Transcript of interview with Tim Root: Medicines Supply Issues

TR: I'm Tim Root. I am recently retired Assistant Head of the NHS Specialist Pharmacy Service. We as in the Specialist Pharmacy Services, we are commissioned by, the service is commissioned by NHS England. We've obviously always had relatively close links with NHS England, less close probably direct links with the Department of Health and Social Security – DHSC – and links with the regulators and with what then was Public Health England is now the UK Health Security Agency – UKSA and those relationships certainly developed, evolved, matured very rapidly during the course of the pandemic in both phases one and two.

TR: We've always said we have four essential functions – medicines procurement which is probably more accurately called medicines supply; the medicines use and safety team; the quality assurance function and what we used to call in the old days medicines information, we now call medicines advice.

TR: I think we are here to talk about the role we played, that is in the whole Specialist Pharmacy Service played in the pandemic which for me falls almost into two parts. The Phase One when my involvement was mainly around medicine supply issues and Phase Two when it was almost entirely on Covid vaccines.

TR: so I guess one of the first things we started to do was think, think very seriously about what the impact might be, how we were going to identify the impact and what we might be able to do to influence it and mitigate the risk of significant supply disruptions. It fairly quickly became apparent that one of the major pinch points was going to be critical care. So yes the second group that was formed and really took the lead on oversight of the medicine supply issues in phase one – the first year of the pandemic - was the allocation and distribution group which Justine chaired and that reported into the MSRG and that group developed and maintained a program of work to monitor in many cases drug by drug on a twice weekly basis exactly how the supply chain was performing.

TR: For me at that stage my involvement really developed into two aspects primarily; not only was the focus obviously very much on injectable medicines for critical care, to provide as much as possible in the way of mainly pre-filled syringes because workforce issues were obviously a tremendous issue, and very rapidly there merged a demand for as many as possible medicines in a ready to inject form to save time and reduce the risk of errors associated with preparing these things in clinical areas and we focussed that effort on mainly four medicines – Midazolam, Morphine, Noradrenalin and Fentanyl.

The other area in which I became progressively involved was that as UK licensed medicines of all sorts came into shortage or as supply problems loomed we were often in a situation where we were forced to consider imports which produced a lot of challenges about assuring that these products before they were even procured, ensuring that if we did bring these things in that they were packaged, labelled and could be made available to clinical staff in a form that was actually safe for them to use, as in the packaging was understandable, was either in English or was unambiguously in A) another language and if and when it wasn't that we could provide resources to ensure that it was safely usable.

For a time money was no object and then of course it became one again, and there were discussions about well what if people don't buy these things? What if they go to waste? Who is going to underwrite the risk of wastage etc.? We started to produce these things in

significant quantities and as I say, by no means solved all the problems which faced ICU staff but it certainly mitigated some of them.

The last aspect I should comment on is the whole medical oxygen scenario, because never at any time was there a shortage of oxygen. We were probably close to capacity but the issue was getting it into the cylinders and getting the cylinders where they needed to be when they needed to be there and getting them refilled and particularly within sites, it was about distributing oxygen around hospital sites in quantities at rates of use for which we simply were not configured, and that you can't suddenly develop a piped oxygen supply to an area of a hospital, a ward, possibly a set of wards, where the infrastructure simply did not exist. You can't solve that sort of thing overnight nor can you suddenly produce two or three times the amount of cylinders of oxygen which you previously used because the empty cylinders don't exist.

TR: Oxygen concentrators became part of the picture, especially small concentrators for home care, but again the number of oxygen concentrators available was nowhere near the potential scale of demand.

TR: Many, many times were really concerned that we were going to be simply without essential critical care medicines. The nice warm feeling inside is of course is we never were. It was pretty close to the wire sometimes but everyone needs a huge amount of credit for the fact that we never, ever completely ran out totally of anything and that was not by accident; it was because a lot of people sweated blood and tears and made it work so that's, that's definitely something that I will always remember and it's something that we can all be very, very proud of.

And the last thing I should really have to say is a massive thank you. I've been privileged to work with a lot of very generous, very skilled, very kind, very knowledgeable people and it's only because of them that we were all collectively able to do what we did. Thank you.