Witness Name: Josh Miller
Statement No.: 1
Exhibits: None
Dated: 21 June 2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF JOSH MILLER

I, Josh Miller, will say as follows: -

Overview of my professional role

1. I qualified as a fully registered pharmacist in August 2019 after completing my mandatory pre-registration year. I began my role as a rotational clinical pharmacist working within the acute sector of a large health board within NHS Scotland. As a registered pharmacist with the General Pharmaceutical Council, I am governed by the regulations to abide by the standards for pharmacy professionals. These are nine standards that every registered pharmacy professional is required to meet at all times, not just during working hours. As a role, a clinical pharmacist is expected to provide pharmaceutical care to patients, working either autonomously or within a multidisciplinary team to provide expert knowledge in the usage and administration of medicines. This can include (but is not exhaustive) patient counselling, prescribing, medicines safety, medicines governance and clinical trials. A particularly important role within acute sites is the clinical screening of prescriptions enabling supplies of medicines to be made and facilitating safe and effective discharge to patients medically fit to return to their place of residence. My role also included providing extended hours of service such as on-call where clinical advice could be sought out with core working hours (9 am – 5 pm) for medical teams working overnight.

2. I have been a board member of the Royal Pharmaceutical Society (RPS) since 3rd June 2022. The RPS is the professional leadership body for pharmacists within

England, Scotland and Wales. Within this role, I, alongside my fellow board members promote the society and help influence and direct the work plan for the society. This includes Great Britain wide work plans as well as Scotland-specific. I was approached to give evidence within the inquiry through my work and association with the Royal Pharmaceutical Society.

Impact on my role during the pandemic

3. During the relevant period, I worked primarily within medical specialities, specifically respiratory and acute medical wards. Typically workforce resources and staffing would suggest that one pharmacist would care for 1-2 wards per day. Within the site where I worked during the relevant period, these wards consisted of 30 beds each – this was specifically four 6-bedded bays and six single-bedded "side" rooms. Initially, patients with confirmed COVID-19 infection were admitted to "side rooms" to enable appropriate isolation and infection prevention protocols. As the prevalence of COVID-19 infections rose, there was limited capacity to facilitate the isolation of these patients, considering that these "side rooms" were also utilised for other infective measures for communicable diseases (for example infective diarrhoea, tuberculosis). These side rooms were also previously used for patients who were in the end stages of their lives and offered families privacy and patients' dignity when palliated.

4. During the relevant period, COVID-19 infections became more common, and over time there was evidence of patient infection within ward areas. These began to affect 6-bedded bays, which resulted in these areas being "closed off", and all patients within these bays isolated. While my role did not substantially change, my procedures and processes had to be adapted to satisfy infection control protocols, but also protection of myself and others. Examples include the inability to speak to patients face to face, as we were advised to limit exposure to COVID-19 infected patients, alas we were also unable to review the patient's own medicines, since there was limited information on the pathogens ability to survive on surfaces, such as medicines packets. These were all processes which make the pharmacist's role incredibly difficult as often times we would assume multiple factors when reviewing a patient without confirming it with the patient their self. For example, assuming patients take their medicines perfectly as

prescribed, while we know upwards of 25% of patients deviate from the prescribed doses, instructions or timings.

5. One of the main roles within a clinical pharmacist's duties is performing a medicines history, where the pharmacist and patient work together to reconcile an accurate list of medicines (prescribed, over the counter and illicit) so that this can be prescribed and/or amended. NHS policy would state at least two sources should be used, including one patient-centred – this would typically involve the GP record and patient or family member confirmation or confirmation of physical medicines brought in by relatives or ambulance colleagues. During the period there was a consensus that we (as a pharmacy team) should limit face-to-face exposure to confirmed infected patients and there were times I could stand outside patient rooms and confirm their medicines while speaking to them using their mobile phones (if they had one, or where able to do this, patients proned and ventilated evidently couldn't). There were also times were we would simply accept that we may not be able to achieve a patient-specific source and as such the reliability and accuracy of our medication histories and reviews were sub-optimal. While I am unaware of any errors made, from published data, we know that patients do not always take medicines as prescribed, and as such there may have been times when patients were inadvertently prescribed incorrect doses (or different to those the patient was taking before admission).

