HCVAction

# HCV ACTION WEBINAR: HEPATITIS C CASE FINDING IN PRIMARY CARE - 5 OCTOBER 2020

SUMMARY REPORT

## Introduction

This webinar focused on how ODNs can support primary care services, specifically GP clinics, in terms of hepatitis C case-finding. Speakers looked at the HepCATT study which evaluated an intervention to support case-finding as well as the current rollout of the Patient Search Identification Tool.

The webinar featured contributions from the following speakers:

- Dr Kirsty Roberts, Health Protection Research Unit, University of Bristol: HepCATT study - overview and lessons learnt
- Helen Treacher, Patient Search Identification Manager, MSD: Primary care search identification tool - overview, how to use and future plans
- Dušan Jovović, ECHO and Engagement Manager, King's College Hospital; Sonia Nosheen, Hepatitis C ODN Project Manager, King's College Hospital; Beth Kirk, Hepatology Testing and Education Coordinator, King's College Hospital: Experiences so far with PSI tool and ECHO project

## Presentations from speakers

Dr Kirsty Roberts, Health Protection Research Unit, University of Bristol

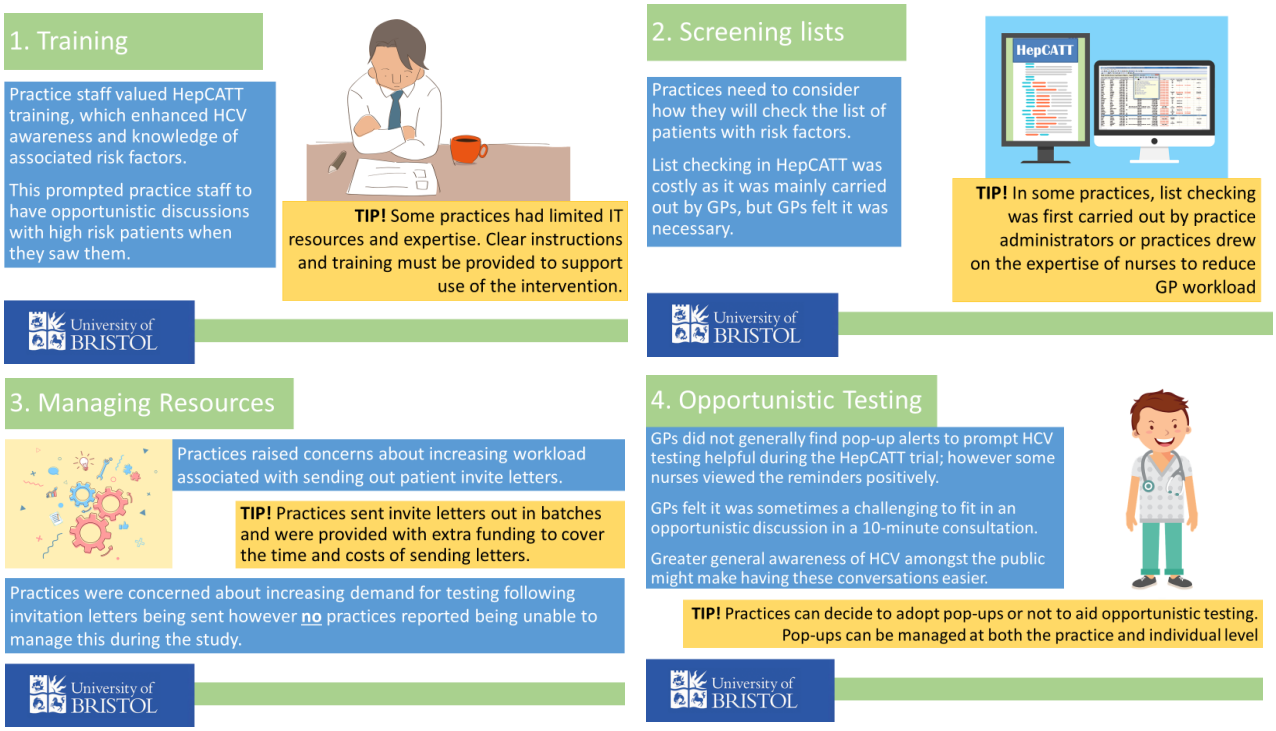
Kirsty outlined the HepCATT study. HepCATT utilised an algorithm integrated into the electronic patient record system to identify high-risk patients for hepatitis C testing. The interventions also included mail merges to support with the sending out of patient invitations and opportunistic testing. There was education and training for practice staff on the tool and hepatitis C. Practices were also encouraged to display posters for their patients about hepatitis C.

The intervention caused a modest increase in testing: 16% of patients flagged as at risk in intervention practices were tested compared to 10% in control practices. This was a 59% increase after adjusting for the differing characteristics of practices.

The intervention was ‘highly cost effective’, costing £4.03 per patient flagged by the algorithm and £3,165 per patient referred to specialised hepatitis C services. It had an incremental cost effectiveness ratio of £6,212 per quality adjusted life year (QALY). This is well below the NICE threshold of £20,000 per QALY gained.

