Hep C U Later Report:

Barriers and Facilitators of hepatitis B testing, treatment, and vaccination in community drug and alcohol treatment services across the NHS Addictions Provider Alliance (NHS APA)

Introduction:

Hep C U Later is an initiative of the NHS Addictions Provider Alliance (NHS APA) commissioned by NHS England. Alongside the extensive hepatitis C work carried out across the community drug and alcohol treatment services to support the elimination of hepatitis C, Hep C U Later brought together multiple representatives from these NHS services to explore the barriers and facilitators to hepatitis B care in June 2025.

The following report details the findings from this scoping work.

Services Providing Feedback:

Feedback was sought through a meeting with representatives from NHS APA community drug and alcohol treatment services and through email communications and discussions.

Not everyone participated in the Menti feedback during the meeting, and some nominated one person from their services to complete it on their behalf.

Areas Explored During Scoping:

The following themes were explored within the scoping meeting:

1. The value and importance of hepatitis B testing in community drug and alcohol treatment services
2. Commissioning for hepatitis B testing and vaccination
3. Reasons for the declining rate of hepatitis vaccines administered in DTS
4. Level of confidence of the DTS staff around hepatitis B testing and vaccination
5. Information sharing and data collection
6. Health information shared with people accessing DTS
7. Hepatitis B testing barriers
8. Hepatitis B treatment awareness
9. Facilitators of hepatitis B testing and vaccination uptake

Findings:

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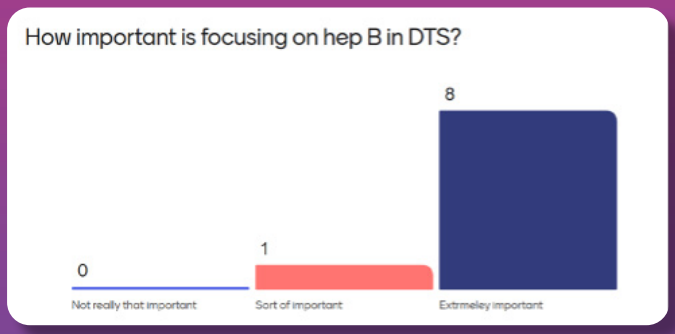
The importance of hepatitis B testing and vaccination within community drug and alcohol treatment services:

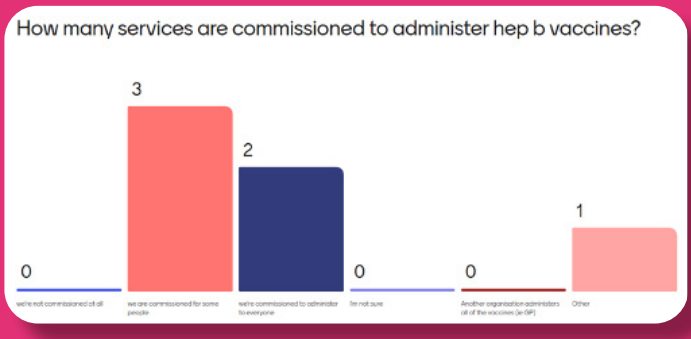
- The participants felt hepatitis B was as important as hepatitis C. Despite the low prevalence within the DTS they felt that the impact of chronic hepatitis B could be more detrimental to an individual. Especially given the complex needs of individuals who attend services. This on balance meant it remained a priority for staff.
- It was also felt that as there is a preventative method available (the vaccination) that this should be utilised to reduce the need for life-long treatment.



"I think it's extremely important is because unlike hep C where most people go on to have a chronic illness, a small amount of people with hepatitis B go on to have a chronic illness and it's essential we pick up those people early enough to engage them in treatment before we go on to have chronic liver disease such as, you know, cirrhosis and cancer. I know the risks of them going on toward a chronic illness are smaller, but it's still important we pick up those people, so testing and then vaccination for people is vital because they're less likely to catch hep B and therefore they won't go on to develop chronic illness and then add to the liver surveillance, transplants, treatment needed form the system."

"It's a lifelong treatment, isn't it? So smaller numbers, but for the smaller numbers of people who do go on to have a chronic illness, it's quite serious."