6. A further change to practice included the inability to adequately counsel patients. Counselling is a fundamental part of patients being aware, informed and engaged within their healthcare. During the relevant period with a large proportion of COVID-19 infections and limited access to appropriately fitted masks, it became increasingly hard to discuss treatments and medicines with patients. Patients at times were prone (positioned face down to aid oxygenation) or on loud and noisy oxygen delivery devices which were extremely uncomfortable and distressing for patients. I often had to resort to contacting family members instead of discussing with patients formally.

7. There was very limited evidence regarding the resonance time of the COVID-19 virus on surfaces, as a result when patients were moved from one area of the hospital their physical notes were "bagged up" and could not be accessed for an ambiguous amount of time. This often prevented me from reviewing patients or reviewing them

appropriately without adequate information regarding their care and management in other areas.

8. As there was a fall in non-COVID-19 admissions, the activity in other ward areas did seem reduced. Within the hospital site where I worked, we were actively supported to consider using annual leave. The usual restrictions were lifted and it resulted in less staffing during the relevant period. While this was a positive step to try and manage wellbeing and support colleagues, it did often feel like a tactic to avoid excessive carry which would burden the organisation in later years. This alongside colleagues contracting the virus and self-isolated resulted in direct increases on the number of patients I was expected to see. There were times during the relevant period were I would be responsible for 3-4 wards, with a total of up to 120 patients (when full). It was felt that the pharmacological involvement in the care of patients with COVID-19 especially in the earlier months of the period was less complex and usually consisted of steroids and supplemental oxygen. Therefore in my opinion the pharmaceutical needs were not as great, and often meant that while the expected patient load increased, the workload felt like it did not. This may have been due to a variety of factors, including the most complex pharmaceutical patients (such as elderly frail patients or those with co-morbidities with polypharmacy) shielding and less likely to be admitted.

9. There was also the issue of rapidly and daily changing landscape of advice, policy and protocols. Working conditions became strained as colleagues struggled to process the events that occurred on a daily basis, and a once friendly office space became socially distanced. Within the specific site where I worked, there was lack of available space for individuals to abide the distancing rules, and many started work and left straight from the ward areas. Professional and personal isolation became commonplace.

10. As the relevant period progressed there was more evidence published and therefore more clinical guidelines which aided clinicians and pharmacists on how to deal with and treat patients. Certainly, during this time my role changed and I became directly involved in daily huddles where the escalation of treatment was discussed. I was expected to disseminate and share findings from national guidance, clinical trials and availability (alongside eligibility) of new or novel treatments. These included potent

immunosuppressants (such as tocilizumab) or novel anti-viral treatments such as Ronapreve or Paxlovid. The landscape of the clinical management of COVID-19 infection changed significantly and to some degree felt like this happened weekly. While I was not expected to, I did feel the need to ensure I remained up to date and it often relied on me reviewing updated guidance after work hours and disseminating it to colleagues. There were times were treatments would be available for specific patients one day and then restricted the next. It was the first time I felt a moral and compassionate strain which I had never experienced prior.

11. During 2020 I was up-skilled in working within the high-dependency unit and following the appropriate local training packs. However this, and I presume all other training materials did not apprehend the vast magnitude of the pandemic and the unpredictability of the disease and the management. I certainly did not feel as confident as I would have liked to, however I sensed that this was a shared feeling between most of my colleagues. Within the hospital site where I worked during the period, the pharmacy team were responsible for oxygen supplies. There was times where there was real concern regarding to the potential shortage of oxygen to support the ventilators and oxygen demands infected patients required. The on-call pharmacy team were advised to become prepared with the potential of out-of-hour call outs requiring a much more physically demanding role, including moving and handling of oxygen cylinders, which was historically done by portering staff during core hours. During the relevant period I never reviewed or was risk-assessed to complete such a task, which is certainly not risk free.

12. As stated above the pharmacy team were encouraged to take annual leave and leave early when required. The on-call rota continued however with sporadic and often unexpected staff illness or self-isolation it often resulted in ad-hoc extra weekend or on-call shifts, further resulting in added pressure and potential for professional burnout. As this was during the lockdown period there was limited opportunity to "switch off" after work. And many of my colleagues used this time to complete additional portfolio tasks which supported our development, this included the post-registration foundation training program for pharmacists. While this was by choice, it seemed a logical opportunity to complete tasks which were otherwise difficult to complete in my substantive post (prior to the pandemic).

