National Strategic Group for Viral Hepatitis (NSGVH)

Minutes of meeting held on 15 December 2020
Virtual meeting

Attendees:

Members:	Will Irving (WI, Chair)	**Invited presenters and observers:**	Daniel Bradshaw (DB)
	Graham Foster (GF)		Emily Phipps (EP)
	Helen Bennett (HB)		Geoff Dusheiko (GD)
	Peter Moss (PM)		Helen Harris (HH)
	Matt Hickman (MH)		Koye Balogun (KB)
	Rachel Halford (RH)		Ross Harris (RoH)
	Richard Tedder (RT)		Stuart Smith (SS)
	Samreen Ijaz (SI)		Tatiana G Vilaplana (TVG)
	Sema Mandal (SM)		Stuart Smith (SS)
	Daniela DeAngelis (DD)		Patrick Kennedy (PK)
	Peter Vickerman (PV)		Ruth Simmons (RS)
	Steve Taylor (ST		Caisey V Pulford (CP)
	Mike Gent (MG)		Graham Cooke (GC)
	Caroline Sabin (CS)		Claire Neill (CN)
	Mark Aldersley (MA)		Katherine Evans (KE)
			Ahmed Elsharkawy (AE)
			Tim Ellis (TE)
			Iain Hayden (IH)
			Noel Craine (NC)

Apologies:

Mary Ramsay
Ceri Townley
Giri Shankar
Mark Gillyon-Powell

1. Welcome

Chair welcomed all those in attendance and requested a round of introductions for new attendees.

SM, ST and MG gave an update on the future of Public Health England (PHE) and the formation of the National Institute of Health Protection (NIHP). All previous work and functions are currently ongoing as usual, and it is expected that the National Infection Service and current work undertaken on hepatitis will continue and move over to the NIHP. It is currently not known in which organisation PHE's health improvement functions will sit.

2. Update and minutes

2.1 The minutes of the previous meeting were agreed as an accurate record

2.2 Update on actions from the last meeting

Action 2.5: A problem was raised around provision of HES data to PHE from NHS digital. HH and SM explained hepatitis codes were stripped from HES data in 2017 due to being classified as an STI and considered sensitive, resulting in the inability to deduplicate HCV and HBV associated end-stage liver disease and monitor incident cases. NHSD admitted this was an error, and mitigations have been put in place including requesting providers to resubmit raw HES data (SUS) but around 60% to 80% of data have been completed. The removal of codes has since been accepted as incorrect. A working group is in place to work through the legal and operational issues, these will ensure that both STI and hepatitis codes going forward are not legally restricted or considered sensitive codes and so PII accompanying STI and hepatitis codes will be shared to PHE for use in public health surveillance. Governance still exists to restrict the sharing of PII between clinicians.

PHE have escalated internally and progress is being made through the cross-agency working group chaired by Peter Bradley; no action is required from the group at the moment.

3. Update from PHE on specific issues

3.1 HBV: Immunisation and screening enhanced pathway

SM provided an update on the hepatitis B antenatal screening and selective immunisation quality improvement project undertaken by PHE's Screening and Immunisation divisions. After a delay from April 2020 launch, this project is due to be launched on 1 April 2021 to ensure an enhanced pathway between screening and immunisation teams. New guidance for maternity

units and primary care staff will become available from January to review care pathways. Main changes to the pathway include:

- addition of new surveillance tests at the time of birth from both mother and baby
- strengthening of the antenatal screening pathway
- educational resources for staff
- leaflets for pregnant women and
- systems in place to facilitate a clear continuity of care from maternity to primary care services

WI raised that WHO have revised their guidelines for antiviral treatment of HBV in pregnancy and asked if these changes were reflected in the guidelines. It was noted the remit for clinical guidelines for management of pregnant women fall with the British Viral Hepatitis Group which are being updated. It is important this guidance is ready by April as the screening and immunisation project guidance makes reference to it.

Action: members of the group in BVHG to follow up on status of these guidelines.

