, and in which locations, to properly evaluate how effective their prevention and testing campaigns are. This will support better coordination with NHS commissioners on capacity planning for testing that is undertaken within the NHS.

Figure 18 – Does the local authority hold data on the number of people tested for hepatitis C?

![Figure 18](image)

Figure 19 shows that over half of NHS commissioners hold figures on the number of people tested for hepatitis C. Amongst the NHS commissioners which responded that they do hold data on the number of people tested for hepatitis C, a number of these (30%) stated that they only hold the information for those tested in drug services. This echoes the local authority findings.

“**We do not know how many people in Brent were tested in total but in 2010, 95% of clients presenting to the (community provider) substance misuse services were offered a test, or assessed as not requiring one and 58% of previous or current IDU clients received a test for hepatitis C.”**

**NHS Brent**

“**Data on high risk groups who are actively screened is available. This includes those in prison at HMP Erlestoke and drug users. It is not possible to get an overall figure as practices do not routinely provide the PCT with this data if testing is requested via a GP.”**

**NHS Wiltshire**

To get a more comprehensive picture of hepatitis C testing, the data held should be broader. We expect the majority of hepatitis C tests to take place in drug treatment centres, but not collecting the figures for community and secondary care means that commissioners are unable to obtain the full picture of hepatitis C testing in their area. NHS commissioners should have comprehensive information on hepatitis C testing in their area. Without it, they are ill-equipped to assess the effectiveness of testing and awareness campaigns and targeted outreach.
There are clinically and cost-effective treatments available that enable around 70% of patients to completely clear the virus.80 Despite this, the latest status report on hepatitis C in the UK from the HPA suggests that diagnoses of hepatitis C are increasing but that the treatment of hepatitis C is decreasing, with only three per cent of people chronically infected receiving treatment each year.81

In 2010, Extent and causes of international variation in drug usage found that usage of hepatitis C drugs in the UK was significantly lower than in comparable countries, with the UK ranking 13th of 14 countries studied.82 The report identified poor service organisation, capacity and planning as potential explanations for the low uptake of treatments in the UK compared to other countries.83 This was confirmed in recent research by IMS Health has also identified poor service configuration and capacity issues as contributing factors in the poor uptake, despite these treatments having a positive appraisal from the National Institute of Health and Clinical Excellence.84

Coupled with this, the HPA has identified a number of reasons for the decline in the number of patients receiving treatment for hepatitis C since 2010, including:

- Clinicians and/or patients waiting for new drugs
- Clinical capacity being met
- Reaching treatment saturation of those individuals who are easy to access

Treating patients with hepatitis C now will help local authorities and NHS commissioners to deliver improved outcomes in liver disease. Furthermore, while patients are not being offered treatment, they are more likely to transmit the virus to other people. Patients who do not receive treatment risk developing more serious liver diseases which place an additional burden on NHS services and will increase mortality from the disease.

HPA modelling suggests that, if treatment was increased to ten per cent in those with moderate hepatitis C, and 20 per cent in those with more advanced hepatitis C, the number of people experiencing liver failure or liver cancer would fall by over 2,000 in the next ten years.85

Estimates of service access, efficacy and cost

Figure 20 shows that only just over half of the NHS commissioners who responded to the audit have an estimate of the number of patients who were initiated on treatment for hepatitis C. A number of NHS commissioners advised the Hepatitis C Trust to contact their local providers for this information directly. A few also said that they are waiting for the information to arrive or are building mechanisms through which this data will be collected in future.

“We are currently waiting for local treatment providers to update the PCT with the numbers of patients with hepatitis C initiating treatment in the previous year.”

NHS Newham

“Data not available at present but PCT is currently developing a service specification with Nottingham University Hospitals Trust which will include this.”

NHS Nottingham City

Figure 21 shows that even fewer (one-third) have an estimate of the number of hepatitis C patients who have achieved a sustained virological response following treatment. Again, several NHS commissioners said that the information had to be obtained directly from those providing services.

“Data is held by acute trusts that provide treatment.”

NHS Sefton

“Information not held. Please contact the direct clinical providers for this level of information.”

NHS Tower Hamlets

Figure 20 - Does the commissioner have an estimate of the number of patients initiated on treatment for hepatitis C?