How many services are commissioned to administer hepatitis B vaccinations?:



- The majority of services were Local Authority commissioned to provide hepatitis B vaccinations for some people who met a criteria within DTS. For example, within Dorset (Avon and Wiltshire Partnership) if a person had a history of injecting, were homeless, had a risk of sexual transmission etc they were offered the vaccine, however, were not routinely offered if they were accessing support for alcohol use without any of these risk factors.
- Some services were commissioned to provide hepatitis B vaccinations to everyone who accessed their services. For example, in Solihull (Birmingham and Solihull NHS Foundation Trust) they routinely offer the course of vaccinations to every person accessing the service, regardless of specific risk factors

Findings:

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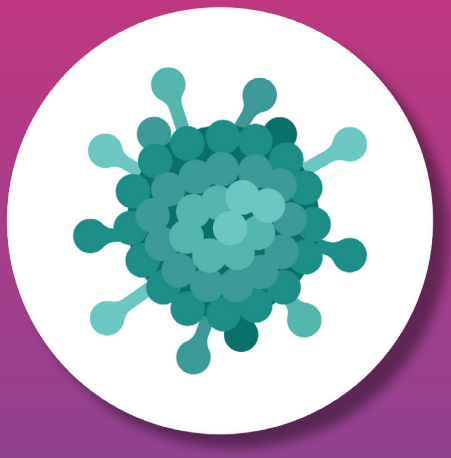
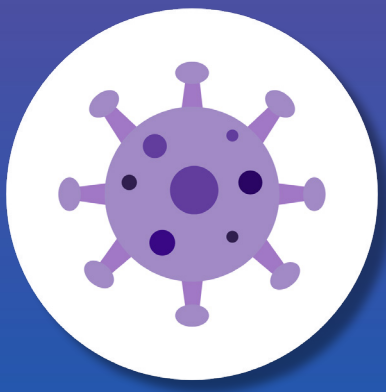
Why have hepatitis B vaccination rates been declining for the past decade?:

- Protocols and out of date policies (and the level of review required) have caused a delay in one service being able to provide the course via a PGD, meaning they needed to prescribe the vaccination for individual people.
- For another service the inaccessibility for HBSAb testing meant that it was hard to determine how many vaccinations a person had in other setting such as prison. One mentioned that a simpler method of completing an immunity check would be a 'game changer'.



"We can't do immunity on DBS which relies on someone who can take blood (we have non-nurses taking blood but they have undertaken advanced venepuncture to support people who might find it difficult to have their blood taken). We also have a self-taken venepuncture policy but this is under nurse supervision."

- It was felt there was variability among staff in ensuring people on their caseloads were encouraged to appointments to complete vaccination courses.
- In line with preliminary data for DTS the respondents felt more people would have had one or two doses and less have completed the course.
- Some of the reasons for a person not completing the course of hepatitis B vaccinations were thought to be:
  - managing withdrawal symptoms
  - dropping out of treatment
  - rough sleeping
  - vaccination being a lower priority than other mental or physical health concerns



- It was felt that often those at highest risk of hepatitis B could be those less likely to complete the vaccination course.
- Many agreed that incentivising vaccinations may improve uptake, however there was a concern raised by one service that this may ultimately have a negative effect on offering interventions where there is no incentive.
- It was suggested that some groups engage very well with appointments for hepatitis B vaccinations, such as men who have sex with men.

Hepatitis B treatment awareness:

- It was agreed by all that better training around treatment would be beneficial for staff to reassure people, even though treatment is not delivered in DTS.

Findings:

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Why have hepatitis B vaccination rates been declining for the past decade?:

"I think we are better at vaccinating our MSM and people who work in the sex industry (as we go into the saunas) than we are for people who inject drugs."

- Some people also simply decline the offer of the vaccines, but it was also suggested that this can vary depending on who was completing the assessment and how it is explained to the person being offered.

"We're doing so many dry blood spots tests and they'll say they've been vaccinated or vaccinated in prison or they don't know how many they've had, but you can't test them for the immunity to check that. And then some of the workers are really good. They'll book them in for every single one and they'll get them to come back. And others, they won't remind them or get them to come back in to do the follow up. Vaccination, so they might only have one or two and not finish and complete the course."

- It was suggested that although hepatitis B testing might have been carried out alongside regular hepatitis C testing there may have been less focus on hepatitis B vaccinations being completed, meaning a focus on identification, rather than prevention.
- Staff capacity was identified as an issue, for example if a nurse leaves a service recruitment times can be long.

"The advantages of Hep C is that most of it can be non-nurse/non-specialist. E.g. all the testing can be done DBS and we can give them their treatment once issued...The vaccinations can only be given by nurses."

Level of DTS staff confidence around hepatitis B vaccinations:

- It was agreed that there is a training need around hepatitis B vaccinations, particularly in relation to the schedules and who it can be administered to.

