



**HCV ACTION WEBINAR: HEPATITIS C
SERVICES DURING AND BEYOND THE
COVID-19 OUTBREAK, 18 JUNE 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 different areas across the country and explore how hepatitis C services can most effectively be re-established as we emerge from the early phase of the outbreak.

The webinar featured contributions from the following speakers:

- Mark Gillyon-Powell – Head of Programme, HCV Elimination, NHS England & NHS Improvement
- Dr Steve Ryder – Chair, HCV Action and Clinical Lead, Nottingham Hepatitis C Operational Delivery Network (ODN)
- Rachel Halford – CEO, The Hepatitis C Trust
- Tracey Kemp – National Hepatitis C Strategy Lead, Change Grow Live

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

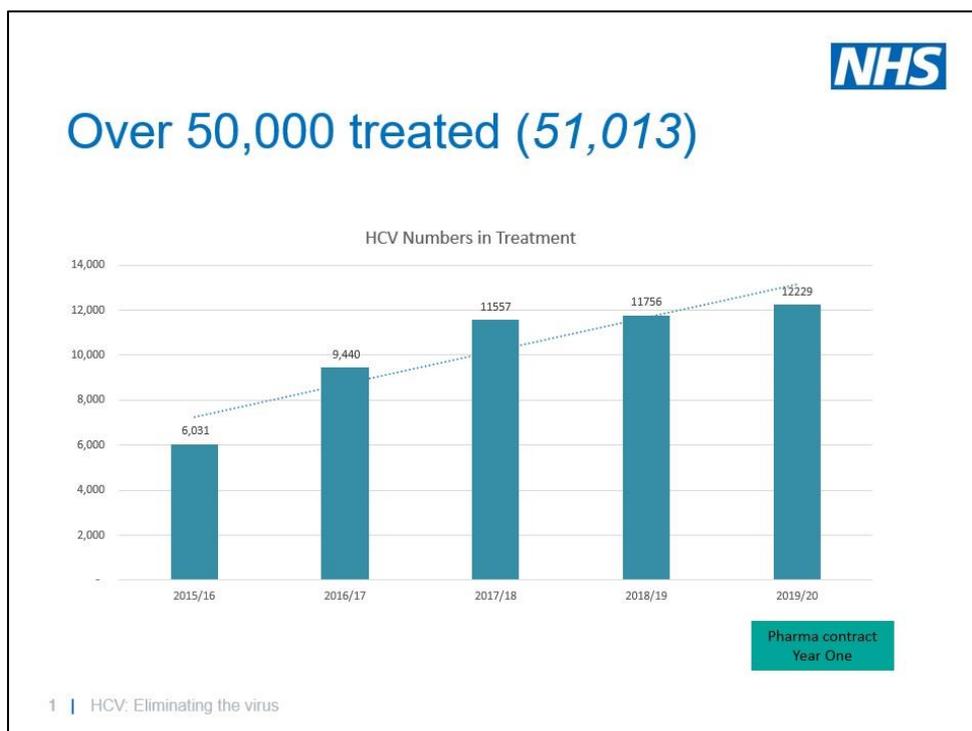
The webinar can be viewed in full on the HCV Action website [here](#).

Contributions from speakers

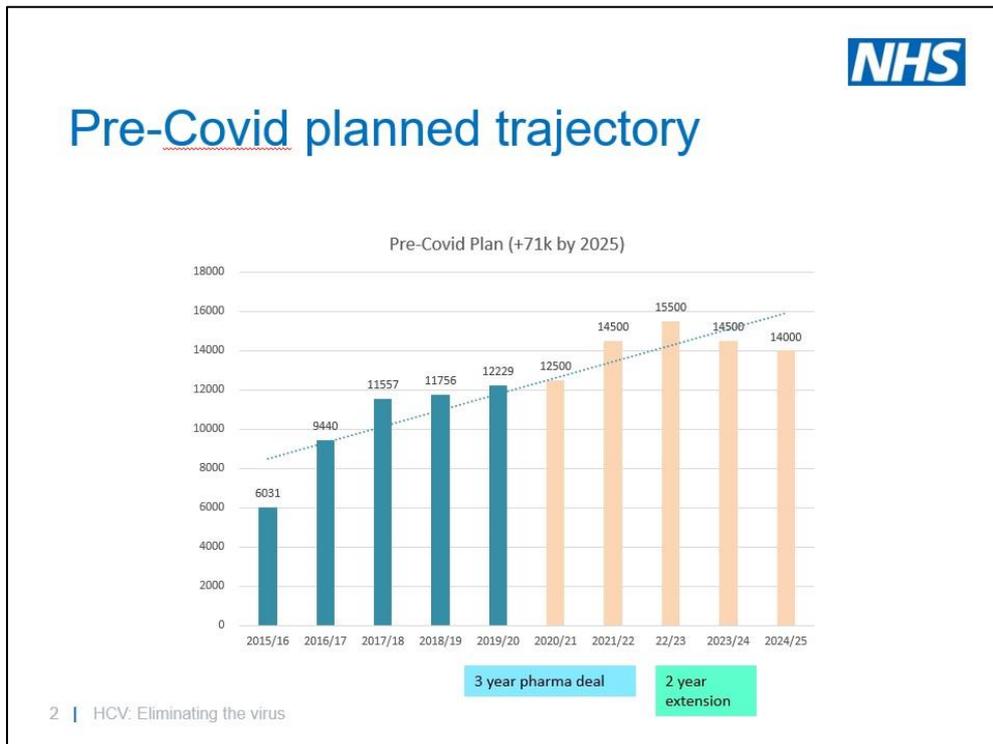
Mark Gillyon-Powell – Head of Programme, HCV Elimination, NHS England & NHS Improvement

