HCVAction

HCV ACTION WEBINAR: MITIGATING THE IMPACT OF COVID-19 ON HCV TESTING – 8TH OCTOBER 2020

SUMMARY REPORT

Introduction

This webinar focused on how the barriers COVID-19 presents to hepatitis C testing could be mitigated. The webinar aimed to explore issues relating to service-based testing, outreach testing and postal or self-testing.

The webinar was chaired by Stuart Smith, Director of Community Services at The Hepatitis C Trust and featured three presentations and talks:

- Overview of testing, before and after COVID-19 - Helen Hampton, Lead Clinical Nurse for Blood Borne Virus, We Are With You
- Outreach testing during the COVID-19 lockdown - Julian Surey, Find and Treat Team
- Postal testing or self-testing - Tracey Kemp, National Hepatitis C Strategy Lead, Change Grow Live

After these presentations and a question and answer session, all attendees went into breakout groups to discuss these three types of testing in more detail. The groups then came back together to summarise their discussions. You can find a recording of the session here.

Presentations from speakers

Overview of testing, before and after COVID-19 - Helen Hampton, Lead Clinical Nurse for Blood Borne Virus, We Are With You

Pre-COVID, We Are With You delivered face-to-face, virtual, and e-learning training to all their staff so they could talk to clients and provide testing to anyone who wanted it.

They offered training to everyone in contact with the service regardless of risk. Most services offer this on an opt-out basis and prior to COVID-19 they were moving towards making this approach mandatory.

Testing was done at assessment, opportunistically and at needle exchanges. Pre-COVID, Helen noted that testing was "firmly on the agenda" and there was a lot of success with people testing positive being placed on the referral pathway as soon as possible.

However, once COVID-19 hit they moved to offering more of a remote service where support was mainly via virtual platforms such as phone calls or WhatsApp. The small number of people seen in service was based on their need and level of risk. Harm reduction advice was delivered through social media, local networks, and the organisation's website. A click and collect needle exchange was also offered. In some of the services, they could carry out opportunistic testing of people who had previously been sleeping rough and were in accommodation. However, testing numbers reduced overall.

Helen said there were concerns among service staff about service users coming back into services for this testing to be performed. High-risk service users who had come into services were being tested opportunistically and the organisation is looking at introducing postal testing.

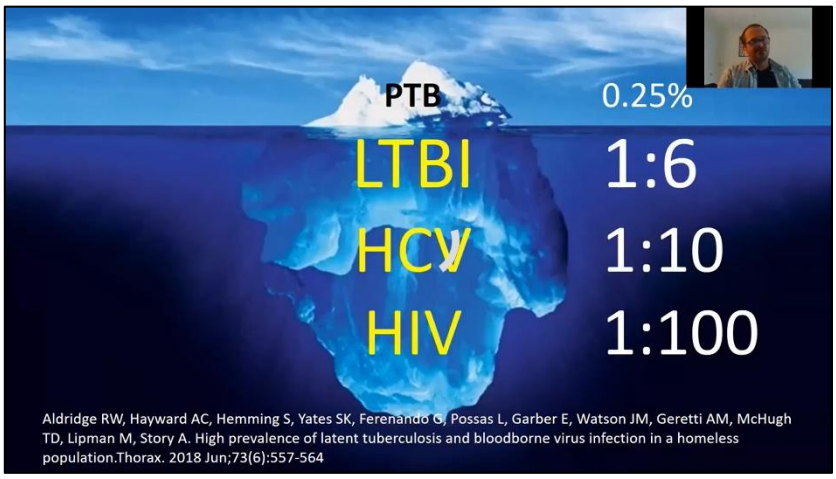
Outreach testing during the COVID-19 lockdown - Julian Surey, Find and Treat Team

Julian outlined the work of the Find and Treat Team, a pan-London mobile outreach service for the homeless population. It was originally set up to provide scanning for active TB and covers about 360 venues or congregate settings a year.

The service uses its van to access these settings and has a low threshold. Service users do not need to be registered with a GP or have proof of name and date of birth.

TB tests are non-invasive tests and results from scans are given straight away. A high proportion of the staff have experience of homelessness or have accessed the kind of service Find and Treat provides.

The van has since added other interventions to its work, including hepatitis C. Julian noted that pulmonary TB was the 'tip of the iceberg' of conditions that affected this group of people.



