

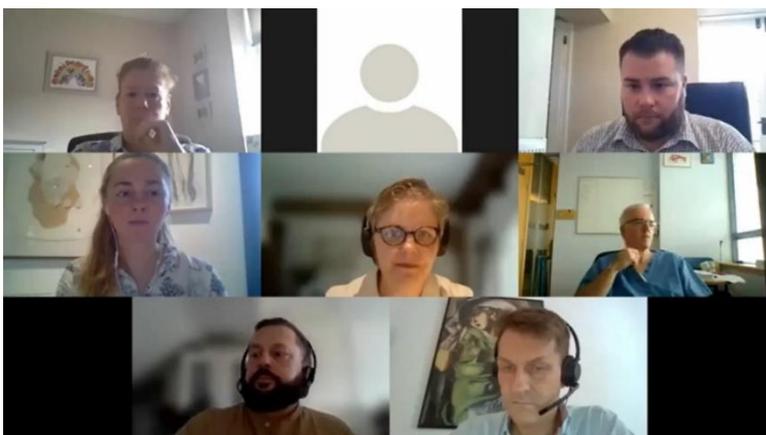


**HCV ACTION WEBINAR: MEASURING
PROGRESS TOWARDS HEPATITIS C
ELIMINATION, 7TH JULY 2021**

SUMMARY REPORT

Introduction

Each nation in the UK has set rapidly approaching targets for eliminating hepatitis C and many areas and services in the community and prisons have done the same. Being able to measure what such "micro-elimination" looks like will be critical to both celebrating and maintaining this achievement.



This HCV Action webinar, held on Zoom on 7th July 2021, heard presentations from Public Health England, NHS England, NHS Tayside and the Practice Plus Group. Following the presentations, there was an opportunity for attendees to participate in a Q&A session to ask questions and share best practice.

The webinar featured presentations from the following speakers:

- Mark Gillyon-Powell – Head of Programme for HCV Elimination, NHS England & NHS Improvement
- Prof. John Dillon – Consultant Hepatologist and Gastroenterologist, NHS Tayside
- Arran Ludlow-Rhodes – Regional BBV Delivery Nurse Manager, Practice Plus Group
- Paul Vanta – Senior Scientist, Public Health England
- Erna Buitendam – Head of Quality Improvement and Quality Assurance for Blood Safety, Hepatitis, Sexually Transmitted Infections and HIV Service, Public Health England

This was followed by a short question and answer session, and the video for the webinar can be found [here](#).

Presentations

NHS England and NHS Improvement: Measuring elimination - Mark Gillyon-Powell

Mark noted that, until now, indicators or targets that relate to notional reduction have been based on NHS England / World Health Organization (WHO) figures. A number of the indicators / targets made a distinction between people from countries with well-established hominisation needle exchange-based systems and people from countries without those systems. It was quite easy for those countries without needle exchanges and a high rate of infection to show a 30% drop in infections, but far more difficult for countries with detailed and accessible systems.

Mark explained that the only way to achieve elimination by 2025 would be through close collaboration, and it would not be something any one part of the system could do alone. NHS England have provided 60,000 treatments since June.

Mark identified three main ways that would be used to evidence elimination.

- Local elimination. This would mean capturing local micro-elimination in prisons, drug services, homeless shelters and among certain population groups.
- Programme narrative. This entails learning and good practice, detailing what was done, how, and what was achieved.
- WHO measures. This means clear and unambiguous evidence of how the measures have been met and maintained for the required two years.

In England, there have already been some notable achievements:

- Over 60,000 treatments provided since June, with ~98% cure
- A run rate for this financial year of 12,500, which the last weekly report indicated they were in excess of 80%
- Reduced hepatitis C mortality by 20% in 2018
- Hepatitis C liver transplant halved from 18% to 9% in the last 10 years

Mark ended on the note that, while there has been progress, it is necessary to review where we are up to, look at the targets and see how we can evidence our collective achievements across elimination.