"We had a successful series of hep b vaccinations through one of our hep C clinics. I think this worked well as the BBV nurse had the expertise for identifying the clients who required vaccinations (likely from the additional tests that they do for hep C clients). The nurse then advised that vaccination or booster was required. We then arranged for the vaccinations to be given at the same time that the client was attending hep c clinic. So reduced the impact on clients having to attend another appointment on another day for vaccination."

"I definitely think there's a training need."

Information sharing and data collection:

- The majority of DTS share information with the person's GP when the course is completed where there is consent to do so.
- Data sharing between prisons and DTS was an issue and some self-reported results and vaccination information was unable to be verified.

Findings:

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Information sharing and data collection:

"We can't get the information from the prison as well. A lot of people will say they've had them (vaccinations) in prison, so we just have to take the word for it and say they're vaccinated...It's a real gap."

"I struggle to find on the shared care records when people are telling me they've had vaccines, but I can't find record of it. So, then I still just have to take the word for it."

- It was felt that the current data collection did not meet the needs of the DTS and a dashboard similar to the Hep C U Later dashboard and associated data would support them to better manage the clinical work.

"We'd need the same kind of thing that we have from Hep C U Later, we would need the same kind of stuff, really."

- It was felt that the data collected often had missing information such as an unknown date of vaccination (normally set as the 1st January of that year) and the data quality needed to be improved.
- Inclusion Hampshire DTS use a piece of software which notifies the keyworker when people are due each vaccination which many find to be helpful.
- Some systems do not pull through data from previous episodes meaning that information can be missed, or staff spend valuable time looking for information through different episodes.
- Other issues with data completion include when a service TUPE's to another provider. If information does not transfer over there is an additional reliance on asking the person whether they had a vaccination/test and relying on their recall. This sometimes means that people confuse hepatitis B and C.
- Due to some services now only testing for HBSAg and not core antibodies data on spontaneous clearance may have been lost.
- It was believed to be important to capture the date of each vaccination on systems.

Health information shared with people accessing DTS:

- Some DTS offered people administered the hepatitis vaccine the leaflet from the medication box but identified that most people decline to take it.
- Some felt that a simplified version of the information with accessible language would be more likely to be taken. However, it was also recognised that some groups may not want to take any information at all such as people experiencing homelessness.
- Participants agreed that further education for people accessing services on hepatitis B compared to hepatitis C may be beneficial, including the importance of vaccination.

Findings:

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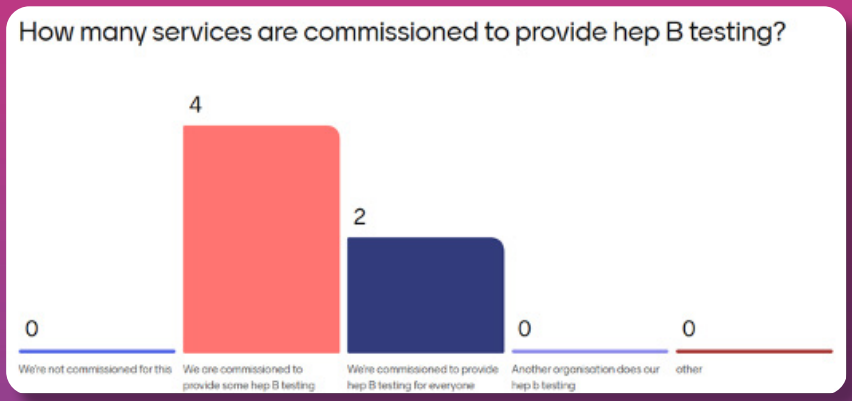
Hepatitis B testing: :

- All services surveyed were either Local Authority commissioned to provide hepatitis B testing to some or all in the DTS.
- Some DTS had KPIs set for hepatitis B testing, however, the appropriateness of these targets may need further exploration.



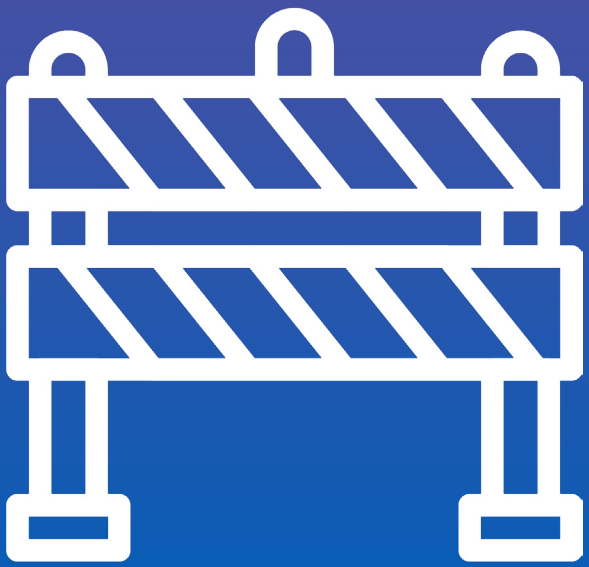
Hepatitis B testing barriers:

- Hepatitis B testing may not have been prioritised previously due to a number of factors. For example, lack of direction and priority setting from team leaders and managers, greater focus on hepatitis C testing, variations in commissioning and funding.

