UK Health Security Agency

National Strategic Group for Viral Hepatitis (NSGVH)

Minutes of meeting held on 29 April 2021
Virtual meeting

Attendees:

Members:	Will Irving (WI, Chair)	**Invited presenters and observers:**	Daniel Bradshaw (DB)
	Graham Foster (GF)		Ahmed Elsharkawy (AE)
	Peter Moss (PM)		Ruth Simmons (RS)
	Rachel Halford (RH)		Helen Harris (HH)
	Richard Tedder (RT)		Koye Balogun (KB)
	Samreen Ijaz (SI)		Ross Harris (RoH)
	Peter Vickerman (PV)		Stuart Smith (SS)
	Steve Taylor (ST)		Katherine Evans (KE)
	Mike Gent (MG)		Stuart Smith (SS)
	Mark Aldersley (MA)		Patrick Kennedy (PK)
	Mark Gillyon-Powell (MGP)		Noel Craine (NC)
			Caisey V Pulford (CP)
			Graham Cooke (GC)
Secretariat	Iain Hayden (IH)		Sara Croxford (SC)
			Katherine Evans (KE)
			Gillian Armstrong (GA)
			Patrick Kennedy (PK)
			Tarun Mahey (TM)
			Giri Shankar (GS)
			Emma Stapley (ES)
			Annelies McCurley (AM)
			Georgia Threadgold (GT)
			Sarah Hart (SH)
			Frankie McQueen (FM)
			Tamyo Mbisa (TMb)
			Bronagh (B)

Apologies:

Mary Ramsay	Matt Hickman	Ceri Townley
Sema Mandal	Caroline Sabin	Eamonn O'Moore

1. Welcome and introductions

The Chair welcomed all those in attendance and requested a round of introductions.

The Chair noted that attendees at the meeting had expanded whilst meetings had been virtual and that attendance may need to be reviewed when the meetings move back to being in person as space will be a limiting factor.

KB updated the group on Public Health England (PHE) transformation into the UK Health Security Agency (UKHSA). This new organisation will be responsible for health protection functions of PHE, bringing in functions of NHS Test and Trace and the Joint Biosecurity Centre from October 2021. Jenny Harries has been appointed CEO and Ian Peters as Chair. PHE health improvement functions will move to the Department of Health and Social Care (DHSC) with Prof Chris Witty being the professional lead. PHE functions covering hepatitis work are expected to move into UKHSA.

Action 1: An organisational diagram will be shared with the group when available.

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 2.2 on agenda: To feed-back on status of the revised clinical guidelines for management of pregnant women with hepatitis B.

MA explained there are three documents dealing with hepatitis B in pregnancy from the World Health Organization (WHO), PHE and BVHG and these are broadly in line with each other. These reference the Green Book and this is a separate document. One of the prominent discrepancies was WHO recommend starting treatment at 28 weeks whilst BVHG guidance recommends commencing at 24 weeks.

RT stated these guidelines are based on the principle of wanting the viral load reduced at delivery and this does not consider the risk of intrauterine transmission. It was proposed an earlier start of maternal antiviral treatment should be considered. PK supported this, commenting patients with a high viral load who were also HBeAg positive often struggle to lower their viral load in time when commencing at 28 weeks.

SI highlighted we are sticking with current WHO recommendations, however the enhanced surveillance on hepatitis B positive mothers and infants which started on 1 April will be able to add to the evidence and assist in changing these policies.

There was discussion on legal responsibility of producing treatment guidelines and whether the BVHG holds this responsibility. It was suggested PHE are most likely to hold this responsibility. Once new data emerges to change guidance this will need to be discussed in the correct fora.

3. Update from HCV issues

3.1 HCV Prevention workstream

GT updated the group on prevention and harm reduction work in NHSE/I. Despite success of the elimination programme, PWID and re-infection have been identified as key weaknesses. A working group has been set up by NHS/PHE to address the issue, key projects include:

- Mapping of OST and NSP in England to understand who and why people are not accessing services
- A 'low dead space' task and finish group to increase provision of low dead space equipment, as this was successful in Wales.
- Group to enact on findings from Dame Carol Black review

PV elaborated the term low dead space refers to the volume of space left in a syringe after plunger pushed, which can retain blood. This space is generally larger with detachable syringes. Work is ongoing to increase availability of detachable syringes with lower dead space. Whilst little evidence that lowering volume of blood left in syringe reduces risk of BBV transmission at a population level, laboratory evidence indicates there is detectable virus remaining in certain syringes. As the cost difference is so low between equipment, only a small effect is needed to make this a cost-effective intervention.

3.2 / 3.3 Recent progress and recovery work and elimination initiatives

GF presented an overview of recent activities and progress towards elimination. Key points included:

- Estimated 30,000 actively infected individuals, concentrated in drug services, needle exchange, prisons, homeless.
    - CGI, the largest addiction service provider are monitoring and incentivising services, have high involvement providing data and feeding back to networks. The reductions in testing and treatment from coronavirus (COVID-19) are back to half their treatments levels compared to pre-pandemic. Most injectors have now been tested with estimated prevalence of 15%, the majority of which are now treated.