Adequacy of IPC and PPE

13. As with the changing landscape of the management of COVID-19, there was rapidly changing guidance on the use of infection control measures and personal protective equipment. Within the initial phases of the pandemic, standard infection control measures were required when entering a COVID-19 room, this included a yellow single-use protective apron, one-use non-sterile gloves and a single-use fluid resistance mask.

14. Within the site where I worked, we would adhere to the most up-to-date guidance on personal protective equipment (PPE). There did seem to be ongoing confusion as to whether the pharmacy department should be classed as a "clinical environment". While we sought advice I do not believe we were ever given a clear answer. This did result in a range of different interpretations from colleagues within the department. While I did not find it, I am aware that there were instances of stigma associated with deviation from the published guidelines. There was to my knowledge ample supply of personal protective equipment such as fluid-resistant masks and gloves.

15. As I had been trained prior in critical care areas, I was asked to be "mask-fitted" to an FFP3 mask. Due to the capacity of mask testing, only a select few members of the pharmacy department were put forward for this. While I do not recall any stigma or bias associated with this, I could see why there may have been, contentious for others, given that the FFP3 masks were seen as "more protective". The process of the mask fitting within the site I worked was rigorously organised and a variety of marks were available, however upon reflection, I am aware now that certain masks became unavailable and such colleagues were called to be re-tested. Plastic visors were also introduced in the latter stages of the relevant period, and while I don't recall specific guidance on the use of these, it did seem from my recollection that these were in "shorter" supply and staff were encouraged to keep these and re-use. Again I don't recall specific information on the re-use suitability of these plastic visors and if these should be cleaned and if so with what.

16. With a larger patient cohort to care for, there was concern regarding the movement of team members between "red" and "green" areas. While the site tried to limit individuals covering both area types, with more relaxed annual leave parameters, there was often no choice. Again from my recollection, there was loose guidance to try and avoid returning to "green" areas when having been within a "red" area. The role of the pharmacist can often be dictated by workload, and this often is limited by discharge prescriptions. These are produced at random times throughout the day, and as such, there were times were I may have had to attend a "red" area to facilitate and discharge and then return to a "green" area to do the same. I would try and facilitate these prescriptions remotely, without entering the clinical area, however often there would be clarification that had to be sought and this movement between areas was unavoidable.

17. In hindsight, we know that some of the infection prevention and control measures suggested during the earlier parts of the pandemic were not adequate, and potentially put patients at risk.

The long-term impact working through the period had on me

18. Having worked in potentially a once-in-a-lifetime pandemic of this magnitude it has made me extremely thankful for the tenacity and dedication of my colleagues and wider clinical teams throughout the country in unprecedented times.

19. I have become far more cynical in my views of the trustworthiness and appropriateness of the political leadership that was directing the rules and regulations forced upon patients and the population. While it was clear that it was a rapidly changing situation, I do believe that there were unnecessary delays that I suspect cost thousands of lives.

20. I think that on a more human level, I am much more understanding of the importance of mental well-being for both colleagues and patients. While I was aware of the importance of this during my youth and undergraduate years, working through such a traumatic time has certainly had a profound impact on the way I approach difficult conversations or patients/colleagues who are struggling. I would like to think that this has bettered my clinical care, leadership and management of others for the better.

This is much the same for "burnout" and being able to identify this and proactively support colleagues prior to that stage, which I feel was not always done within the pharmacy setting before the relevant period.

21. Having been still fairly naïve to clinical practice when the pandemic hit, upon reflection I was surprised at how subjective the management of those infected was. When attending daily meetings discussing the escalation plans for patients (i.e who was given a chance in critical care settings) it was very evident that there was very limited information on the prognosis of patients at that time, and it seemed almost that the inclusion was almost arbitrary. Often it was dependent on who was present, how much emphasis the presenting team made, what the patients "mobility/frailty/past history" was and how busy or full the critical care unit was.

22. When considering standards and guidance, we as a team were always following the most up to date policy, although there were times were potential "guidance fatigue" became apparent. Consistency with mask wearing or social distancing slipped, perhaps more apparent in the times were colleagues were under strain and stress.

23. I would like to think that if this scale of a pandemic were to happen again, there would be a much quicker mobilisation on personal protective equipment and guidance would have been clearer in regards to who it affected, where it should be adhered to and why this was the case.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Personal Data

Dated: 21 June 2024