"I think we have definitely put Hep B on the back burner - it started when our service got cut and we lost one of our nurses – that made it really difficulty to do the opportunist vaccinations and also the necessarily flexibility of appointments for people (and especially those who face SMD)."

"There hasn't been the same push nationally as there has been for Hep C."

- However, some conversely felt that hepatitis B testing was routinely done alongside hepatitis C testing and would therefore be less of a priority to improve upon than vaccination rates.



- Lack of immunity testing methods were raised as a barrier in reducing the burden on testing, meaning if effective immunity checking was in place and a person was deemed to have sero-protection further testing would not be necessary.
- There is a difference geographically in terms of prevalence of hepatitis B, for example, London services may have a greater need to test.

Findings:

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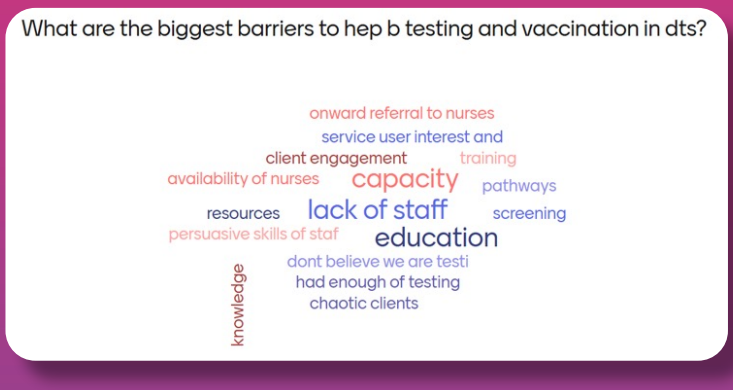
Hepatitis B testing barriers:

"As we have a lot of people who have been in drug treatment for a long time, I expect they will be immunised but we need to do a mass immunity check (or at least see if they have any records on the system). We need to pick up all the people who are newer to injecting heroin/crack too. Plus people who use IPEDs and people who are DIYing."



- If immunity checks are being carried out via venous sampling this may be hindered significantly by arduous pathways, cost and poor venous access.
- If venous bloods are required there was a feeling that there were not enough people available or with the skill set to take bloods. It was felt that there was a willingness for more people to have the training however it was not readily available.

"I don't think there is enough people that can take blood. There have been a few people just recently gone through the training, but potentially we need some more training around that because I think there's a willingness. There's a willingness of some of the recovery workers that really want to do it, but I think don't think the training's that readily available."

- Services covering a wide geography were required to take venous bloods with different colour bottles, adding to the confusion for teams.
- There were issues with obtaining ICE licenses, particularly if more than one was required.
- Transporting venous samples to the lab was also identified as challenging with a variety of methods used such as staff transporting them directly, staff using a collection service or staff dropping them at a local GP practice for local collection.
- Results interpretation was also required, and a clear process of logging results. One DTS reported that a doctor had to sign off all results in a particular service before they were uploaded.

Facilitators of hepatitis B testing and vaccination uptake:

- It was felt that a new focus on hepatitis B was necessary to drive improvement.
- More accessible immunity checking.
- Utilising organic ways for people to spread key awareness messaging
- Improved training offer for staff
- Data which better identifies each action required by staff
- Protected BBV nurse time
- Outreach approaches such as utilising buses
- Relying more on opportunistically testing and vaccinating rather than clinics due to the DNA rate
- Utilising incentives such as the UAM survey alongside the hepatitis B offer
- Building evidence around the local needs of the population to ask for better resources

Learning:

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Hepatitis B work in DTS is valued: :

Our scoping with DTS has resulted in an understanding that hepatitis B work in these services is considered as valuable, particularly due to the impact a positive diagnosis can have on a person's life, despite the low prevalence.

It is also believed by DTS staff that should someone have a positive hepatitis B result there may be more complexities in managing treatment and meeting monitoring requirements due to a sometimes low prioritisation of physical health needs. Additionally, as a vaccination is available to prevent the infection it was felt that this should be utilised.