TABLE 1 Summary of impact and programmatic targets for country validation of elimination for HBV EMTCT, HCV incidence and HBV/HCV mortality

Elimination targets	Elimination of chronic HBV infection as a public health problem		Elimination of chronic HCV infection as a public health problem	
	Incidence	Mortality	Incidence	Mortality
2030 GHSS relative reduction reference targets (compared to 2015)	95% reduction	65% reduction	80% reduction	65% reduction
HBV- and HCV-specific absolute prevalence, incidence and mortality targets	HBV EMTCT ≤0.1% HBsAg prevalence in ≤5 year olds ^{a,b} Additional target: ≤2% MTCT rate (where use of targeted HepB-BD) ^c	Annual mortality^e (HBV) ≤4/100 000	Annual incidence (HCV) ≤5/100 000 ≤2/100 (PWID)	Annual mortality^e (HCV) ≤2/100 000
Programmatic targets ^d	Countries with universal HBV vaccine birth dose (BD) ≥90% HepB3 vaccine coverage ≥90% HepB timely hepatitis B BD (HepB-BD) coverage ^g Countries with targeted HBV vaccine birth dose (BD) ≥90% HepB3 vaccine coverage ≥90% coverage of those infants at risk with targeted HepB-BD ≥90% coverage of maternal antenatal HBsAg testing ≥90% coverage with antivirals for those eligible ^f	Testing and treatment ≥90% of people with HBV diagnosed ≥80% of people diagnosed with HBV and eligible for treatment are treated ^h Prevention ≥90% HepB3 vaccine coverage ≥90% HepB-BD coverage	Testing and treatment ≥90% of people with HCV diagnosed ≥80% of people diagnosed with HCV are treated ^h Prevention 0% unsafe injections 100% blood safety 300 needles/syringes/PWID/year	

Hepatitis C in Scotland: recently arrived but soon to depart? - Prof. John Dillon

John noted that when thinking about eliminating hepatitis C it is important to consider the people we are trying to reach. The majority of people who have acquired hepatitis C have done so through some form of drug use in the past. Many of those patients are stigmatised and have had adverse experiences with healthcare.

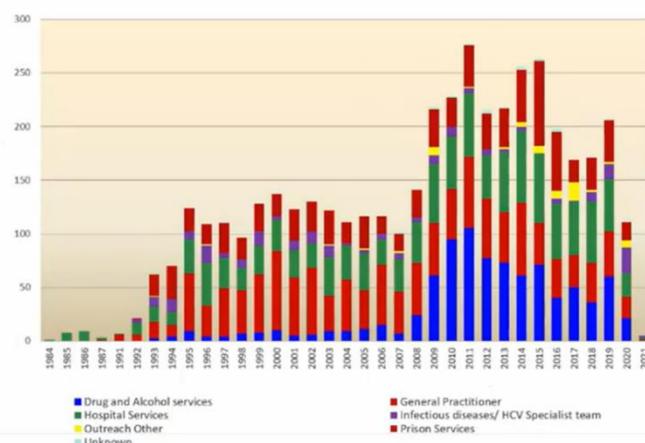
NHS Tayside were able to administer discrete choice experiments around hepatitis C testing and asked people how long they were willing to wait for different services. The results were the following:

Preference	Willing to Wait
Own rather than other pharmacy	4.25 weeks
Own pharmacy rather than GP	2.11 weeks
Own pharmacy rather than drug worker	0.08 weeks
Treated with respect	7.42 weeks

John explained that venepuncture is a specialist skill which involves moving the patient to someone who can do the testing, and many people are lost in this journey. An alternative form of hepatitis C testing is dry blood spot (DBS) testing, which anyone can be trained to administer. This means that patients can be tested where they are, whether that be drug treatment centres, homeless outreach, needle exchanges, etc. Between 2008 and 2009, Tayside trained people to carry out DBS testing, leading to a surge in the number of diagnoses without causing a fall in venepuncture testing. This means that they were reaching a new cohort of people who would not have been accessed before and moving them into engagement with care. GPs and secondary care have each found a third of the overall patients, while the other specialist pathways have found the remaining third. Each pathway is able to find different factions of the populations at different timepoints of the epidemic, and each pathway is necessary for the collective effort.