Figure 21 - Does the commissioner have an estimate of the number of patients that achieved a sustained virological response following hepatitis C treatment?

This lack of information amongst NHS commissioners is worrying. A clear message came across from the audit that some NHS commissioners consider these areas to be the responsibility of providers rather than something which they should be monitoring. As the commissioners of hepatitis C services, NHS commissioners should routinely be collecting information about the numbers of patients being treated, and how many of them successfully clear the virus, to assess how effective the services they commission are. This will enable more effective service planning.

Coordination will also be required to ensure that data on patients whose treatment is managed by the NHS Commissioning Board are effectively monitored.

Recommendation 11: Clinical commissioning groups should regularly work with providers to gather data on how many patients with hepatitis C are initiated on treatment and how many achieve a sustained virological response.

Measures to increase treatment

As highlighted previously, modelling by the HPA suggests that increasing the proportion of patients treated by as little as 10%, among those people with moderate hepatitis C and to 20% among those with more advanced disease, could reduce the number of new cases of cirrhosis or liver cancer by more than 2,000 over the next ten years.86
There is therefore a powerful case for NHS commissioners at both a national and local level to introduce measures to increase the number of patients with hepatitis C being treated. However, as Figure 22 demonstrates, just over half of NHS commissioners have any such measures in place. Of those that do have measures in place to increase the treatment of hepatitis C patients, some of them have focused on treatment for patients using drug treatment services, although there is some wider provision too.

“In partnership with the DAAT, we commission a BBV Service from East London NHS Foundation Trust, which is based in the Tower Hamlets Specialist Addictions Unit, part of the aim of which is to increase treatment of Hepatitis C.”

**NHS Tower Hamlets**

“Commissioners are currently working on plans to increase treatment capacity and bring treatment to the immediate locality (currently patients have to travel to Ipswich or Addenbrookes for treatment)”.

**NHS North East Essex**

**Figure 22 – Has the commissioner put in place measures to increase the number of patients with hepatitis C being treated?**

<table>
<thead>
<tr>
<th>44%</th>
<th>56%</th>
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</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
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</tbody>
</table>

Clinical commissioning groups should work to increase the number of hepatitis C patients in their area who are receiving treatment. This will reduce the burden of liver disease on the NHS in the long-run. To help support this, the NHS Commissioning Board should assess whether there are service models which can help improve treatment uptake. This is particularly relevant given its role in commissioning hepatitis C treatment that is classified as specialised.

**Recommendation 12: The NHS Commissioning Board should consider models that may improve the uptake of hepatitis C treatment.**

It is a time of great change in the NHS and the reforms to commissioning present a real opportunity to ensure that hepatitis C is given greater priority and managed more effectively at a local level. We urge local authorities and clinical commissioning groups to seize this opportunity. We have the chance to act now to prevent infections, test and diagnose people, and make sure that people receive the treatment and care that they need – if we do, the impact on long-term health outcomes, including liver mortality, will be considerable.

**Public health**

The transition of public health responsibilities to Public Health England and local authorities should be used as an opportunity to renew momentum on hepatitis C prevention and testing. NICE has recently published guidance on ways to promote and offer testing for hepatitis B and hepatitis C which is a useful tool for public health leads to drive improvements in hepatitis C testing.

A key part of the move to greater public health responsibility will be to assess the future, as well as current, burden of hepatitis C in the local area. Unfortunately, Figure 23 demonstrates that only a quarter of local authorities have done this so far. This is concerning, given that this should already part of their role in undertaking the Joint Strategic Needs Assessment. Amongst those local authorities that confirmed that they have undertaken an assessment, a number of them highlighted that this was part of their regular needs assessment process.

**Figure 23 – Has the local authority undertaken an initial assessment of the current and future burden of hepatitis C?**

<table>
<thead>
<tr>
<th>24%</th>
<th>76%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
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</table>

Clinical commissioning groups will need to do better than this. In partnership with local authorities, they will need to identify local need related to hepatitis C, and plan, design and monitor services accordingly. Thinking ahead needs to be an integral part this process so that services will work now and in the future.