3.2 HBV elimination strategy and report

SM drew attention to key points of the draft HBV elimination strategy which focuses on prevention through immunisation but areas needing further work are estimating numbers infected and those in treatment. AE raised that there were no targets or estimates of current number of people with HBV in the UK. The group expressed a desire to get a strategy down on paper and signed off in 2021. MH mentioned work with PHE, MRC had begun on prevalence estimation methodologies and this could be picked up in the HPRU.

GD highlighted there will be large numbers of serological testing undertaken in 2021 to study coronavirus (COVID-19). This could be exploited to get sentinel data and estimate the prevalence of HBV in the population. He expressed that the group should use COVID-19 to attract funding.

PM highlighted that the NHSE clinical reference group, focusing on HCV was dissolved and that other ways need to be explored to persuade NHSE to use their current hepatitis C networks to explore HBV and HEV.

3.3 SABTO Occult Blood Infection Working Group update: Safety of blood tissue and organs advisory group.

WI summarised recognition of the risk of transmission from blood donors of occult HBV infection, as HBV DNA is screened for in pools of 24 in current practice, it may result in a failure to detect in low level DNA positive donations. SABTO working group have suggested possible interventions, reducing the size of pools, the introduction of anti-HBc screening and individual NAT testing might address

this. Once the working group have finalised their analysis a wider consultation is needed to identify what the acceptable risk is. This issue is to be re-addressed next meeting when recommendations are available.

AE raised concern that any recommendations to include PCR testing may have a knock on effect for hepatitis E. WI responded that is recognised, and SaBTO are creating a working group under the chairmanship of Prof Peter Simmonds (Oxford) to examine this.

RT highlighted that modellers need enough data to look at the distribution of HBV DNA levels in occult B patients.

3.4 HAV

KB noted that currently there are no major outbreaks or incidents and vaccine supply was sufficient for demand (noting impact of COVID-19 on services and epidemiology)

3.5 HEV

SI reported to the group that molecular surveillance had be paused since March 2020 and there were no plans to restart this currently. Diagnostic services have continued although fewer numbers were being received, most likely due to reduced testing during the COVID-19 epidemic.

NSGVH has discussed setting up a register of chronic HEV cases through the BVHG. SI highlighted one already exists however would be good to work to improve it so more data could be captured.

4. Research to support elimination

4.1 HPRU UCL: BB&STI

CS presented an overview of the NIHR HPRU at UCL, described the focus for the HPRU, introduced the group to key HPRU personnel and summarised some of the projects that have been proposed for the next 2 to 3 years. These projects fall into three themes:

- understanding risk and risk reduction for STIs and BBVs
- reducing the burden of undiagnosed STIs and BBVs
- improving the care and management of those with STIs and BBVs

Much of the work on hepatitis revolves around the analysis of large datasets to describe the characteristics of those with BBV in England and Wales, particularly in underserved populations, and to explore the feasibility of using surveillance datasets to support interventions to reduce new infections and to improve the management and treatment of those with infections. There is also a planned programme of genomic work to support improved treatment algorithms. Whilst the HPRU does not have an unlimited budget, the team is keen to undertake any

research necessary to support for PHE's routine surveillance and health protection activities and, as such, is welcome to suggestions for collaborative projects and support in grant applications.

4.2 HPRU Bristol

MH summarised upcoming work from the Bristol HPRU.

Four workstreams have been set up, 2 under the theme of behavioural science and 2 under clinical epidemiology and modelling. Future business plans have been submitted and will be summarised and shared once they have been agreed with NIHR and PHE. Core projects included:

- optimising case-finding in primary care
- piloting new pathways in primary care for example via birth cohort screening
- estimation of chronic HBV in England
- modelling hepatitis A outbreak control
- evaluating novel HCV case-finding interventions – with Vickerman HTA funded study
- realist evaluation of NSP – funded by NIHR led by Alison Munro
- evaluating promotion of Low Dead Space Syringes

MH gave highlights from EPITOPE NIHR Programme Grant

- Preliminary results from experiment to scale-up HCV treatment in Tayside has achieved a two-thirds reduction in chronic HCV to <10% in PWID. More results to follow. Evidence does suggest that incidence is still quite high.
- Protocol and methods for evaluating HCV TasP in England have been drafted and will be discussed at future meetings and submitted for publication.

