

Screening by invitation:

using GP patient registers to invite people born in endemic areas for viral hepatitis screening

Who are you?

My name is Jan Kunkel and I am a medical doctor and Hepatologist in training based at the Blizard Institute part of Queen Mary University of London. Together with my colleague Prof. Graham Foster, I coordinated the HEPscreen pilot project in East London. We were supported by colleagues in the Clinical Effectiveness Group (CEG) of the Blizard Institute¹, Yasmine Koodun, an administrative worker from our team, Dr. Jose Figueroa, Deputy Director of Public Health for Hackney Borough, and Prof. Jane Anderson, Director of HIV services in the local hospital.



Where are you based?

The Blizard Institute is based in Whitechapel, East London. The researchers in the Hepatology Team also have clinical roles in the Royal London Hospital's Hepatology Unit, which is a tertiary referral centre for hepatology cases from the surrounding GP practices and District General Hospitals in East London. For the HEPscreen pilot we worked with GPs in the East London borough of Hackney, a municipal area of 250,000 people. From the 2011 Census, we know that around 40% of people in Hackney were born outside the UK, half of whom have been resident in the area for 10 years or more². Epidemiological data also tells us that many of these countries of origin are also medium to high hepatitis B/C prevalence countries.

Which population did you hope to reach? Why was this group targeted?

We aimed to reach people born in medium to high prevalence countries, specifically Turkey, Pakistan, Nigeria, Ghana and Somalia. Alongside a higher risk of chronic hepatitis B, due to exposure to HBV as infants and children in countries of origin, and of chronic hepatitis C, due to exposure to unsterile medical, dental or shaving equipment, studies also suggest poorer outcomes from

viral hepatitis related-liver disease. For instance, studies show an increased risk of end stage liver disease from HCV in people born in Pakistan living in the UK. As the proportion of people in Hackney that are registered with a GP is very high, we worked with two GP practices which, according to population reports, should have a substantial number of registered patients who were born in these countries.

What did you do?

We used ethnicity and time since registration as variables to select across the two GP practices a sample of 1000 people that were expected to have been born in medium to high prevalence countries. We then invited people by letter to come to the practice for testing for viral hepatitis. We developed a randomised control trial model where half (500 people) were randomised to just an invitation for viral hepatitis and the half to viral hepatitis and HIV testing. Randomisation was at individual level and care was taken to randomise participants sharing a household in mini clusters to the same study arm (i.e. with or without HIV). Along with the invitation letter, all participants were sent an information sheet about the project. These were available both in English and in Turkish (for people whose first language was

¹ <http://blizard.qmul.ac.uk/research-groups/253-clinical-effectiveness-group.html>

² http://www.hackney.gov.uk/Assets/Documents/HWP-Chapter-1The_people_of_Hackney_and_the_City.pdf

recorded as Turkish). A requirement of the ethical committee decision to approve the study was that potential participants had to opt in i.e. make an active decision to come to the surgery and be tested. Ethical requirements also prevented further follow up of people invited via the telephone although a proportion did receive a second invitation by letter if there was no reaction to the first one.

Did you provide language support to people offered testing? Translated materials or interpreters?

We translated the materials sent out to people offered screening into Turkish.

What training did you offer to workers involved either in inviting people for an offering testing?

The GP practice staff did not require training as their task in the pilot was very similar to their day to day activity i.e. book potential participants who 'phoned the practice into the HEPscreen clinics. Yasmine received brief training was given on how to invite participants by letter.

When did this intervention take place?

Our pilot took place between September 2012 and October 2014, including the time it took to submit to and receive approval from the ethical committee.

What was the uptake? How many people benefited from the intervention?

Uptake of the offer of screening by invitation was 2.3% (n=13/560). We also didn't identify any viral hepatitis or HIV.

What are the key lessons learnt? If another service were to replicate your model, what advice would you give? What would you do differently if you were to repeat the intervention? What would you repeat?

As we received a disappointingly low uptake, we wouldn't replicate this model in this way. Part of the problem could have been due to the difficulty of implementing this approach as a research study since the ethics committee and R&D decisions required a long planning phase and subsequent decisions included conditions that made it very hard for an invitation-based RCT.

For example, a big drawback in our study was that we did not have ethics permission to give invited individuals a follow up telephone call, which probably had a substantial negative impact on participation. We would advise others to ensure phone call reminders are part of the screening campaign. New/social media could also be explored as a way to raise awareness. However, GPs to offer testing is very promising but it is essential that screening methods are kept very simple due to GPs' limited time. Try to integrate screening via invitation within existing GP infrastructure. For example, the use of IT systems could be very helpful to prompt GPs to offer screening to people who attend the practice that were born in medium or high prevalence countries.