**Recommendation 13: Local authorities should refer to the HCV Action commissioning toolkit to help inform the public health commissioning process.**

**Health commissioning**

It is clear from the audit that NHS commissioners have not been giving hepatitis C the priority required to ensure that it is managed effectively. Figure 24 shows that that only two-thirds of NHS commissioners have assessed the current and future needs relating to hepatitis C in their area. This should be a key element of their role so this figure is disappointing.

**Figure 24 - Has the NHS commissioner done an assessment of current and future need relating to hepatitis C?**

<table>
<thead>
<tr>
<th>24%</th>
<th>76%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
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</table>

Clinical commissioning groups, in partnership with local authorities, should assess current and future local needs related to hepatitis C to inform the commissioning process.
### Appendix 1 – List of NHS commissioners which responded to the audit

<table>
<thead>
<tr>
<th>NHS Ashton, Leigh and Wigan</th>
<th>NHS Heywood, Middleton and Rochdale</th>
<th>NHS Southampton City</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Barking and Dagenham</td>
<td>NHS Hillingdon</td>
<td>NHS Southwark</td>
</tr>
<tr>
<td>NHS Barnsley</td>
<td>NHS Kensington and Chelsea</td>
<td>NHS Stockport</td>
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<tr>
<td>NHS Bassetlaw</td>
<td>NHS Knowsley</td>
<td>NHS Stockton on Tees</td>
</tr>
<tr>
<td>NHS Bath and North East Somerset</td>
<td>NHS Leeds</td>
<td>NHS Stoke-on-Trent</td>
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<tr>
<td>NHS Berkshire East</td>
<td>NHS Leicester City</td>
<td>NHS Suffolk</td>
</tr>
<tr>
<td>NHS Berkshire West</td>
<td>NHS Leicestershire County and Rutland</td>
<td>NHS Sunderland Teaching</td>
</tr>
<tr>
<td>NHS Bexley Care Trust</td>
<td>NHS Lewisham</td>
<td>NHS Surrey</td>
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<tr>
<td>NHS Blackburn with Darwen Teaching</td>
<td>NHS Lincolnshire Teaching</td>
<td>NHS Tameside and Glossop</td>
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<tr>
<td>NHS Blackpool</td>
<td>NHS Liverpool</td>
<td>NHS Telford and Wrekin</td>
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<tr>
<td>NHS Bolton</td>
<td>NHS Luton Teaching</td>
<td>NHS Torbay Care Trust</td>
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<tr>
<td>NHS Bournemouth and Poole</td>
<td>NHS Manchester</td>
<td>NHS Tower Hamlets</td>
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<tr>
<td>NHS Bradford and Airedale Teaching</td>
<td>NHS Medway</td>
<td>NHS Trafford</td>
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<tr>
<td>NHS Brent Teaching</td>
<td>NHS Mid Essex</td>
<td>NHS Wakefield District</td>
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<tr>
<td>NHS Brighton and Hove City Teaching</td>
<td>NHS Middlesbrough</td>
<td>NHS Walsall Teaching</td>
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<tr>
<td>NHS Bristol</td>
<td>NHS Milton Keynes</td>
<td>NHS Waltham Forest</td>
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<td>NHS Bromley</td>
<td>NHS Newcastle</td>
<td>NHS Warrington</td>
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<tr>
<td>NHS Buckinghamshire</td>
<td>NHS Newham</td>
<td>NHS Warwickshire</td>
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<tr>
<td>NHS Bury</td>
<td>NHS North East Essex</td>
