HCVAction

HCV ACTION WEBINAR: HEPATITIS C SERVICES IN SCOTLAND DURING AND BEYOND THE COVID-19 OUTBREAK AUGUST 2020

SUMMARY REPORT

Introduction

With the Covid-19 outbreak having caused significant disruption to healthcare services, including those for hepatitis C, this webinar was organised to discuss how services have been affected in Scotland and explore how hepatitis C services can most effectively be re-established to continue the drive to elimination by 2024.
The webinar featured contributions from the following speakers:

- Professor John Dillon, Clinical Lead for Blood Borne Viruses, NHS Tayside
- Leon Wylie, Lead Officer, Hepatitis Scotland
- Rachel Halford, Chief Executive, The Hepatitis C Trust
- Petra Wright, Senior Scottish Officer, The Hepatitis C Trust

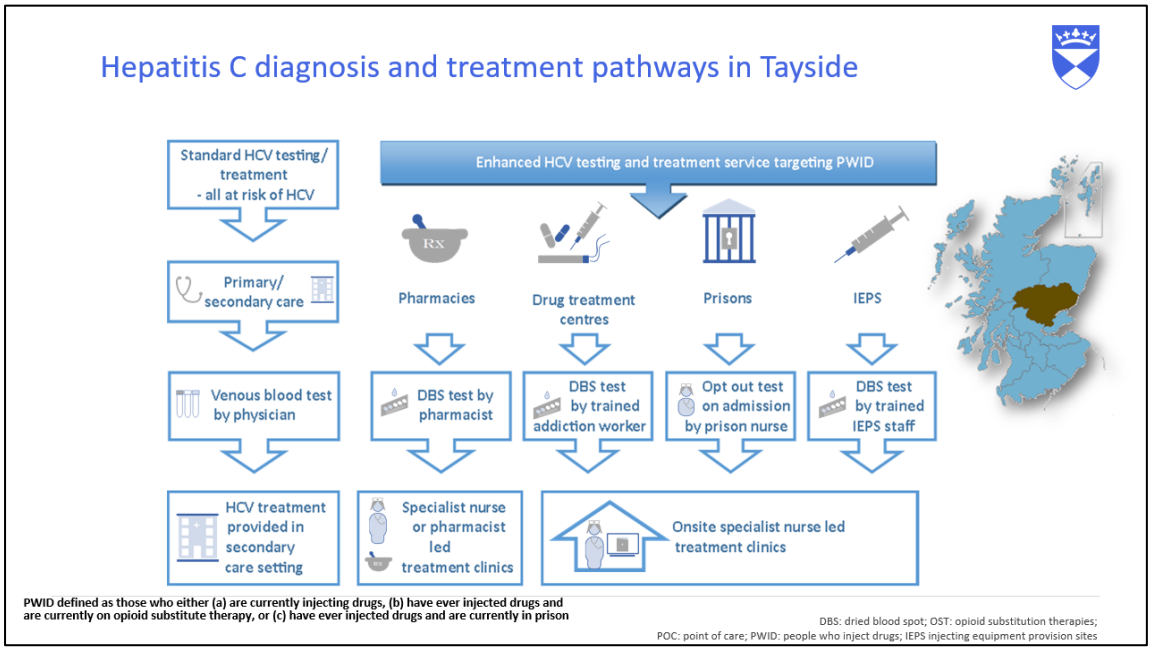
Following initial contributions from each of the speakers, the panel then answered questions from members of the audience.

The webinar can be viewed in full here.

Contributions from speakers

Prof John Dillon – Clinical Lead for Blood Borne Viruses, NHS Tayside

Professor John Dillon started by noting that services were not aiming to return to the norm which existed before the Covid-19 pandemic, as not enough people were being treated for hepatitis C then. The aim is to improve services to treat more people than were being reached before the



pandemic.