Mark Gillyon-Powell began by thanking services for their continued efforts in tackling hepatitis C and for the way those working in hepatitis C care and related services have responded to the extremely challenging circumstances.

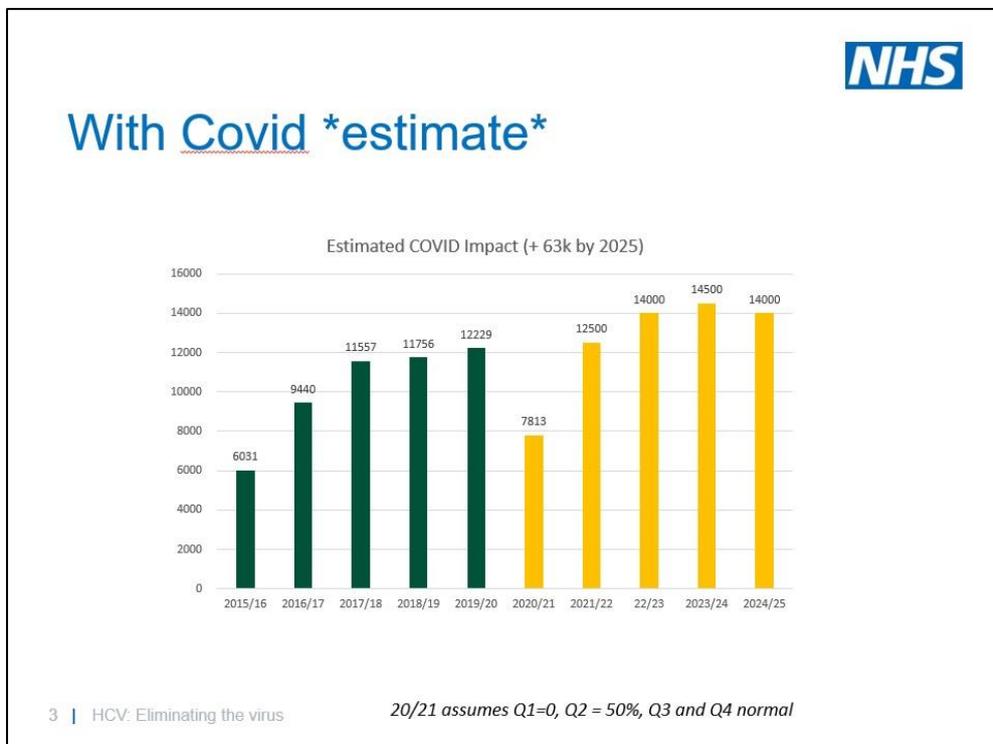
Mark noted that treatment numbers in 2019/20 were very positive, with the run rate exceeded. A slide was shared showing hepatitis C treatment numbers since 2015, with over 50,000 patients having now received direct acting antiviral (DAA) treatment in England:



A second slide showed the expected trajectory of hepatitis C treatment rates prior to the Covid-19 outbreak:



Following this, a slide was presented outlining an updated estimate of treatment rates produced in light of the disruption caused by the Covid-19 outbreak:



As the slide shows, the NHS England assumption was that there would be no treatment starts in the first quarter of 2020/21, due to the impact of lockdown, followed by 50% in Q2, returning to expected levels in Q3 and Q4. In reality, the situation in Q1 has been better than feared, with some

treatment starts being possible thanks to innovative practice from ODNs and the opportunity to test and treat homeless individuals being accommodated during the lockdown period. As such, Mark and NHS England colleagues think that it should be possible to get closer to 10,000 people on treatment in 2020/21, rather than the circa 7,800 predicted in the slide.