<td>NHS West Essex</td>
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<tr>
<td>NHS Calderdale</td>
<td>NHS North East Lincolnshire</td>
<td>NHS West Kent</td>
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<tr>
<td>NHS Cambridgeshire</td>
<td>NHS North Lancashire</td>
<td>NHS West Sussex</td>
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<tr>
<td>NHS Central and Eastern Cheshire</td>
<td>NHS North Lincolnshire</td>
<td>NHS Westminister</td>
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<tr>
<td>NHS Central Lancashire</td>
<td>NHS North Somerset</td>
<td>NHS Wiltshire</td>
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<tr>
<td>NHS City and Hackney Teaching</td>
<td>NHS North Staffordshire</td>
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<td>NHS County Durham</td>
<td>NHS North Tyneside</td>
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<td>NHS Derby City</td>
<td>NHS North Yorkshire and York</td>
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<td>NHS Derbyshire County</td>
<td>NHS Northamptonshire Teaching</td>
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<td>NHS Doncaster</td>
<td>NHS Northumberland Care Trust</td>
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<td>NHS Dorset</td>
<td>NHS Nottingham City</td>
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<td>NHS Dudley</td>
<td>NHS Nottinghamshire County Teaching</td>
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<td>NHS Ealing</td>
<td>NHS Oldham</td>
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<tr>
<td>NHS East Lancashire Teaching</td>
<td>NHS Oxfordshire</td>
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<tr>
<td>NHS East Riding of Yorkshire</td>
<td>NHS Peterborough</td>
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<tr>
<td>NHS East Sussex Downs and Weald</td>
<td>NHS Plymouth Teaching</td>
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<tr>
<td>NHS Eastern and Coastal Kent</td>
<td>NHS Portsmouth City Teaching</td>
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<tr>
<td>NHS Gateshead</td>
<td>NHS Redbridge</td>
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<tr>
<td>NHS Gloucestershire</td>
<td>NHS Redcar and Cleveland</td>
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<tr>
<td>NHS Halton and St Helens</td>
<td>NHS Rotherham</td>
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<tr>
<td>NHS Hammersmith and Fulham</td>
<td>NHS Salford Teaching</td>
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<td>NHS Hampshire</td>
<td>NHS Sandwell</td>
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<tr>
<td>NHS Harrow</td>
<td>NHS Sefton</td>
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<td>NHS Hartlepool</td>
<td>NHS Sheffield</td>
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<td>NHS Hastings and Rother</td>
<td>NHS Shropshire County</td>
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<tr>
<td>NHS Havering</td>
<td>NHS South Gloucestershire</td>
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<tr>
<td>NHS Heart of Birmingham Teaching</td>
<td>NHS South Staffordshire</td>
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<tr>
<td>NHS Herefordshire</td>
<td>NHS South Tyneside</td>
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<tr>
<td>NHS Hertfordshire</td>
<td>NHS South West Essex</td>
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</tbody>
</table>
Appendix 2 – List of local authorities which responded to the audit