    - Funding is being allocated to the poor performing drug addiction services.
    - Putting peers into networks increases numbers of individuals treated by about 12%.
    - Struggled getting into needle exchanges due to COVID-19, hoping to access more in next 6 months.
    - A pilot programme to allow community pharmacies to dispense medication in London is planned, with hope this will move to increasing uptake of testing subsequently.
    - 30 prisons have now been tested and treated with 70 to go.
    - Testing in A&E has begun in some ODNs, anticipated to be an effective component in the future.

- 34,000 with past risk factors for HCV.
    - Most of which are immigrant populations or past injectors, awareness campaigns have been launch in south Asian community in June.

- Unknown amount of unknowns.
    - A trial is underway to test a cohort of 100,000 random people without risk factors to identify any other cohorts that remain untested.
    - Sexual health and maternity screening initiatives being considered to investigate.

It was raised to the group the importance of understanding re-infection and new infection. This will inform if current strategies will be effective and it was requested that the group looks to answer this question as a priority.

The group discussed various possible routes and challenges to achieving HCV incidence figures, some solutions included:

- Molecular work if capacity allows in PHE. Good sequencing can be achieved from DBS results.
- Avidity testing would need significant development, but may be possible, although funding would be an issue.
- There is an NIHR study to sequence those with acute infections and understand transmission networks.
- There is scope in PHE current datasets to investigate serial testing and re-infection and plans are in place to use these.

GF suggested funding might be available from NHSE elimination initiatives which have increased by 25% in 2021/22.

Action 2: Subgroup to meet to discuss how to fund or design a study to estimate HCV incidence.

The terms of reference for the NHS hepatitis C data group were shared with the group.

3.4 Update from Hepatitis C Trust

RH gave an update of recent work undertaken by the Hepatitis C Trust and key problems encountered. These included:

- The Hepatitis C Trust has been working with NHSE across most elimination initiatives.
- A pan London testing van is about to go live.
- Testing in prisons is increasing and whole prison testing events are re-commencing.
- In response to HCV incidence ascertainment the peers at the hepatitis C Trust could obtain qualitative information.
- Where re-infections are identified in some prisons tracking and tracing who they have been using drugs with has begun.
- The term micro elimination has been used but this isn't properly defined or when is it appropriate to be declared.
- On the infected blood Inquiry, a commitment has been made to a compensation framework, hearings are about to recommence.

Action 3: RH asked for future meeting with PHE to determine and define the term micro-elimination.

3.5 HCV Dashboard and pathway implementation

PV showcased new developments to the HCV dashboard to the group. Major changes included:

- A move from Excel/PDF to PowerBI.
- Data can now be viewed by CCG
- New indicators are included from the HCV treatment registry

CP presented recent updates on HCV Care Pathway Pilot Workshop in Nottingham ODN. This is a framework for operationalising ODN data with key stakeholders at a local level. The workshop received good feedback which will be evaluated for implementation at the next meeting in the summer.

3.5 PHE reports update – UAM

SC reported a summary from the 'Shooting Up' report published in December 2020, an annual report of infection in PWID across the UK.

Key highlights included:

- HBV infections among PWID are down from 16% in 2010 to 9.5% in 2019. About a quarter of PWID have never been vaccinated, which was particularly low in under 25s.
- Prevalence of HCV antibodies has remained stable in recent years, except in Wales where antibody prevalence has increased 32% since 2010, consistent with high risk/frequency injecting behaviour.

- There is early evidence chronic HCV might show a modest reduction in recent years likely due to an increased uptake of DAA.
- Uptake of HCV testing has increased 5% in 2019.
- Proportion of PWID that report seeing a specialist for their HCV infection increased 19% between 2011 and 2019.
- There was no change in risk behaviours over time.
- Preliminary data suggest COVID-19 pandemic has had an impact on PWID service provision. With difficulties accessing drug services and increasing risk behaviour.

The group discussed methodology of the UAM survey and SS suggested an update is needed as the survey was first drafted 30 years ago.

4.0 – Update from HBV issues

4.1 HBV Immunisation and screening enhanced pathway

IH highlighted that the Enhanced Hepatitis B Antenatal Screening and Immunisation Pathway was launched on 1 April 2021 and guidance for this was published in December on gov.uk.

4.2 HBV elimination strategy and report

RS informed the group that PHE are collating data for the hepatitis B which will help identify gaps in our knowledge. Systematic reviews on case finding are underway as well as work on data linkage to identify underserved populations.

WI asked when a draft is available this is circulated for further discussion.

4.3 SaBTO Occult Blood Infection Working Group update

WI updated the group on SaBTO recommendations which were to universally screen donors for anti-HBc once to try to identify those with occult hepatitis B. This was to reduce the risk of HBV transmission via blood transfusion.

5.0 Update on HEV

SI presented on the establishment and results of the surveillance of chronic hepatitis E at PHE. Key points included:

Diagnostics and testing

- Developments have been made in diagnostics to include RNA testing and stool testing to guide treatment.
- Of 94 initial cases, majority of are from solid organ transplant setting and small number in HIV infected individuals with low CD4 counts.
- Of those with biopsies or scans, 25% had advanced liver disease, 25% mild and 50% had no evidence of significant liver disease.
- There was evidence of delays in diagnoses with median 38 weeks of viraemia before HEV diagnostic testing was initiated.