RT raised the issue that there was a significant rate of HCV re-infection and asked if sequencing was being undertaken on those re infected to compare with the original infection strain. MH responded there are plans now to monitor post SVR.

Both CS and MH agreed to share forward business plans with group if no changes requested by NIHR.

Business plans are submitted each year, if work is needed these can be included in the following year's business plan.

5. COVID-19 Impact on hepatitis services and elimination

5.1 COVID-19 – impact on hepatitis (A-C) services and epidemiology (PHE)

TGV presented data on the impact COVID-19 has had on hepatitis A, B and C testing, diagnoses and treatment between January 2020 and end of June 2020. Results from 3 PHE surveillance systems were reported.

- PHE's Sentinel Surveillance of Blood Borne Viruses (SSBBV) system which records positivity and number of tests.
    - 60% decline in testing for hepatitis A and B between January and April, over 70% decline for hepatitis C.
    - Declines were seen across all settings, sex and regions. Antenatal testing for HBV saw the smallest reduction in testing.
    - Drug services saw the largest drop in testing for hepatitis C and have shown the smallest recovery in May and June
    - HCV positivity has fallen, most notably in middle age groups and in drug services. Numbers of tests since April are small giving little confidence in positivity results.
    - HCV positivity in prisons was less affected, recovering more rapidly than other services.

- NHSE's Hepatitis C treatment registry which records outcomes and treatment for hepatitis C
    - Number of treatment initiations fell by over 60% across all ages, settings and sex groups between January and April. These falls were observed across multiple parts of the care pathway.
    - There is some recovery since June 2020 although number of people starting treatment remained lower than January 2020 and June to July 2019.
- PHE's Second generation surveillance system (SGSS) which records new diagnoses
    - Number of new diagnoses of hepatitis A fell by >80% between January and June 2020
    - Number of new diagnoses of Hepatitis B fell by 75% between Jan and April 2020.
    - Number of new Diagnosis of hepatitis C fell by 85% between January and April 2020
    - Declines in hepatitis A diagnoses were expected and explainable from travel restrictions.
    - There is a recovery in the number of new diagnoses of hepatitis B and C in May and June, although these have not returned to February 2020 or June 2019 levels.

International comparisons from published European data show similar reductions in testing and treatment from March to May 2020 compared to 2019.

5.2 NHSE/ODN – perspectives

Graham Foster presented and summarised recent data derived from NHSE elimination initiatives:

Population being followed up was grouped into three –

30,000 actively infected identified through drug services, needle exchanges, prisons.

- 95% of drug services are engaged.
- Peer support in every ODN
- Cephid point of care testing selectively deployed
- Increased testing in unmanaged groups
- Community vans to start in new year

Less than 34,000 with past risk factors.

- MSD supported algorithm under evaluation
- Initial engagements with GP commissioners made

Unknowns infections.

- Identified by sexual health initiatives
- Maternity screening

A study has been funded with Bristol to screen 100,000 randomly selected individuals from primary care to investigate positivity.

It was highlighted the impacts of COVID-19 on HCV elimination were not as bad as anticipated with treatment still occurring. Concerns were raised of the impact on transmission over the period, and that long term impacts on engagement were not clear.

5.3 Hepatitis C Trust perspectives

RH provided a summary of recent experiences from the Hepatitis C Trust detailing how they had worked during and after the lockdown with PHE, NHSE, local NHS Trusts and ODNs working across prisons and local communities, this included great innovations seen during the period, such as:

- Peer Support workers fulfilling roles usually completed by NHS colleagues such as delivering medicine
- The National House the Homeless campaign – the Hepatitis C Trust Peers supported whole testing events in hotels and hostels where the homeless have been housed across the country. Piloted in London, in partnership with the Find and Treat team, local ODN's including clinicians and nurses, hepatitis C Peers provided support to engage people to access HCV, HBV and HIV testing. where positive antibodies were identified a Cepheid machine was used to enable immediate treatment and linkage to care. The model was taken across the country and adapted according to resources
- Peer support workers in some ODN areas were given lookback lists that hospitals had on positive HCV cases that had not accessed treatment, the peers worked on engaging the people back onto the care pathway.
- Whole prison testing events were cancelled during lockdown however they started again in quarter 3 with several taking place.