Mark then talked about the current situation and next steps. Many ODNs have been prioritising taking the opportunity to test homeless individuals in temporary accommodation. NHS England, ODNs and MSD have been collaborating around the Primary Care Patient Search Identification Tool, with some GPs actually finding that they have had more capacity due to in-person consultations being suspended, presenting an opportunity to search records for those at risk of hepatitis C.

Telemedicine and virtual multi-disciplinary team (MDT) meetings have been taking place in many ODNs. As we begin to emerge from lockdown, Mark outlined the importance of adopting innovative approaches to testing and supporting services such as substance misuse services and prisons to re-establish hepatitis C care.

Dr Steve Ryder – Chair, HCV Action and Clinical Lead, Nottingham Hepatitis C ODN

Dr Steve Ryder, providing his perspective as an ODN Clinical Lead, noted the geographical differences in the impact Covid-19 has had, even within ODN areas, which has inevitably impacted hepatitis C services to different extents.

Within the Nottingham ODN, a decision was made early on to continue to offer hepatitis C treatment to as many patients as possible. The most challenging impact of the Covid-19 lockdown was on outreach testing, but there were a number of patients already known to the Nottingham ODN who they could support to engage in treatment. The time was also used to forward-plan regarding testing, remote working and patient identification.

One factor that helped the Nottingham ODN continue to deliver care was that it already had mechanisms for remote working (such as medication being accessible via home delivery), which were upscaled. Doing this involved a fair degree of pragmatism, taking the approach that as long as they could be fairly sure the medication would reach the intended person, they would go ahead and do it.

Continuing to offer hepatitis C care in prisons was a particular challenge given the stricter lockdown that happened in secure settings. Testing was heavily impacted but the Nottingham ODN was able to continue to deliver treatment to those in prisons. The ODN also used the opportunity of homeless people being accommodated to test a group who are often challenging to engage.

Rachel Halford – CEO, The Hepatitis C Trust

Rachel Halford provided an update on The Hepatitis C Trust's operations during the Covid-19 outbreak.

The Hepatitis C Trust produced informative materials on Covid-19 aimed at those the charity supports. The Trust's peer-to-peer support staff and volunteers have continued to support patients by delivering medication and food parcels with the appropriate personal protective equipment (PPE) and risk assessments in place, and by providing telephone-based support. Experiences across the country have been incredibly diverse and the impact on services has been varied, with knock-on implications for the amount of support The Hepatitis C Trust's peers were able/needed to make.

The Hepatitis C Trust's data shows there have been 190 treatment starts across the country while lockdown has been in place, which demonstrates how well services have adapted to the changed circumstances.

Rachel noted that along with the many restrictions as a result of the response to Covid-19, there have also been opportunities, particularly in relation to providing care to the homeless population and the use of telemedicine. Working in partnership with University College London Hospitals NHS Foundation Trust, Mortimer Market and many others, The Hepatitis C Trust's peers have been able to contribute to testing 399 people across 29 events in London alone. There are now at least two High Intensity Test and Treat (HITT) events taking place every day across the country. The Hepatitis C Trust's outreach van is also now back in operation, going out and providing support to those at risk.

Rachel concluded by highlighting that the partnership working between services has been a very positive outcome and may help us to resume progress towards elimination sooner than might have been expected. The priority is now finding innovative ways of expanding testing as we emerge from lockdown.

Tracey Kemp – National Hepatitis C Strategy lead, Change Grow Live

Finally, Tracey Kemp provided attendees with an update on how substance misuse service provider Change Grow Live (CGL) has been able to continue supporting hepatitis C patients.

CGL had to pause dry blood spot (DBS) testing for blood-borne viruses (BBVs) at the beginning of the lockdown to protect staff and patients and react to Government guidance. The service CGL offers has been adapted, with a move to more remote support. Adopting video communication as a core part of the service has had positive impacts, allowing people to feel empowered and in control of their treatment.

CGL is about to launch a new postal BBV testing pathway which will involve DBS tests which people can complete themselves at home. The pathway will initially be piloted in key sites before being rolled out, accompanied by various guidance documents. Opportunistic testing will also be important, such as in needle exchanges, utilising relationships with pharmacies.