Practice staff were found to value HepCATT and liked the fact that it enabled them to identify patients for testing and gave them the opportunity to discuss testing with patients. The recommendation from this HepCATT trial was to rollout the intervention across the NHS.

Kirsty then outlined the lessons learnt during HEPCATT which would support any future attempts at similar interventions:




The study also had a 'practice roles and responsibilities' agreement in place. This outlined the roles and responsibilities of each GP practice involved. Whilst this was part of the study and in line with the research governance guidelines, it did help clarify what each practice was being asked to do so could be helpful for others doing similar interventions.

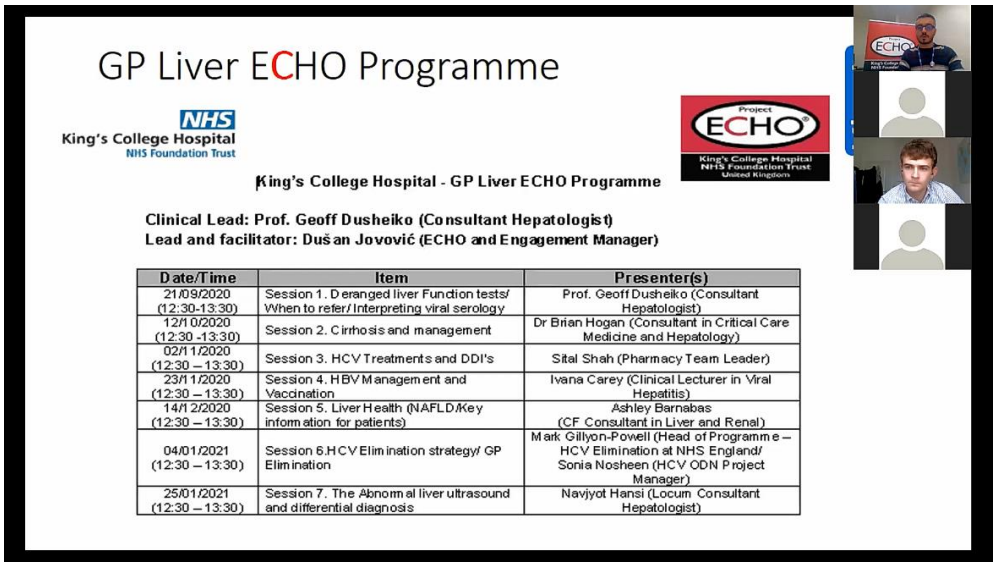
The team plan to do an evaluation of the rollout of primary care HCV case-finding. The rollout (discussed in the next presentation by Helen Treacher) is similar to HepCATT with some modifications. The team plan to evaluate the rollout in two phases: the first would involve contacting all ODNs to find out about the engagement strategies being used. A second phase would involve more detailed data collection in two to three ODNs and up to 100 GP practices. Whilst HepCATT was cost effective, the team will also be assessing the cost-effectiveness of the rollout.

Dušan Jovović, ECHO engagement manager, King's College Hospital

Dušan noted that the ECHO project was originally started to support treatment for hepatitis C outside of specialist centres. It involves specialist centres giving assistance digitally to clinicians in other settings. There are now hundreds of ECHO projects globally. ECHO is not traditional telemedicine where the specialist assumes responsibility for managing the patient; instead, it is a guided practice model where the participating clinician retains responsibility for managing the patient.

Dušan described the UK project, which involves interactive sessions through Zoom of between 30- and 60-minutes containing lessons as well as case studies. These are recorded and available to everyone registered.

Registrations for clinical staff in primary care are still open and any questions can be directed to: kch-ty.echoproject@nhs.net