In Tayside, alongside the standard pathways from primary / secondary care to hepatitis C treatment there are four specialist pathways where all staff have been trained to do DBS testing and anyone testing positive is treated by an onsite nurse:

Testing for Hepatitis C by various health care services in Tayside



1. Pharmacies, where people on opioid substitution therapy (OST) were DBS tested
2. Drug treatment centres
3. Prisons
4. Injecting Equipment Provision Service (IEPS)

These pathways work together to minimise journeys and times to contact, ensuring that people are not lost in the process.

Between 1998 and 2021, of the 43% of positive cases in the population, 87% had had SVR tests. Only 1% had been lost to the

data. With these statistics, there is an estimated hepatitis C chronic prevalence of 1,975, of whom 1,970 have been found and 1,813 have been treated.

John ended by cautioning that elimination is a transitory achievement; it is also imperative to commit to keeping elimination going. Once elimination has been achieved, repeated testing is necessary. If enough treatment episodes are scattered through networks of hepatitis C patients, it can be possible to track them down transmission lines and reduce the numbers of patients who become infected.

Micro-elimination in prisons - Arran Ludlow-Rhodes

Arran said that over the past two years, the Practice Plus Group had worked hard with their sites to provide specific blood-borne virus (BBV) training, implement point of care (POC) testing and embed reception and referral processes. This led to them being in a position where they could micro-eliminate in prisons. Several sites had already micro-eliminated, and Arran hoped to have ten such sites by World Hepatitis Day. This was achieved and measured in the following ways:

- **Weekly manual data triangulation** where sites submit their weekly BBV data, which is then analysed and cross-checked against patient data so that sites and individuals who may need additional support and resources are flagged. This approach embeds an “opt-out” BBV testing process.
- **Targeting testing events and high intensity test and treat initiatives (HITTs).** These can take many forms, including adding extra clinics during the week, adding alerts to notes so that patients can be identified and offered BBV tests, coinciding testing events with wellbeing days, targeted testing days, and assertive outreach.



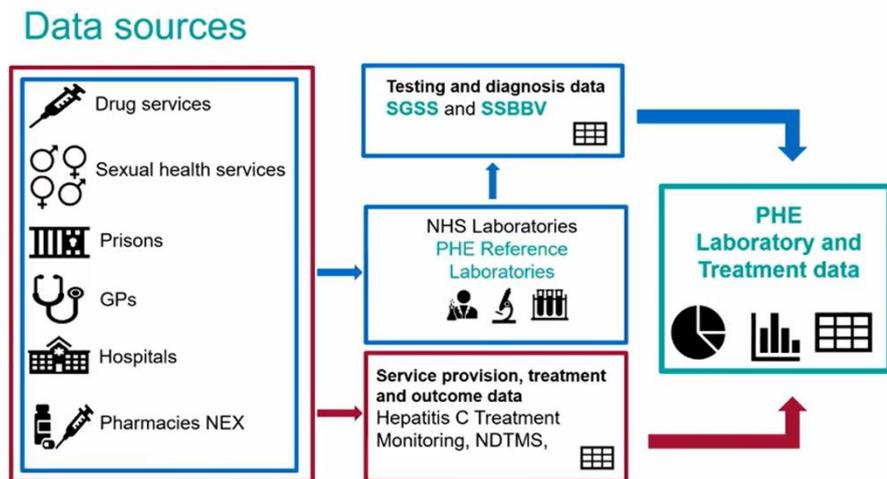
One of the biggest challenges is the maintaining of micro-elimination. There are multiple reasons for this:

- **Time.** The time taken from the multiple steps of reception, PCR tests, bloods coming from the lab, referral, consultation, medication delivery.
- **Receptions.** A lot of busy prisons have constant throughput of receptions, meaning that by the time they had treated patient A, patient B and C already need to be addressed.
- **Patients declining treatment.** Although education is always a big focus, there will be some who do not want treatment, making it difficult to get treatment figures above 90%.

- **Staffing.** Covid-19 has had a massive impact and has left sites depleted of staff, with others redeployed.