- Median viral load at diagnosis was high at 1.8 x 10^6 IU/ml with all being HEV G3 (80% clade 2). 82% were HEV antibody positive, which indicated relying on antibody testing only wouldn't pick up all infections.

Treatment and outcomes

Several treatment pathways were commenced for the patients:

- 8 reduced their immunosuppression levels, resulting in 6 viral clearances.
- 2 were treated with PEG-IFN resulting in viral clearance in both.
- 65 were treated with Ribavirin, 48 reaching viral clearance.
- 15 of those with outcome data died with viraemia.
- 16 had a virological rebound (11 of which had no detectable RNA in plasma or stool at treatment cessation).
- Seronegative patients at diagnosis may have poorer outcomes with 42% suffering relapse following treatment cessation.
- Large range of Ribavirin dosage used, 64% had dose reduction due to side effects.

SI asked the group to consider the broader range of patients at risk outside solid organ transplant and raised several questions to the group. praised the value of available BTS guidelines although raised the issue of relapse despite them being followed. Several questions were put to the group:

- How to address the delays in diagnosis and underdiagnosis?
- What can be done to raise awareness of persistent chronic hepatitis E?
- How to understand the factors associated with virological relapse?
- There is a lack of samples coming through at 3 to 6 months to confirm SVR despite guidelines recommending them. How can this be increased?

Work to increase case capture through SGSS is in the pipeline at PHE and there is potential to explore data linkage to other outcome databases.

The group discussed the questions raised and concluded the first step would be to identify other centres undertaking testing via sentinel surveillance system at PHE. Transplant clinics both solid organ and haematology oncology should be the targets to raise awareness. AE suggested going through advisory groups or undertaking a national audit of physician awareness. Questions were also raised if there is enough messaging around food safety.

AE raised an initiative NHS spine project allowing clinicians to view lab results for any patient across the country, although this is still preliminary stages. This may allow wider access to results needed to investigate outcome data in the future.

The group discussed if searching GP databases for raised ALT or using primary care algorithms might be effective and concluded this would be expensive to find small number of patients and using algorithms in primary care for HCV have not been that successful, with large numbers of individuals with raised ALT and very few seeing a hepatologist.

Two issues remained, firstly collating information on diagnosed cases of HEV, the first step being to identify which sites are undertaking HEV RNA testing. Secondly the issue how to

raise awareness of undiagnosed patients, progress is mostly needed across haematology/oncology patients rather than in solid organ transplant. Groups writing guidelines for these patients could be approached to raise awareness and incorporate testing for HEV.

Action 4: SI to identify a haematology/oncology contact to invite or start discussions with to and raise awareness to encourage testing in this patient population for HEV.

Action 5: WI raised a call out through CVN could be made to identify who is doing HEV testing and

Action 6: RS to compile data from PHE Sentinel surveillance on sites currently undertaking HEV testing.

6.0 – Inoculation and human bites SOP

MG raised an issue from the PHE Inoculation and Human Bites SOP about testing for BBV after an injury. Current advice is to take a sample post incident and store for 6 months without testing. It was asked whether this was still appropriate in the climate of encouraging BBV testing and what other guidance might exist that still recommends this.

The group discussed the benefits and rationale for testing recipients of injuries, and concerns were raised that operationally laboratories would find testing all or offering baseline testing to all recipients upon consent difficult as often clinical information received with samples from needlestick injuries is poor. It was recommended that guidance remains as it is currently.

7.0 – General update of HAV

KB briefed the group about an outbreak of HAV identified in people eating dates which has been ongoing since January. Based on evidence provided by PHE and the Food Standards Agency the specific food product lines were withdrawn.

RS highlighted another cluster of HAV is under investigation in a traveller community.

8.0 – Update on HDV

WI informed the group Gilead have announced a grant scheme with particular interest in HDV, inviting bids to understand the epidemiology of HDV in the UK.

9.0 – Research update

This item was deferred to the next meeting.

10.0 Any Other Business

GA wishes to begin more collaborative working between the devolved administrations to discuss and share experiences and progress towards elimination. It was suggested to start a smaller group with attendance from each devolved administration's public health agencies. Attendees from England and Wales welcomed the idea and would take this forward outside the NSGVH.

The Chair thanked those in attendance and advised the group meet in 3 months' time with a hope that this would allow for an in-person meeting.

Actions from 29 April 2021 meeting:

Action number	Action	Who
1	UKHSA Organogram to be shared with the group when available	IH
2	HCV incidence meeting to be set up	WI & IH
3	PHE and Hep C Trust to discuss and define the term Micro-elimination	RS & RH
4	Identify a suitable contact from the Haematology/Oncology field that can influence guidelines to promote awareness around testing for HEV	SI
5	Call out through the CVN to identify who is undertaking HEV testing	WI
6	To compile data from PHE Sentinel surveillance on sites currently undertaking HEV testing.	RS