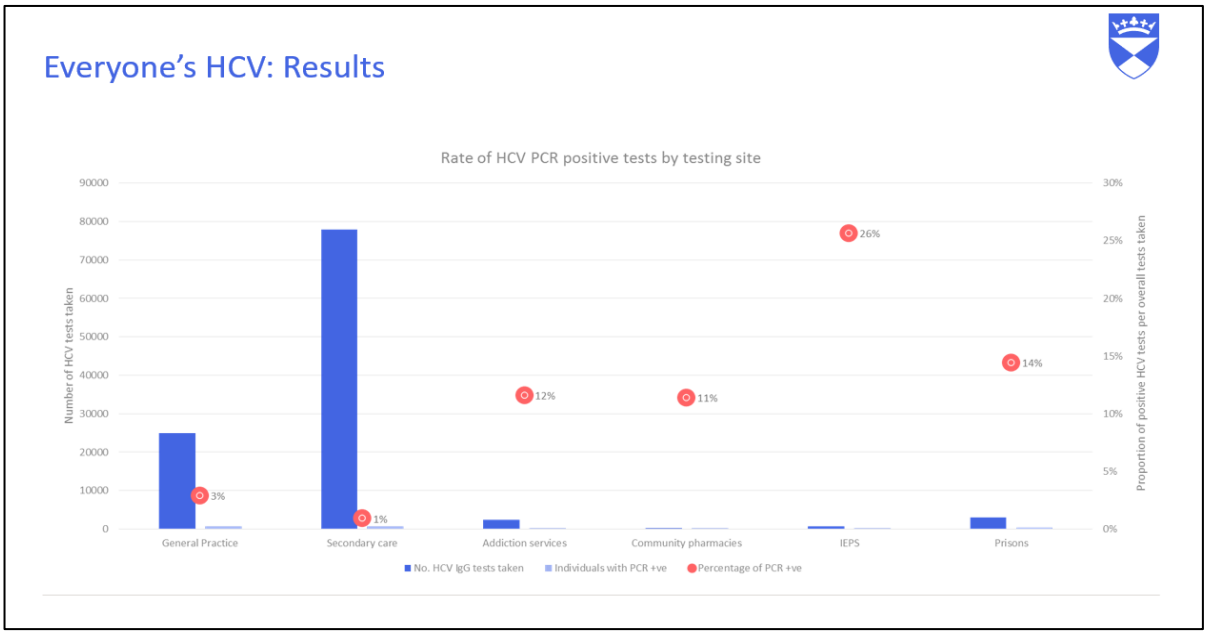
Prof Dillon then outlined the pathways available in NHS Tayside for hepatitis C testing and treatment, which have helped them to achieve elimination in the area.

First, the standard route of going through primary or secondary care might incorporate innovations like telemedicine to improve access, but that even with these innovations, testing and treatment through these routes were not sufficient to achieve elimination on their own.

In Tayside, pharmacists had been trained to deliver dried blood spot testing for BBVs. The pharmacist or an outreach nurse could then prescribe and deliver treatment to people within that pharmacy. One set of conventional venepuncture or ultrasound delivered by a nurse with a portable scanner was required to get a fibrosis measure. Prof Dillon said that these tests did not change the treatment, they only changed the follow-up, meaning they should not be a blockage on treatment.

In drug services, all the key workers were trained to deliver dried blood spot testing. Nurses were embedded on-site to deliver therapy if clients tested positive. Similar pathways existed in prisons and needle exchanges.

Simple technology was key for all this, namely dried blood spot testing. This meant testing could be done without venepuncture and could be delivered by many people, not just clinicians.



Prof Dillon noted that although the percentage positivity rate for general practice and secondary care was low, the number of positives picked up was still relatively large, due to the number of tests carried out. However, despite many years of testing in these services, they were clearly not reaching everyone. This showed the need for a variety of pathways.

Summary over time of Testing data

	Anti-HCV tests taken	Individuals with PCR +ve	Percentage of PCR +ve
General Practice	24969	718	3%
Secondary care	77885	701	1%
Drug treatment services	2415	280	12%
Community pharmacies	193	22	11%
IEPS	753	193	26%
Prisons	2970	428	14%
Mosque	177	6	3%

Prof Dillon noted that treatment advances meant much less monitoring was now required, compared with when treatment was interferon-based, allowing the pathways to be made much simpler. He repeated that getting an estimate of liver damage was important but that it should not be an obstacle to hepatitis C treatment.

The concept of treatment as prevention was outlined, which meant treating people whose behaviour made them more likely to pass on the virus, to prevent future transmission. Treatment as prevention is a separate concept to elimination but if treatment as prevention works, as is being studied in Tayside, then it would make maintaining elimination easier.

Prof Dylan then outlined the figures for people tested and treated for hepatitis C in Tayside. Overall, 1,813 people have been treated in Tayside, over 90% of the estimated prevalence of hepatitis C, meaning Tayside has successfully eliminated the virus as a public health concern.

Prof Dillon concluded by noting that to reach the elimination target in each area, health boards would need to revise and extend diagnostic pathways, acknowledging the need to continue testing for hepatitis C if we are going to be living with Covid-19 for a long time.