ODN hepatitis C testing and treatment dashboard - Paul Vanta

The idea of real-time local data in the form of a one-stop dashboard tool was conceived in 2018. The aim was for this tool to inform local efforts to improve prevention, case-finding, and treatment for hepatitis C infection, as well as monitor progress and support action towards elimination and micro-elimination.



The starting point for the dashboard was testing activities from various settings and sites. All of this information is processed by NHS labs and PHE reference labs, and then flows to PHE surveillance systems. These same testing activities also collect additional data on service provision, treatment, and outcomes. These two sources give a comprehensive data base for building the dashboard.

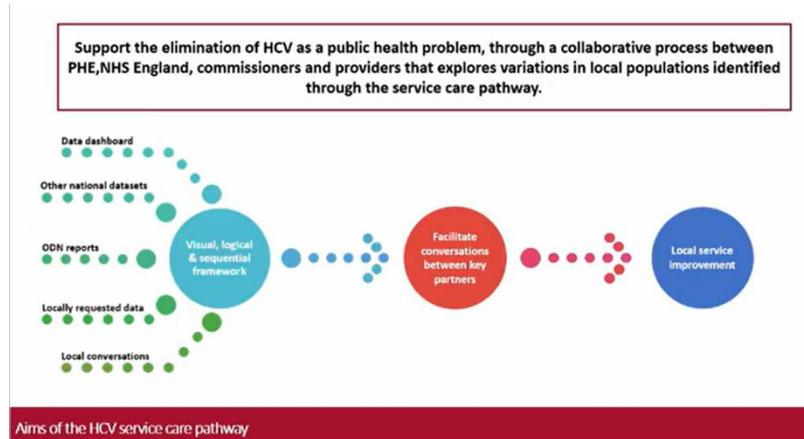
The first dashboard was created in 2019 in the form of an Excel sheet. Paul said that in 2021, PHE hoped to transition to a new, more dynamic, Power BI platform which would hopefully be more user friendly.

Hepatitis C Service Care Pathway - Erna Buitendam

Erna outlined that Service Care Pathways were another way in which PHE was trying to work with ODNs to support the elimination agenda. PHE aimed to use national datasets and locally requested data to work with ODNs, and would be creating a visual, sequential framework to present at ODN level. She said that they hoped this would facilitate a conversation between all stakeholders in the ODN area in virtual, workshop settings and lead to action planning and local service improvement.

Patients come into different hepatitis C pathways from a variety of settings, all of which provide data collection points. The ODN dashboard uses four data sources to give a comprehensive and in-depth dataset for each ODN:

1. Prevention
2. Initial screen
3. Tests and diagnose
4. Treat and cure



This has now been developed further to add local data and data from the Unlinked Anonymous Monitoring survey for people who inject drugs (UAM) to create a service care pathway at ODN population level.

Erna said that the feedback from stakeholders and participants for the Service Care Pathways had been very positive. Using the feedback given, a new version of the Service Care Pathway is underway which has eight steps within the initial four components, with a particular focus on prevention. The pathway is still in draft form and will be further streamlined, but hopefully this tool can be used alongside the ODN dashboard to aid the elimination agenda.

Questions from the audience

Following contributions from each of the speakers, questions from attendees were answered by the panel. A summary of the Q&A follows:

Will the PHE dashboard provide local prevalence estimates so ODNs can identify how close they are to elimination?

Erna responded that PHE would try to do this but were not entirely sure whether this would be possible. Mark said NHS England had previously looked at prevalence by ODNs, but it seemed to be stretching the model too far, so they might need to do something different to get local prevalence data.

Can speakers provide their perspective on how much of a barrier reinfections are to elimination – in the cases of people who have received treatment but then become infected again. How can this best be captured, and what can be done to reduce these cases?

Arran reflected that it had been a very challenging year, with the provision of needle exchanges not as prevalent as it had been previously. He said they might be able to give a more accurate representation of data as courts and services began opening back up.

Paul responded that they were currently looking into algorithms for how to identify reinfections and were planning to add this to the dashboard.