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:

How can we ensure hepatitis C remains a priority when providers are struggling with resource issues, capacity, long waiting lists and adjusting to Covid-19?

Tracey Kemp said that it is important leaders within organisations are fully bought in to prioritising hepatitis C and communicate this to staff.

Mark Gillyon-Powell confirmed that hepatitis C elimination continues to be an organisational priority at the very top of NHS England and that steps are being taken to support Trusts and ODNs and understand the individual pressures they are under.

Are ODNs testing for SVR [sustained virologic response] and how are they treating people with liver damage?

Steve Ryder said that treatment should be the priority, rather than testing for SVR – we know that 95% of people will be cured and the worst thing would be to not treat someone for a curable disease because follow-up is not possible. Most people with decompensated cirrhosis will be picked up by services, even during the Covid-19 outbreak.

How can we utilise the media interest around health and infectious diseases to garner support for hepatitis C testing?

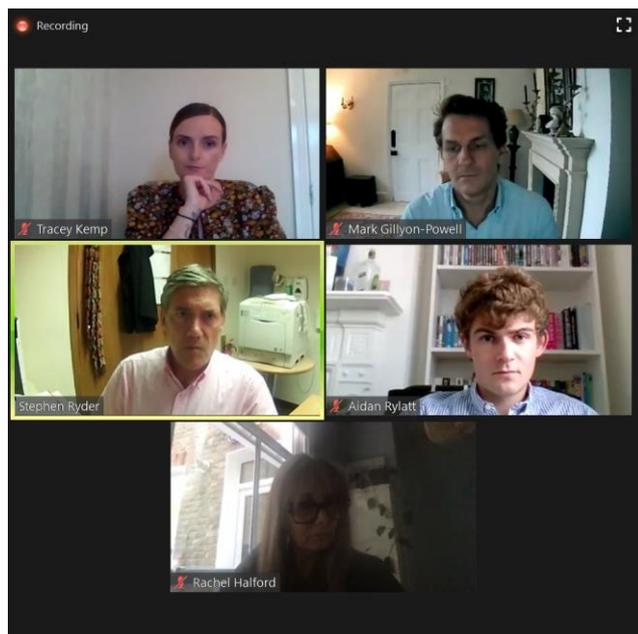
The panel agreed that it is difficult to say whether this will lead to increased awareness, especially as it is difficult to get media interest in any health stories other than Covid-19 at the moment. There may be opportunities for messaging around hepatitis C as the focus begins to widen to other health issues.

Where are the key sites for CGL's home testing pilot and how were they identified?

Tracey Kemp said that the sites are Southwark, Luton, Rotherham and Holton. They were identified with regional coordinators based on which sites would provide maximum opportunity to test the system. The pilot aims to create space within services as they move back towards resuming operations.

Are ODNs planning to maintain virtual clinics and other innovations introduced during lockdown?

Steve Ryder said that the outpatient model generally is going to be different post-Covid. People have become used to being able to have consultations with their family around them, for example. This is a positive development for hepatitis C and has helped us to move away from an outdated system that meant people had to attend a secondary care site, instead moving out into the community and into people's homes. Some of these structural changes will continue.



Are there any opportunities to increase harm reduction measures given the impact that lockdown may have had on increasing behaviours that put people at risk of BBVs?

Rachel Halford said that harm reduction is extremely important, especially in the context of the difficulty people are having in accessing needle and syringe exchanges during lockdown. Some services are very concerned that this will lead to a spike in cases. Mark Gillyon-Powell added that there must be a partnership approach between local authorities, NHS England, Public Health England and service providers to ensure people have adequate needle and syringe provision. Elimination will not be possible without better prevention measures – we cannot achieve elimination by treatment alone.

What are the plans for the CQUIN [Commissioning for Quality and Innovation] targets beyond this year?

Mark Gillyon-Powell responded, saying that payment by results was stopped from 1st April and Trusts are now being paid by block contract. The plan had been for there to be no CQUIN next year,

although recent conversations with NHS England colleagues suggests that hepatitis C may now be part of the CQUIN next year.

Questions from the audience – not answered during the webinar

Time constraints meant that a number of questions were not able to be answered during the webinar. The speakers from the event have since provided written answers to these questions. All answers below are the personal view of the individual.

Emily Phipps: Should we consider the impact of the pandemic on incidence of HCV infection as part of the (estimated) treatment aims and innovative recovery planning?