Appendix 2

Barking and Dagenham Council
Barnet Council
Barnsley Council
Bath and North East Somerset Council
Bedford Borough Council
Bexley Council
Birmingham City Council
Blackpool Council
Bracknell Forest Council
Brent Council
Bristol City Council
Buckinghamshire County Council
Bury Metropolitan Borough Council
Calderdale Council
Camden Council
Central Bedfordshire Council
Cheshire West and Chester Council
City of London Corporation
Cornwall Council
Durham County Council
Coventry City Council
Croydon Council
Cumbria County Council
Darlington Borough Council
Derby City Council
Derbyshire County Council
Doncaster Council
Dorset County Council
Ealing Council
East Sussex County Council
Essex County Council
Gloucestershire County Council
Hackney Council
Halton Borough Council
Hampshire County Council
Haringey Council
Harrow Council
Havering Council
Herefordshire Council
Hertfordshire County Council
London Borough of Hillingdon
Hounslow Council
Isle of Wight Council
Isles of Scilly Council
Islington Council
Royal Borough of Kensington and Chelsea
Kent County Council
Hull City Council
Kirklees Council
Knowsley Council
Lambeth Council
Leeds City Council
Leicester City Council
Leicestershire County Council
Lewisham Council
Liverpool City Council
Luton Borough Council
Manchester City Council
Medway Council
Middlesbrough Council
Newcastle City Council
Newham Council
Norfolk County Council
North East Lincolnshire Council
North Tyneside Council
North Yorkshire County Council
Northamptonshire County Council
Nottingham City Council
Nottinghamshire County Council
Oldham Council
Oxfordshire County Council
Peterborough City Council
Portsmouth City Council
Reading Borough Council
Redbridge Council
Redcar and Cleveland Borough Council
London Borough of Richmond upon Thames
Rotherham Metropolitan Borough Council
Rutland County Council
Salford City Council
Sandwell Council
Shropshire Council
Slough Borough Council
Solihull Council
South Gloucestershire Council
Southampton City Council
Southend-on-Sea Borough Council
Southwark Council
St Helens Metropolitan Borough Council
Stockport Council
Stockton-on-Tees Borough Council
Stoke-on-Trent City Council
Suffolk County Council
Sunderland City Council
Surrey County Council
Sutton Council
Swindon Borough Council
Tameside Metropolitan Borough Council
Telford and Wrekin Council
Thurrock Council
Tower Hamlets Council
Wakefield Council
Warrington Borough Council
Warwickshire County Council
Westminster City Council
Wirral Borough Council
Wokingham Borough Council
Wolverhampton City Council
Worcestershire County Council
City of York Council
Request #1 Please confirm or deny whether there is a lead for hepatitis C in the PCT.
Request #2 Please confirm or deny whether the PCT has a strategy in place for managing hepatitis C in its area.
Request #3 Please confirm or deny whether the PCT has arrangements with the relevant local authorities to ensure coordination of hepatitis C commissioning in its area.
Request #4 Please confirm or deny whether the PCT has a hepatitis C clinical network in place.
Request #5 Please confirm or deny whether the PCT has undertaken an assessment of the current and future health needs of its population in relation to hepatitis C.
Request #6 Please confirm or deny whether the PCT has developed an estimate of the overall prevalence of hepatitis C in its area.
Request #7 Please confirm or deny whether the PCT has developed an estimate of the number of people diagnosed with hepatitis each year in its area.
Request #8 Please confirm or deny whether the PCT has any data on the number of people tested for hepatitis C in its area.
Request #9 Please confirm or deny whether the PCT has an estimate of the number of patients with hepatitis C accessing NHS services in its area.
Request #10 Please confirm or deny whether the PCT has an estimate of the number of patients with hepatitis C that were initiated with treatment for hepatitis C in the last year in its area.
Request #11 Please confirm or deny whether the PCT has an estimate of the amount spent on drugs for the treatment of hepatitis C in its area.
Request #12 Please confirm or deny whether the PCT has details on the number of exceptional case requests that were made for hepatitis C treatment in (a) 2009-10, (b) 2010-11 in its area.
Request #13 Please confirm or deny whether the PCT has details on the number of exceptional case requests that were approved for hepatitis C treatment in (a) 2009-10, (b) 2010-11 in its area.
Request #14 Please confirm or deny whether the PCT has an estimate of the number of patients with hepatitis C that achieved sustained virological clearance following hepatitis C treatment in its area.
Request #15 Please confirm or deny whether the PCT has measures to encourage hepatitis C testing in local GP practices.
Request #16 Please confirm or deny whether the PCT has measures to increase treatment of patients with hepatitis C in its area.
Request #17 Please confirm or deny whether the PCT has communicated with local providers on how clinical outcomes for hepatitis C patients can be improved.
Request #18 Please confirm or deny whether the PCT has undertaken an audit of the quality of hepatitis C services in its area.

Request #1 Please confirm or deny whether there is a lead for hepatitis C in the local authority.
Request #2 Please confirm or deny whether the local authority has a strategy in place for managing hepatitis C in its area.
Request #3 Please confirm or deny whether the local authority has arrangements with the relevant primary care trusts to ensure coordination of hepatitis C commissioning in its area.
Request #4 Please confirm or deny whether the local authority sits on a hepatitis C clinical network.
Request #5 Please confirm or deny whether the local authority has provided any guidance to local health and wellbeing boards on hepatitis C.
Request #6 Please confirm or deny whether an assessment of the current and future burden of hepatitis C in its area has been undertaken by the local authority.
Request #7 Please confirm or deny whether the local authority has developed an estimate of the number of people diagnosed with hepatitis C each year in its area.
Request #8 Please confirm or deny whether the local authority has developed any local awareness raising campaigns on hepatitis C.
Request #9 Please confirm or deny whether the local authority has worked with the local NHS to develop any local testing campaigns on hepatitis C.
Request #10 Please confirm or deny whether the local authority has any data on the number of people tested for hepatitis C in its area.
Request #11 Please confirm or deny whether the local authority has any targeted measures in place to prevent hepatitis C transmission in those at risk in its area.
Request #12 Please confirm or deny whether the local authority has undertaken an audit of the quality of public health measures to tackle hepatitis C in its area.