Julian noted that other services and interventions had been attached to the original TB work the van carried out, including hepatitis C mouth swabs, fibrsocanning and flu vaccine.

During COVID-19, a 'Triage Assess Cohort and Care' plan was set up for London using hotels to keep homeless people safe. This service had three prongs, a facility for people with suspected or confirmed COVID-19, facilities for those who were eligible for influenza vaccines or over 55 years old and so more suspectable to the virus, and facilities for everyone else in the regular hotel estate.

Julian outlined the COVID-19 surveillance network set up across this estate, including COVID-19 testing services. The strategy seemed to have had success in stemming COVID-19 infection and he noted estimates that around 3-4% of London hotel residents had been infected with COVID-19, compared to 30-40% of residents in US hotels.

After a "rough and ready" testing service was set up to test these people, a number of organisations thought about setting up other services to support these people, include hepatitis B, hepatitis C and HIV testing.

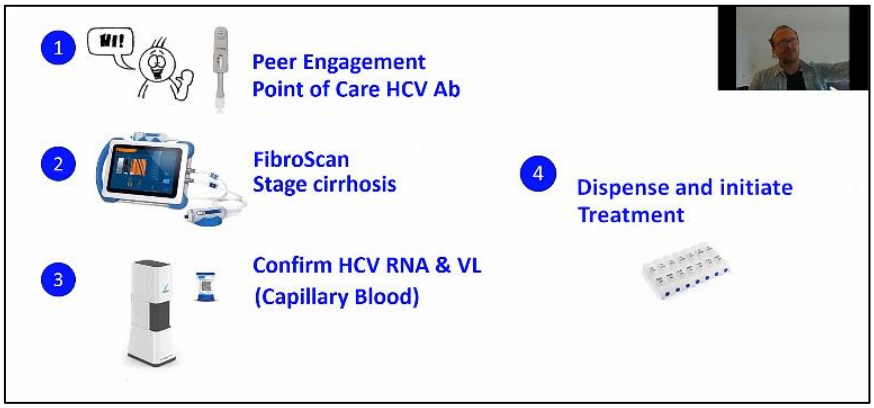
This was a collaborative effort with inclusive testing teams, including peers, health advisors and advocates. Testing was easy to carry out and anyone could be trained to carry it out. He noted the teams needed to be flexible in arranging testing in whatever locations were available.

Julian noted that they had developed a same-day referral scheme in North Central London where people with an RNA positive result, who had received a fibroscan, and had no other complicating medication, could be approved for treatment through a WhatsApp group chat with a pharmacist and consultants at the Royal Free Hospital. This meant medication could be dispensed quickly.

Overall, 827 former rough sleepers were screened at 66 different venues between the middle of May and June 2020. Fourteen per cent were female with a mean age of 42, 76% were male with a mean age of 41. The mean duration of homelessness was 3.5 years. Seventy-six different countries of birth were recorded. Thirty-three per cent were born in the UK, 28% in Eastern Europe and 39% were born in other countries.

Sixty-eight (7.5%) returned a positive antibody test result for hepatitis C. Of these 38 (4.2%) returned a positive RNA result.

Julian outlined the pathway the team used:



Julian noted that peer support was important and helpful to the work, saying this brought out a real enthusiasm to deliver this testing and support.

Fifteen (1.8% of population) were positive for HIV and 1.7% of those tested for syphilis returned a positive result.

He noted the team had applied for funding for video observed therapy for complex patients and hoping to work more on sexually transmitted infections. Finally, he noted that as we go into winter those working with homeless people will need clear strategies to prevent COVID-19 infections.

Postal testing or self-testing – Tracey Kemp, National Hepatitis C Strategy Lead, Change Grow Live

Tracey spoke about how the pause in testing due to COVID-19 was an opportunity to review the testing offer and develop a Blood Borne Virus Toolkit, which included a self-test or postal test option.

She noted the collaboration between peers and the national service user's council. The council suggested calling it a 'self-test' option rather than a 'postal test' as this puts more emphasis on the need for someone to complete the test.

The service was trialled through 23 people who were members of the council who said they would be happy to 'stress test' the service. Out of these 23, 21 tests were posted out and 19 results were received. None of the completed tests returned an indeterminate test result. She noted this did occasionally happen with dried blood spot testing, even when done in a service, so this was a positive sign. It showed that a group of people not used to testing could carry it out.