Mark Gillyon-Powell: I think that we should, moving forwards; there is the possibility that prevalence could be affected in multiple ways (less injecting due to drug market supply issues, or more risk-taking behaviour through non-availability of some NEX supplies in lockdown, for example). Time will tell, but it is certainly something that will need to be considered as a part of future prevalence calculations.

Louise Johns: In regard to using pangenotypic medications, were there any barriers with market share allocation through their ODN? i.e. free reign to treat all unknown genotypes or limited allowance?

Steve Ryder: Not really. The 20% covers quite a bit and we will be able to catch up with G1 specific drugs once we can do more genotyping. Mark may wish to comment but I would feel sure NHSE will not be concerned short term so long as we can recover the position later. Quite a few people who have been tested before will have a genotype so it's more the urgent settings where you have one shot at it which are critical.

Mark Gillyon-Powell: I agree; we have been clear with ODNs that during this difficult time the NHS England priority is getting people treated in the most effective and expedient way possible – including use of pangenotypic medication where we don't already know a genotype. We may have to juggle things later in the year to get back to our committed market share, but we can deal with that.

Vikki Charles: To move forward with treatments, more access to pangenotypic medication is essential if we are doing more outreach/home testing. Currently it's only 20% of total drug use to be used as pangenotypic.

Steve Ryder: Agree but I guess we are where we are with the overall treatment deal and we should I think be grateful that we have pretty flexible access – see above for details

Mark Gillyon-Powell: We'll manage things later in the year to get us back in balance.

Jackie Webley: There are some excellent examples of good practice happening across the country. However, there are some Trusts that are unwilling to treat patients without some level of fibrosis assessment. How can we better communicate to Nurses and Consultants directly to encourage them to treat differently? Hep C treatment should not be a postcode lottery!

Steve Ryder: I am surprised if this is the case. A fibrosis assessment is not mandated, it is a patient's choice. It can be done anytime – after treatment is perfectly acceptable as the only real implications are long term (if you believe in things like HCC surveillance). It may be a motivator for people to work on the alcohol side of things but has no effect on their HCV therapy really. If you have specific examples of ODNs insisting, we can try and do some communications of best practice.

Duncan Cresswell: How are you identifying cirrhotic and non-cirrhotic patients for treatment with only an RNA positive result? Are you treating all patients without liver function tests or have you only been treating specific patients (under 40 years old for example)?

Steve Ryder: If we can get a fibrosis assessment we do, this can be fibroscan (the nurse team take it with them), blood tests (APRI etc.) or best guess given history. In reality cirrhosis really only affects a few treatment choices and we have enough flexibility to avoid those (eight weeks Harvoni, for example, is probably not enough in cirrhosis but you can use Zepatier or just tick the cirrhosis box if your suspicion is high). The only group where it does matter are decompensated cirrhosis and this is usually pretty obvious even in remote consultation and you can respond appropriately. I think a totally pragmatic view is the right thing as it's better that a cirrhotic patient gets treated even if it's not with the perfect regimen – cure rates will still be good. I have occasionally started and modified regimen if a fibrosis marker later suggests a change which matters but this is hen's teeth stuff.

Tamara Robinson: Hi all - Tamara Robinson, CGL HCV Regional Coordinator here. Wondering if there are any established platforms or plans to establish ways to share learnings from ODN to ODN; those innovative and pragmatic approaches to treatment delivery that we'd like to see rolled out more widely? Many thanks

Steve Ryder: HCV Action! The ODNs meet although this isn't frequent. I think the best practice examples via HCV Action are a key resource.

Mark Gillyon-Powell: We have a section on 'NHS Futures' which is currently open to ODNs to access (and share) a range of materials, including shared learning. We can look at widening access to this if there is an appetite to do so, though some sections remain closed (for example, to the National NHS England Team).

Petra Wright: DBS can be difficult (filling the circles, lancet not working); for self-testing are there no other more user-friendly methods i.e. mouth swab?

Tracey Kemp: There are of course other methods of testing, and at this stage we have not ruled out expanding the menu of testing options further. The pilot of the new BBV postal testing pathway will help guide the next steps. Feedback from the service user council was interesting – out of the possible testing options, it was the self DBST that was voted as the preferred option.

Steve Ryder: Yes, and you can access them. Most ODNs use a combination of test types to respond to different environments. The oral swabs can be helpful but if positive you still need a blood test. Capillary sampling is probably going to be a significant improvement on DBS too – it's certainly easier to get the required amount of blood into a capillary tube than fill the dots on the card. This has been used for self-testing.