Leon Wylie – Lead Officer, Hepatitis Scotland

Leon Wylie outlined how Covid-19 had affected drug services. The Scottish Drug Forum had heard examples of issues people faced in accessing OST (opioid substitution therapy) and NSP (needle and syringe provision), as well as incidents which had stigmatised those people. In May 2020, the organisation published Guidance on Contingency Planning for People who Use Drugs and COVID-19. There was a move to longer takeaway prescriptions for OST as well as changes to needle and syringe distribution and an increase in naloxone distribution.

SDF Scotland has also held webinars on issues relevant to hepatitis C, including on BBVs, wound care and harm reduction's role in elimination.

New forms of needle and syringe distribution included peer-based distribution and postal distribution. Midlothian has been able to continue hepatitis C treatment throughout lockdown by 'piggybacking' on other service appointments. Clients have also responded positively to engagement via phone or video appointments, but this depended on clients having access to devices to use these services.

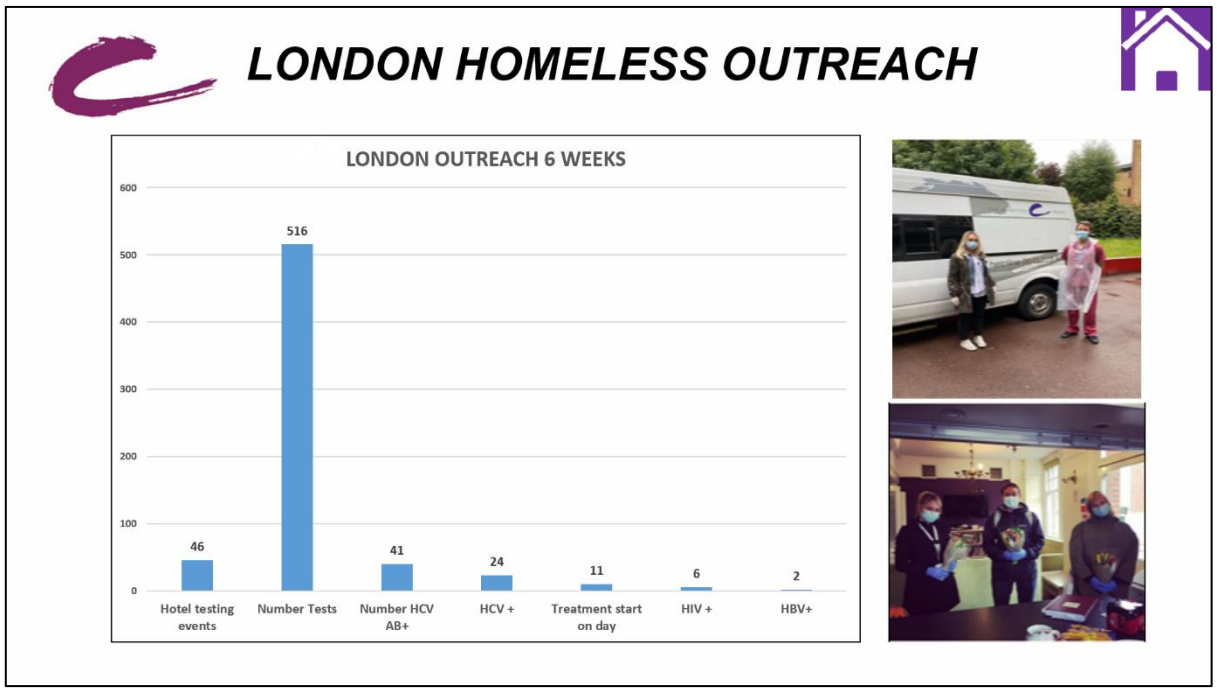
The uncertainties around how Covid-19 will have affected hepatitis C prevalence and the infection rate was noted. For example, isolation could have decreased sharing drug-taking equipment, but it will likely have increased re-use of equipment. There are also signs of drug-related deaths increasing. The need for increased focus on prevention, as well as monitoring to ensure any upticks or outbreaks in BBVs are dealt with, was emphasised. Reaching elimination and maintaining it would "sink or swim" based on prevention work.

Rachel Halford – CEO, The Hepatitis C Trust

The Hepatitis C Trust had to put in place its own guidelines and operating procedures to protect its staff before it could engage in outreach work.