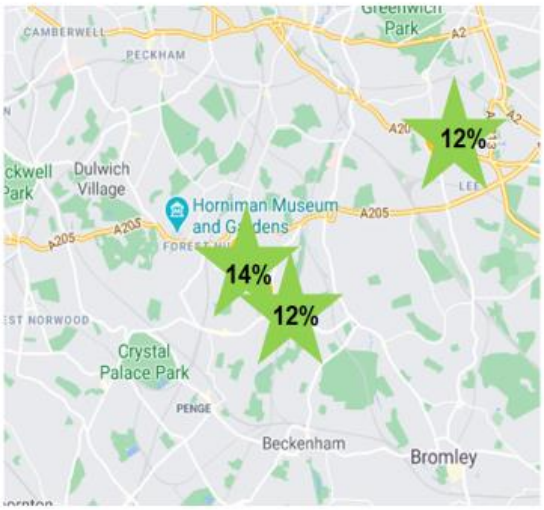

Sonia Nosheen, Hepatitis C ODN Project Manager, King's College Hospital

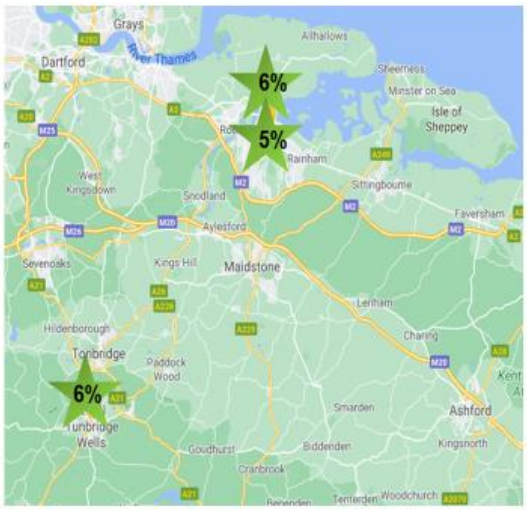
Sonia spoke about the work King's College Hospital has done to deliver case-finding support in primary care. So far, the team has been asking clinics to run the tool to gather information about the numbers they would be working with. Engagement has been quite sporadic so far, in part due to COVID-19. Across South East London, the team has been able to engage with primary care network leads, federation leads and individual practices.

The issue of the tool flagging large number of patients with HIV codes had been a particular issue in South East London, where many clinics screen for HIV at registration. The team are also considering postal testing and how to run this.

Beth Kirk, Hepatology Testing and Education Coordinator, King's College Hospital

Around 17 practices have so far returned numbers of patients who have been flagged by the tool. Beth noted the differing numbers returned by three surgeries in South East London, which were flagging around 13% of their patient cohort as 'at risk', compared to three in Kent where surgeries were returning an average of 6%.




Beth talked through the numbers returned from one clinic in depth and noted the small number of patients flagged as having hepatitis C positive results. When the team reviewed these records fully, most had no record of hepatitis C treatment.

**Question and answer session**

**Does the tool tend to pick up more of a particular cohort of patients?**

Kirsty replied that a high number of patients were flagged for opioid use and for being previously tested for hepatitis C, although this was from the HepCATT study period (2015-16).

**Would the clinic have the opportunity to review the patients flagged before invitations to get tested were sent out?**

Beth responded that the current plan was to send letters out to every patient registered in line with the aim of finding those patients who might not normally be thought of as at-risk or the typical patient.

**Are there any plans to offer financial incentives to GP clinics to support case-finding?**

Sonia said that King's were looking at financial incentives but there were already reimbursements planned to cover the costs of letters sent out or other communications used. She also said that there were more diffuse cost-savings for practices in other areas. These less tangible benefits mean it is in practices' interests to support the process before other incentives are factored in. When these kinds of diffuse savings are made clear, as well as the education and specialist support which is being offered, practices might be more positive and engaged.

Sonia emphasised that running the patient search tool does not involve a significant amount of work. However, there may be more barriers around testing, particularly if COVID-19 restricts face-to-face testing.

Kirsty added that HepCATT incentivised the intervention by providing funding to practices to set up the algorithm, run the algorithm, attend training and collect data for analysis. However, this is common practice within research at primary care.

Helen said that it is important to recognise that GPs might not have resources for all the things involved in the intervention, so offering resources such as time for nurses to review the at-risk list could be a really important incentive.

**Had any reinfected patients been found through this method?**

Dušan noted that the hepatitis C outreach testing van which King's run had picked up people who had been reinfected. However, this targeted a different group of people than the primary care intervention.

**What should a GP interested in supporting this work do?**

Sonia advised that if any GP or practice was interested in engaging in this type of work, they should reach out to their relevant ODN. They would be able to provide support, both with case-finding, testing and treatment and this expertise would be useful to colleagues in primary care.

Dušan added that from his experience in primary care patients were much happier to go into their GP clinics rather than hospitals for testing, particularly during the COVID-19 outbreak.

Helen Treacher said that the benefit of the tool and the intervention was that ODNs and practices could adapt it to whatever worked for them. ODNs had rethought plans developed at the start of the year due to the impact of COVID-19 but in most cases these could be adapted.

**What are the options if an ODN is having difficulty getting their CCG to support their initiative?**

Sonia suggested trying to get data sharing arrangements in place first. NHS England had clarified that this was not an artificial intelligence tool: it is there to pick up and highlight patients and nothing else. Including that in agreements might ensure that CCGs were clear on what the tool was there for.

Kirsty responded that the practice responsibilities form was useful during HepCATT and a 'blank' or template contract might be helpful for codifying with the CCG what practices were being asked to do.

Helen added that while each CCG might have their own question or form to complete for this project, the questions were common across multiple CCGs. Therefore, she was working to link together people who had been successful in order to share learnings on what worked.

**Further reading**

Lessons learnt from HepCATT for ODNs and GP practices

Evaluation of HepCATT intervention in primary care services

*HCV Action would like to thank Dr Kirsty Roberts, Helen Treacher, Sonia Nosheen, Beth Kirk and Dusan Jovovic for speaking, as well as Dr Clare Thomas for her help arranging the webinar.*