She said in conversations with the council, the test users said an advantage of the self-test was that it allowed the creation of space and calm in someone's own environment to carry out the test. This stood in comparison to testing in services which might be busy and where workers would have lots of different priorities. Tracey said this was an issue that it might be helpful to talk to the testing workforce about.

Tracey noted the points to consider with the self-test:

- First, she noted the need for services to be patient. Uptake can be slow with self-testing. In the current world where staff and service users are anxious, we need to create space so that people become confident in the concept. Support is needed to make people feel confident in the process of self-testing. It is not just a matter of sending out tests.
- Regional variation in restrictions also makes it difficult for services to plan for the future.
- Self-testing is not a one-size-fits all. Service workers need to assess the likelihood of someone engaging with self-testing. A 'shotgun' approach of sending out as many tests as possible is not appropriate. Currently CGL are figuring out the best way to support the 'back end' of the process, whether through check-ins, talking someone through the test via phone and ensuring people understand the guidance.
- Despite the availability of self-testing, it was still important to work with staff to make sure they felt safe and supported. This includes talking through risk assessment tools, PPE availability and the options available more generally to help get testing off the ground and increase confidence in on-site testing.

Tracey said the tool is available for all to use, is an open-resource and she is more than happy to answer questions from anyone looking for help or with questions.

The resources include:

- an implementation tool – a step-by-step guide to how different types of testing had been implemented by CGL.
- A frequently asked questions document
- A prioritisation matrix
- A guide to self-testing to help staff identify the most appropriate testing option
- Service-user information like step-by-step guides
- Supporting guidance for staff

She noted the self-test launched on the 6th August but the figures for self-testing were much lower than service-testing. This was against expectations for the workforce to go to the self-test option immediately. Over September, there was an increase in the number of self-tests being carried out so that the two test types were more on-par. The key was to make sure that self-testing was an appropriate option for each individual.

Question and Answer session

What is the role of self-testing/postal testing at We Are With You?

Helen Hampton: In Cornwall, self-testing was being used as soon as someone completed their treatment and needed to test whether they'd reached SVR (sustained virological response).

What can be done to reassure staff about their concerns around COVID-19?

Helen Hampton: Concerns which might impact hepatitis C testing included not wanting to keep service-users on site for too long when they had come in for a priority issue. Rota systems were used to prevent too many people being in the building at any one time when clinics were being run, alongside one-way-systems.

How are Find and Treat's additional service funded and commissioned?

Julian Surey: Early work was done through research funding. This gave a strong evidence base and helped lead to the service being commissioned by NHS England. Julian noted he did not want to just deal with people's hepatitis C, but all of the issues people are facing where possible.

Would you start someone on treatment without a liver assessment or scan?

Julian Surey: If needed, we would probably start someone on treatment without a liver scan. Overall, it's important that the pathway is simple and where possible peer-led. The service do try to scan wherever possible.

Stuart Smith: There has been debate around liver scanning and assessment and whether this should be done prior to or after treatment. This had been discussed at the ODN Stakeholder Event earlier that week. The message seems to be that liver damage should be assessed wherever possible as good practice.

What proportion of self-test users had been tested before?

Tracey Kemp: We are still in the early stages of collecting data. This is complicated by the fact there was a lag in tests landing at the lab with self-testing, as people will not carry out a test as soon as it arrives with them. In September, 457 tests were posted out, but clusters of services seemed to be better at getting their tests back to the lab quickly. One area in the North East had their tests arrive extremely quickly back at their lab. Self-test is a new concept, and it will take time for good practice like this to bed in. Between August 6th and September 30th, 75 people returned a self-test.

Julian Surey: One idea which had been floated was to incentivise people who had tested positive to have their friends and network take up testing and give them several self-tests to distribute. This was still an idea, but it might be helpful.

How are services ensuring self-testing equipment is being disposed of safely?

Tracey Kemp: This had been discussed extensively. The lancet for self-testing had been particularly discussed. The team had liaised with Manchester Labs and sexual health services about their guidance on this as the self-test had been used in other areas before. Ultimately, the lancet retracts into its plastic casing once used, making it safer. However, this issue is a reminder of the importance of making sure self-testing is appropriate for each individual it is suggested to.