Mark Gillyon-Powell: We are looking at a range of options but trying to avoid those where there would be a need for multiple tests (e.g. oral swab for antibody, then a follow up test for PCR, then a follow up test for genotype). DBST and capillary are the two currently that can do all of this, and both are being used in different settings so we can review their comparative effectiveness.

WS: When are CGL planning on re-opening their sites to clients and also for HCV outreach clinics?

Tracey Kemp: The first step is to bring the workforce back into services in a way that safeguards them and enables us to follow Government guidance. We are about to launch a staff risk assessment and PPE guidance document that will support services in reopening their doors. The timescale for this will be variable across services and will be better managed at a more local level.

Emily Phipps: What's the best way to monitor treatment completion in the absence of SVR to ensure people aren't lost in the system?

Steve Ryder: Who cares if people are lost in the system so long as they have been treated? 95% will be cured and my experience is that we encounter most clients again at some point and can check SVR for them then. A number remain at risk of reinfection so just taking every opportunity to test will pick up most, I think. The PHE national dataset is helpful too as I will always offer a test to people treated outside my ODN who appear in Nottingham, this will get fed back to the national dataset so we (NHSE) will find out in the end. This is not to say we don't try to obtain SVR blood – it's good for that client to know they are cured but just to make the point I don't lose sleep over it if we can't.

Anonymous Attendee: Do you have any feedback or views on current contributions from AbbVie/MSD/Gilead into elimination at this point in time? Should we read anything into their absence from this webinar?

Mark Gillyon-Powell: They weren't absent from the webinar; representatives of each of the companies were dialled into the webinar. NHS England values the efforts that each of the companies are putting into patient-finding, testing etc., and they add significantly to the partnership effort we need for elimination.

Steve Ryder: Personal view is that all have contributed and the novel commissioning strategy has delivered. I think all of us would rather that AbbVie had spent their money on case finding rather than lawyers but in practice all the initiatives that I have been involved with from the companies have been both well intentioned and productive. Do not underestimate the magnitude of the change this way of dealing with industry represents. I feel perhaps for the first time in all my years of working alongside pharma using their drugs that this is a partnership which means something and the aims are truly joint ones.

Anonymous Attendee: What is the panel's view on the use of cash/voucher incentives to increase testing?

Steve Ryder: Pretty essential for some client groups and very relaxed about it. We have personal experience that it does help engagement.

Mark Gillyon-Powell: Completely support; NICE have long recommended contingency management as an approach to incentivising behaviour change. Regardless of that, appropriate incentives save the health system more than they cost; increasing the acceptability of testing and linkage into treatment for someone with HCV, or co-infected with HIV for example, not only represents a personal milestone for the individual – but also an excellent public health/infection-prevention achievement and a cost-saving for the NHS in long-term care costs. Win/win.

Tracey Kemp: Let's not rule out contingency management for testing, especially whilst we look to reinstate testing and launch new pathways.

Peter Hawley: What plans does everyone have for World Hepatitis Day now we are in Covid world?

Rachel Halford: The Hepatitis C Trust's staff and volunteers will be climbing peaks (in a responsibly socially-distanced manner) across the country to collectively climb the equivalent of the height of Mount Everest. This will raise money for the Trust and the mental health charity Mind, in recognition of the mental health impacts of lockdown restrictions and the crucial role Mind plays as a source of support for many for whom this has been a difficult time. Our peer support staff and volunteers will

be taking part in local testing and awareness-raising initiatives across the country and we will be raising awareness through media pieces and by working with our supportive political contacts.

Steve Ryder: Joining the challenge Everest event by team walking up Kinder Scout in Derbyshire. We may even have a pub garden open by then to celebrate the achievement.

Mark Gillyon-Powell: Some comms plans, to share where we are now up to and hopefully the good news about the work that has been taking place with homeless/temporarily housed populations.

Tracey Kemp: Lots of presence on social media, share tools that will support the workforce and help with the revival of HCV. We are still in the planning stage, but rest assured we will shout loud about this!

Christine Taylor: Hi Rachel! Amazing work supporting the homeless housed in London. Are you able to confirm those numbers again? I think I got 399 tested, 28 AB+ and was it 17 RNA+?

Rachel Halford: Yes, these figures are correct [for outreach The Hepatitis C Trust has been involved in].

Mark Gillyon-Powell: From my awareness, we are just short of 600 screened currently [overall]; I don't have to hand all of the cascade data.