Paul John and Rhys Oakley - Blood Borne Virus Specialist Pharmacist Transcript

Introductions

Rhys Oakley

My name is Rhys Oakley, I'm a pharmacist from Cardiff and Vale working in infectious diseases.

Paul John

My name is Paul John I am the all-Wales blood borne virus community lead pharmacist. So, our roles are to expand on blood borne virus testing and ultimately leave no one behind when it comes to treatments. We mainly work out of the hospital sector. However, we are expanding into prisons, community pharmacies, outreach posts - wherever we can find our patients, we will obviously go to. We are part of a huge team in Wales, a very experienced team, working to achieve the World Health Organisation goal of eliminating blood borne viruses by 2030.

Impact of the roles on healthcare

Rhys Oakley

In addition to what Paul has mentioned, we also offer a migrant health screening service which picks up individuals with some of these blood-borne viruses. We see these individuals away from the hospital setting, in a setting that is more familiar to them; but also note, this is due to the lack of funding given to migrants through the governmental systems. It's [actually] more appropriate that we deliver care closer to their setting where we're able to pick up peo-ple with blood borne viruses more quickly, engage them in care, and provide them with the long-term care if required, or offer them treatment rapidly. My role was a new role in post in the Health Board and was unique. It has essentially been a job that I have made into something that I want it to be; very much integrating with marginalised communities and reaching out to them and taking every opportunity that is available, working as part of a multidisciplinary team, to promote the role of pharmacy within that team, and with the ultimate benefit in impacting on patients' healthcare.

Paul John

My role was created by Public Health Wales when they identified a need to test in community pharmacies and in pris-ons. We've started introducing a new enhanced service into the community pharmacies, especially those who have opportunities to test patients that have access to needles, for methadone, for buprenorphine - the high-risk patients that have come into contact with hepatitis - those are our target at the moment, but again, we're expanding through all the health boards as fast as we can, and efficiently as we can, to reach our target by 2030. Service users were ini-tially taken a little aback, because the testing had been different in years gone by. It's been typically venepuncture samples, and with the injecting drug use, the veins aren't always easy to access. As time has moved on, our technolo-gy has changed, we've introduced things like the oral lateral flow test, which has a 20-minute window to produce the results (very similar to COVID). This is a real game changer. We've also been doing dry blood spot testing as well, which just involves quick fingerprick tests. That's opened a whole new world to quicker results, and by quicker results we can then get them onto treatment quicker. Without our roles I fear that we would have a progression in liver dis-ease and infectious diseases because of the nature of hepatitis C. It takes quite a number of years to progress to the end game, but this can be quickened by lifestyle choices such as alcohol and medication. I think the service users took well to it in general.

Challenges, rewards and developments

Rhys Oakley

So, from my colleague's perspective, I think we've been very grateful to have pharmacists on board in terms of hope-fully achieving the W.H.O. target of eradicating viral hepatitis by 2030. The treatments for hepatitis C were revolution-ised in 2015 with the advent of the directly acting antivirals and some of these first-generation treatments had lots
of drug interactions which needed the expertise of pharmacists to interpret these interactions and make sure that the patients were able to benefit from therapy. We were also integral to making sure that therapy was delivered cost effectively through the development of the home care systems in the different health boards. We've also been able

to develop national guidelines as a team to promote prudent health care, ensuring that all individuals get the same access to therapy, and that it is very clear on what therapy should be offered in what situations.

Paul John

I suppose, because of the demographics of the patients that we work with, they do need a lot of encouragement to stick to, and adhere to, the medicines that we're doing. We've had projects in the past and Rhys is running one now, where [patients] are filming themselves taking medicines and sending videos in, again, just for encouragement and reminding them to take [their] medicines. They are living in various places around Wales, whether that's in shelters, in tents or in homes, so it's a reminding factor of how important it is to finish their course of antivirals because at the end of it, it's a cure, and a cure for life, as long as they don't put themselves at risk.

Benefits

Rhys Oakley

The benefit of treating Hepatitis C is that we prevent the sequelae of long-term hepatitis C, such as the development of cirrhosis which can lead to hepatocellular carcinoma, needed liver transplantation, or death. By treating hepatitis
C early, all those consequences can be prevented; we are able to get in that early. Anyone diagnosed with hepatitis C, we get onto therapy as quickly as possible. We get them on therapy early to prevent the the consequences of untreated hepatitis C, as well to prevent the transmission to other individuals and reduce the impact on general public health. Hepatitis C used to be the leading cause for liver transplantation in the UK; however, hepatitis C is no longer the leading cause and there's actually a downward trend in the number of individuals that require liver transplantation. This is a result of the treatments that are available for hepatitis C and the good work that the teams across Wales, and in the UK, are doing in terms of testing individuals, [in ways] that actually engage them, getting them on therapy, helping them through therapy, making sure that they eradicate hepatitis C, whilst also also providing them with the harm minimisation. How do they prevent themselves from getting hepatitis C again? How can they link their peers into treatment? There's a lot of good work that has gone in, which all results in a massive benefit to patients and wider public health.

Lessons learned

Paul John

I've touched on the part of encouragement, really because I think that's one of our lessons learned - if we simply provide the medicine to the patients without this sort of encouragement, there is a minority to some degree won't be cured because they haven't taken it; and again, that leads to resistance. In the NHS specifically, that resistance is something that we obviously don't want because that means re-treatment costs and variations in that virus as well. So, there is one thing that we have learnt, which is to very much encourage and stick by these patients throughout their whole journey. I think, when we look at the bigger picture, medication and life changing health benefits are
not on their list, which is more about food, shelter for the night, even drugs and money; [medication and life chang-ing health benefits] come very low on that list. So again, we want to stick with them throughout the whole of the roadmap. I think that's part of our role, as well as of the nurses', and we have a great band of nurses and consultants. We have slowly started to train up people in the substance misuse services - in pharmacy settings, in any outreach settings that really want to engage with our cohort - and we train them over a day. We tell them all about hepatitis
C and the blood borne viruses; we train them up in the point of care testing that's been given to us by Public Health Wales; and obviously that leads to the main benefit of the patients getting cured and in the long term will save a lot of consultant time, medication operations, and transplant lists if we hadn't cured them at this stage.

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Outcome

Rhys Oakley

As a consequence of the improvements in the therapies for hepatitis C, other patient groups have been able to benefit from treatment for it. For example, Cardiff was the first centre in the UK to offer kidney transplants from hepatitis C positive donors to a negative recipient and be able to develop a rapid protocol to treat these individuals, which ulti-mately has a benefit in terms of reducing waiting list times for people who need kidney transplants. We are now get-ting other centres across the UK who are looking at what Cardiff developed and implemented and trying to replicate it so that other people across the UK can also benefit from therapy.

Paul John

The World Health Organisation have set targets for hepatitis B and hepatitis C - to reduce the incidence by 90% and reduce mortality by 65%. So that is our end game, to basically diagnose at least 90%, and to treat as close to 90% as we possibly could. That will bring mortality down. The World Health Organisation strategy that every country in the UK signed up to, Wales, England, Scotland, Ireland, as well as other global countries, is working towards achieving its goals by 2030, if not before.