RH noted that the Trust has concerns regarding the possible increase in prevalence during lockdown due to reduced efficacy of harm reduction services, specifically needle exchange. Reduction in these services indicated need to take services into the community as opposed to hospital based.

5.4 Drug service commissioners and providers perspectives

ST Reported that many drug service providers had little or no access to PPE at the early stages of the pandemic and developed non-contact ways to support people (for example video calls, telephone) and provide injecting supplies and access to hep C testing (for example postal or direct deliveries). PPE supply is much improved now and, although face-to-face contacts are still being restricted to protect staff, service users and the community, they should be available in all services for new and vulnerable people who need them, and for people and interventions that can't use non-contact methods.

6. HCV activities to support elimination

6.1 NHSE elimination initiatives

This topic was covered in previous presentations.

6.2 NHSE Prevention in PWID Strategy group

EP raised that PWID infection and reinfection was a weakness in the HCV elimination strategy. EP commented that a NHS and PHE working group has been formed with aims to identify multi stakeholder projects to address this issue. Key themes were to identify low dead space equipment, better mapping of harm reduction services (OST/NSP), and data systems to monitor coverage of OST/NSP

6.3 NHSE Data group

HB informed the group the terms of reference had been circulated to stakeholders and were waiting chair ratification. These TOR will be circulated to the group after ratification.

6.4 PHE HCV Dashboard and pathway implementation

RS reported that dashboard development is ongoing.

- Discussions are needed with Arden and GEM to extract data from the testing register which has been set up collect testing data conducted by initiatives which do not use routine reporting, such as point of care.
- RNA data is not routinely reported by laboratories through their LIMS to PHE. This is a limiting factor to identify who is currently infected. Work is ongoing to rectify this by the relevant teams but is not going to be fixed overnight.
- Hep C Trust data was requested from testing and treatment from mobile vans.

- Previous issue raised about capturing dried blood spot tests from private companies have been resolved, although any new testing that starts must be raised to PHE.

6.5 PHE HCV Prevalence estimates

RoH reported that latest HCV prevalence estimates were 88,000 for 2020, although this estimate had not used HES or injecting drug data in the model, which are usually included parameters. There is a plan to incorporate these data into the model and stratify the estimate.

6.6 PHE Reports update (UAM/HCV)

EP highlighted that the 'Shooting Up' report is due to be available in January 2021.
CP summarised upcoming work to identify gaps in the HCV care pathway beginning with workshops to explore at a local level.

HH highlighted the HepC in the UK report had been published on 14th December along with summary infographic and slide set and gave an overview of progress towards hepatitis C elimination targets:

- Prevalence of chronic HCV infection had fallen by one third to 118,000
- Deaths from hepatitis C were down 25% by end of 2019 when compared to 2015 baseline, this is against a WHO target of 10% by 2020
- Since 2014 numbers accessing treatment have more than doubling to 15,449 treatment initiations in 2019 to 2020.
- No evidence of a fall in new infections, incidence was stable at 10 to 16 per 100,00 person years

7. Any other business

7.1 Infected blood Inquiry

RH reported that the Inquiry started in March 2019, the last 18 months has been focused on evidence, witness statements from individuals who have been affected by or received infected blood or blood products. Following a short break, the Inquiry re started in October 2020, the focus is now on the history – what was known about the infected blood, who knew such as governing bodies, clinicians – the inquiry is presently focusing on the haemophilia centres across the country.

The Inquiry was originally expected to take 2 to 3 years but will now take longer. A majority of the Hepatitis C Trust helpline calls are now focused on the Inquiry

Actions from 15 December 2020 meeting:

Action number	Action	Who
1	Chair of BVHG to follow up and feedback on the status of revised clinical guidelines for the management of pregnant women with hepatitis B	Mark Aldersley