- Presenting Gloucestershire experience of Roche reagent supply problems.
- Not just my individual opinion, this is the collective view of our clinical and management teams.
- Lessons to be learned for individual labs and network.
- Although focus of this meeting is on prioritisation of testing, there are steps that can be taken ahead of this, which may mitigate the need for getting to the stage of having to prioritise tests/workload.
- We became aware of the Roche reagent supply problem when we only had part of an order delivered. Following discussions with Roche, it became apparent they were unable to fulfil this order, or the scheduled delivery that was due later in the week. It was also concerning that they were not able give us further information of when the problem might be rectified.
- At this point we assessed our reagent and consumable stock levels. Due to preparations for Brexit and the first COVID peak, we had ensured we had 6-8 weeks' worth of stock for all assays. So, we felt we were in a good position going forwards into this crisis and would be able to maintain our service fairly well as usual.
- However, following discussions between the labs in the WofE South 3 network, it became apparent that some labs were not in the same position, and may well run out of crucial supplies within the week.
- The decision was taken as a network to divide supplies between us all, dependent on service need.
- At this point communications were sent out to the GPs, that we could only accept urgent requests. Unfortunately, this was sent out without prior clinical input. Following clinical review, further comms was sent out giving the likely timeframe for resumption of a full service. We requested that if routine testing could be delayed until the beginning of November, then to please do so. However, if the GPs assessed that patients clinically needed testing sooner, then to do so. It was also clarified at this point, that in the main it was Chemical Pathology that had the problem, the other services were largely unaffected. GPs/Practice managers were encouraged to call and speak to the clinical team if they had concerns, in general or for particular patients.
- Communication also went out to the Acute Trust clinicians, asking them to please consider if they really needed the tests they were requesting.
- We had a 58% fall in GP requests during this period.
- We did not have to turn down any requests that came through our door during this time.
- We took the decision not to reject any tests specifically, as many tests although not normally clinically urgent, may delay treatment in some circumstances. For example, a Vitamin D result not being available may delay a patient having treatment for osteoporosis.
- We already demand manage many tests using RCPath minimum retest intervals and vetting others for clinical appropriateness (following best practice/guidelines), which saved capacity.

- We have a pathology optimisation group (involving Pathology users), with work ongoing to rationalise testing and introduce appropriate pathways and testing, e.g. thyroid pathway and abnormal LFTs.
- We are already using electronic requesting to aid clinical decision making about what tests are indicated in particular clinical scenarios, and this will certainly become even more useful in the future, as better technology comes along.
- GIRFT Deep Dive for our network is taking place in the New Year. This will be useful to examine how we are using tests across the network and identify unwarranted variation. Some of this was certainly observed during the Roche problem. We supplied what for us was a week's worth of magnesium reagent to another lab within the network, only to find that they used it in a day! (Gloucestershire assay 50 magnesiums a week, the other lab 800). This was because magnesium is included in their 'bone profile', but not in ours, where clinicians need to request it separately, if they require it. There are some exceptions to this, magnesium is automatically reflexed on low potassium and calcium results (below particular concentrations) and is in some requesting profiles, e.g. decompensated liver disease.
- Storage of samples for a prolonged period is largely not appropriate - due to analyte stability, carryover (particularly PSA, Prolactin, HCG), storage capacity, assay validation (would be required if storage beyond manufacturer's recommendations).
- POCT may help in future - but needs to be an integrated approach with Trust/Community/Pathology Network to ensure appropriate clinical governance.

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