The charity had over 2,000 people UK-wide that it was supporting through its peer programme as the county went into lockdown. At the start of lockdown, the organisation was focused on telephone contact to ensure people were okay, delivering medication so people did not need to visit pharmacies or hospitals to collect it and giving further support where needed, such as delivering food parcels.

The Trust's peer volunteers were trained and supported via Zoom and telephone. The organisation also designed its own information resources for people who inject drugs about Covid-19. One covered general advice relevant to all members of the public and another focused specifically on harm reduction for people who use drugs.



An overview was provided of the partnership working that the Trust had been involved with to support people who would otherwise be homeless who were accommodated in hotels in England.

The model of HITTs (High Intensity Test and Treat) which had previously been carried out in prisons to test all residents in a single setting were applied to these hotels and other accommodation.

In London over 40 hotels had testing events, in which 500 people were tested. Forty-one were found to be HCV antibody positive. It was noted that while these numbers were relatively small, this was a group of people who had really struggled to engage with services previously. Similar events had also happened in Edinburgh and Glasgow.

Concerns for the future were identified, including the prospect of a spike in Covid-19, getting hepatitis C testing back on track, and ensuring optimal and equitable needle exchange provision for all.

Petra Wright – Senior Scottish Officer, The Hepatitis C Trust

Petra Wright emphasised importance of paying attention to Scotland's towns and rural areas. In Glasgow and Edinburgh some form of services had been maintained but the smaller health boards had not been able to run services at all during the height of the outbreak.

She noted that Forth Valley has started to bring services back and was prioritising the six-monthly screening for those people who'd been treated.

The importance of testing labs was also highlighted. She noted that whilst antibody testing could be done, there have been issues with dried blood spot testing due to a lack of laboratory capacity meaning they were unable to test samples. Near-patient testing had been vital to allow the bigger boards to keep services running, allowing them to rapidly test and start people in treatment on the same day.

It was noted that not all the people who needed to be treated were in contact with drug services or treatment. Future work will need to consider how these people will be reached. The Hepatitis C Trust team in Scotland had tested people in their own homes who could not be persuaded to go to services, for example. These people are often in work and use drugs recreationally, and therefore do not necessarily fit the typical idea of an injecting drug user.

Questions from the audience – answered during the webinar

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

Question: I noticed that NHS Tayside carried out testing in mosques, how was this arranged and done?

> Prof John Dillion noted that there was a higher prevalence of hepatitis C in Pakistan. Due to the large Pakistani community in the area and the high degree of concern in the community, the health board approached the Muslim Council of Dundee to arrange engagement. The team then visited the four mosques between sermons and prayers on a Friday. Prof Dillion's presentations about hepatitis C were translated into Urdu as he spoke. The team were invited back to the four mosques to carry out testing and doctors and nurses volunteered their time on a Friday afternoon to support this. There was also an upsurge in the number of people of South Asian ethnicity visiting clinics and asking for hepatitis C testing in the following weeks.

Petra Wright said there had been successful events at Melas in Glasgow, where people were tested using oral swabs for antibodies. A South Asian charity group had asked The Hepatitis C Trust to deliver training to their team who intended to travel to Pakistan to support elimination there.

Wright noted that there was significant amount of travel between Pakistan and the UK by the community here, not just to visit family but also for surgical enhancements and dental surgery which could be cheaper in Pakistan. Raising awareness is therefore important and could help people keep themselves safe.

Question: What is the best way we can get through some of the new challenges that Covid-19 has imposed with testing?

Prof John Dillon pointed out the need to look at testing in terms of how it links to treatment. Where people are coming to services every week, for example, there is not a need for a point of care test. In a one-stop environment where it is unlikely someone will see a patient again, services need to know how they link the patient into treatment if they do get a positive result. Additionally, point of care testing still involves people waiting for their results, potentially for over an hour, meaning services need to plan an appropriate environment so that people can wait for their results. Some point of care testing options need a high degree of training and quality control. Therefore, whilst they might be very useful in some settings like prisons, there needs to be a 'mixed economy' in testing technology.

Leon Wylie noted that when point of care testing machines were being used in Glasgow the key advantage of them was that they allowed services to know someone's status, rather than the patient knowing, as this enabled the service to put actions into train on the same day.

Rachel Halford said that peers could be useful in improving testing. By having peers engage with someone, you increase their chances of coming back. She also noted the importance of incentives for testing, such as vouchers. Although some are sceptical about their use, they are successful when used. Peers and possibly incentives are a key part of any conversation about testing.