Does CGL deliver services in Wales?

Tracey Kemp: CGL delivered educational and employment services rather than prescribing services in Wales but encourages any services to use the toolkit developed by CGL.

Asked about how self-testing results were delivered, Tracey said this was agreed in the same way it would be with dried blood spot testing pre-COVID. For example, would people be happy with a phone call or like to come into services. This agreement should be informed by an individual's own circumstances and what's appropriate for them.

Is the data from the self-test fed into national testing registries and dashboards?

Tracey Kemp: The data is fed into Public Health England by the labs.

How would harm reduction advice be delivered alongside self-testing?

Tracey Kemp: This should go hand-in-hand with conversations around offering self-testing in the first place.

How would people who tested positive and used self-testing be engaged in treatment?

Tracey Kemp: Processes to get people into treatment, like with every service, had to be adapted due to COVID-19. She said this would vary depending on the region and the different pathways present in each place. However, this underlined the importance of the discussion about how results would be communicated, and people would be engaged.

Feedback from breakout group discussion

Attendees then went into breakout groups to discuss testing in more detail. The facilitators for each group then reported back on what their group had discussed.

The four facilitators were:

- Archie Christian, National Training and Volunteer Manager, The Hepatitis C Trust
- Stuart Smith, Director of Community Service, The Hepatitis C Trust
- Helen Hampton, Lead Clinical Nurse for Blood Borne Virus, We Are With You
- Tracey Kemp, National Hepatitis C Strategy Lead, Change Grow Live

Archie Christian said his group had agreed that service, outreach, and self-test testing all had their own advantages, and the overall advantage of having all three of these was an increase in choice available to service users and services. He noted that self-testing could provide a degree of anonymity and an extra layer of confidentiality.

Helen's group agreed that having these different options was important, different service users would need different models of care and testing. Local authorities' support for homeless people had been helpful as had the links with The Hepatitis C Trust peers. She also noted that getting people into treatment was key and her group had emphasised the need to "get the treatment to the person" rather than getting them to find treatment.

Tracey's group had discussed the advantage of physical contact and conversation with service-based testing to slip in 'conversation starters' which lead to bigger and wider conversations around healthcare needs which can be helpful. One crucial point raised was that during testing, including self-testing, there were really key points where assessment took place and people were given reassurance. She noted that during these points, there could be an effort made to link someone into a peer support worker who could give specific support around hepatitis C. This was done with other types of testing but had not yet been done with the self-test, and Tracey planned to follow this up with CGL's offer of self-testing.

Stuart said his group had really appreciated the CGL toolkit. Note was made of the need to communicate with ODNs about how much testing was being carried out and positive cases being found. Overall, self-testing is another 'arrow in the quiver'. This is important as, once the 'easier to find' patients have been identified, new tools will be needed to find the remaining undiagnosed patients.

The group had likened self-testing to pharmacy testing, now launched in England. Whilst this was not a 'self-test' it was remote testing carried out outside a service that has traditionally offered hepatitis C testing. He noted that in some pilots of pharmacy testing only 20% of positives found went on to engage with treatment. When a whole-team approach had been taken to boost engagement in treatment, rates had reached 80%. This had underlined what Tracey's group had highlighted about the need to involve peer support workers with self-testing.

Stuart's group had also noted the success of whole-service testing in drug services where everyone in contact with a service was tested in a short time frame. These are like HITTs (high intensity test and treats) in prisons where whole prison populations were tested and enrolled in treatment quickly. It was possible to carry these out in drug services and he noted We Are With You have had success with this.

Further reading

Avramovic, Gordana et al. "A Case study of a Service Innovation Project Aiming at Improving the Elimination of HCV in Vulnerable Populations in Four European Cities", *International Journal of Infectious Diseases* (2020)

Change, Grow, Live Blood Borne Virus Toolkit

Surey, Julian et al. "From peer-based to peer-led: redefining the role of peers across the hepatitis C care pathway: HepCare Europe.", *The Journal of antimicrobial chemotherapy* vol. 74,Suppl 5 (2019): v17-v23.

Acknowledgement

HCV Action would like to thank Helen Hampton, Tracey Kemp, Julian Surey, Archie Christian and Stuart Smith for their contributions to the webinar as well as all those who took part in our breakout groups for their thoughts.