There are some 'easy wins' in DTS:

Staff education, training and awareness was felt to be a tangible target which could lead to improvements. Equally, the simplification of 'patient information' may lead to greater knowledge of the importance of vaccination courses and awareness of the risks, as well as people being more likely to accept the written information.

There are barriers to hepatitis B testing and vaccination, but many of them can be solved:

Hepatitis B might not have been set as a priority by organisations, however, there is the willingness to drive forward this work. Some felt that there may be less need around testing than vaccinations due to the testing completed alongside hepatitis C.

Lack of immunity testing methods were raised as a barrier in reducing the burden on testing, meaning if effective immunity checking was in place and a person was deemed to have sero-protection further testing would not be necessary. If HBSAb testing can be improved upon this may have the effect of filtering out a portion of work, however, cost, pathways and issues with venous sampling may need to be overcome to enable this.

Data recording, sharing and data quality would help to focus work:

There were lots of considerations around data. Improving the data collection system alongside NDTMS may be necessary to bring the hepatitis B dataset in line more with the hepatitis C dataset. Each NHS Trust's ability to use the data to focus testing and vaccination could be improved with the use of a dashboard, similar to the one created by Hep C U Later for hepatitis C.

A dashboard using NDTMS data may be able to resolve the issues around missing information, particularly where data is recorded on previous episodes. A dashboard would benefit the system and services by allowing the capacity they do have to focus on clinical work. Additionally, some work may need to be done to improve individual electronic recording systems.

Data sharing and the accessibility of results were an issue, with the two particular points raised about prison data sharing and access to the ICE system. Additionally, further exploration of what KPIs DTS have (and the appropriateness of them) is required which may mean commissioners need to be engaged.

Learning:

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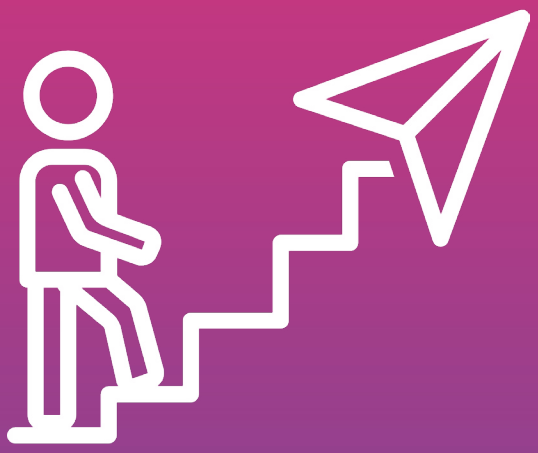
A programme of hepatitis work in DTS would be valuable:

There appears to be a willingness to engage with a new focus on hepatitis B to drive improvement for people where there may be a significant impact should they develop a chronic infection.



Across the NHS APA Hep C U Later could provide a valuable service by reducing the capacity needed for improving data quality, allowing more focus on clinical work.

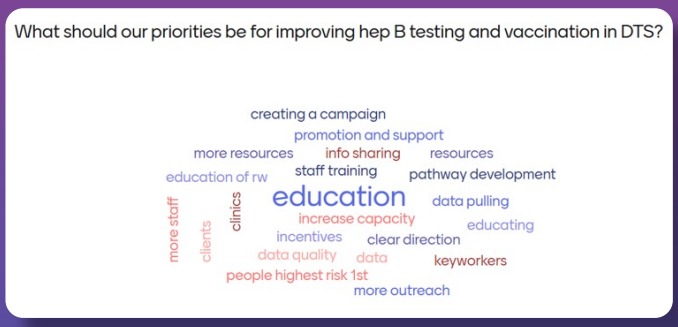
Additionally Hep C U Later can deliver education, training and awareness raising for staff and people accessing DTS.

Hep C U Later can further drive improvement through sharing best practice and engaging services in forums to troubleshoot issues, as well as by being a mechanism to link organisations and share resources.

Focusing on driving HBSAb (immunity) testing, completing vaccination courses and improving pathways would likely have a significant impact.

Next steps:

1. **Hep C U Later will outline a detailed action plan.**
2. **Hep C U Later will engage with key stakeholders to raise the barriers.**



Our key learning:

1. **Building education and confidence is key.**
2. **Data quality, recording and sharing will be important for focussing work.**
3. **Exploring simpler pathways or more accessible emthods of HBSAb (immunity) testing will have a comsiderable impact on understanding the need within DTS.**

How do I find out more information?

- **Hep C U Later** – for queries and further resources & information (you can also email **connect.HepCULater@mpft.nhs.uk**)
- We now have a specific hepatitis B and D section on our website, click **here** to find out more.

Follow us on: