Pharmacy enters the premiership

Progress and challenges in medicines management were discussed at the 10th Hospital Pharmacist conference. Speakers focused on areas in which NHS trusts need to improve, as highlighted by the Healthcare Commission. Rachel Graham and Hannah Pike report.

Pharmacy needs to be in the position where the public fully understands the scope of pharmacy services and demands those services, Keith Ridge, chief pharmaceutical officer for England, told conference attendees. He proposed a new vision statement for pharmacy (see Panel below [right]).

Leadership

Chief pharmacists in NHS trusts need to become stronger leaders to ensure that clinical pharmacy continues to develop, Dr Ridge said. He used a football analogy to describe the situation in the NHS. “Hospital chief pharmacists are currently playing in defence, having to balance service delivery with service development in an atmosphere of financial constraint,” he said. “This ‘defender mode’ is understandable at present, but they need to move back up to midfield quickly, supporting their clinical strike force and dictating the pattern of play.”

He said that it is not just local leadership that needs to be strengthened to support the enhanced clinical role of pharmacy, but leadership at a national level. He called for “strong professional leadership that promotes excellence and scholarship, and can develop, deliver and support the enhanced clinical role for pharmacy so that medicines are utilised in a safe, clinical and cost-effective way, and most importantly patient care is improved.”

Collaboration

Dr Ridge called for a more collaborative approach between pharmacists working in different sectors of the profession. The way health services in the future will be provided will require a new level of collaboration within and across the profession, he said. “Is pharmacy mature enough to take on a more collaborative approach to practice?” he asked.

“Irrespective of where you practise, there will be a significant shift of services into the community,” he said. Acute hospitals are going to become a lot more specialised and hospital and community pharmacists will need to work together, particularly with more community pharmacists specialising in clinical areas.

“It seems inevitable that there could be a net export of skilled pharmacy staff to primary care. This alone will need much closer working between the sectors,” he said.

Turning to plurality of service provision, Dr Ridge said that NHS patients treated in private facilities also need treatment with medicines, and we would expect the same standards of care and professional standards to apply. “This might mean, under suitable contractual arrangements, that private sector pharmacy may need to access NHS pharmacy services like medicines information,” he said. “Pharmacy leaders should be actively pursuing this need.”

Another area for improvement is communication, said Dr Ridge. The Healthcare Commission identified that many non-pharmacy staff in hospitals were not fully conversant with the role of pharmacy. “If we are to continue to have the respect, confidence and understanding of the public in our growing clinical role then we may need to do something about the language we use,” he said.

Turning to mental health services, Dr Ridge said that, despite concerns about the methodology used in the Healthcare Commission’s report on medicines management in mental health, mental health pharmacy is ahead of the game in many ways. However, it has been the “Cinderella service” for too long. “Within the Department of Health we are thinking about how best to help you and other professionals involved in medicines management in mental health tackle this problem,” he said.

New expectations

With extra responsibilities come extra expectations of safety and quality, Dr Ridge said that these things are the bedrock of pharmacy. “It is how we are trained. Meticulous detail for meticulous care. I think the public would want that too.”

Dr Ridge pointed out that in order to take the new opportunities and deliver the expected benefits to care, some tasks that have traditionally been performed by pharmacists will need to be done differently or not at all, for example, dispensing. He said that although significant progress has been made since automation was first suggested as a way to free up scarce resource, he questioned whether pharmacy made the most of automation.

“What is the next step for dispensing and automation?”, he asked. “Regional dispensaries or even some dispensing or medicines supply moved out, thereby enabling staff to focus on clinical activities?”

Returning to the football analogy, Dr Ridge said: “Pharmacy is about to enter the premiership. I want to see a meteoric rise up the table. You will need to think much more radically to transform service delivery in a manner you previously thought unimaginable.”

Dr Ridge’s vision for the future

“A vision of the future, not just for pharmacy, but for the public and patients too, is one where clinical care, by pharmacists, direct clinical care of people, is not simply central, but also intrinsically valued by the public as materially benefiting their health and wellbeing.”
Medicines management is not just a pharmacy problem, Gill Harvey, assistant director, medicines management at the National Prescribing Centre told conference attendees. “It is everybody's business, and that includes management, support services, patients, nurses and medics.”

Describing the background of the hospital medicines management collaborative (HMMMC), she reminded attendees that the aim of the collaborative is to share what is happening in “pockets of good practice” across the country. “A collaborative is about the spread and adoption of existing good practice,” she said, “it is not necessarily about innovation, although there are a lot of innovative ideas and certainly innovative approaches to improvement that come out of the programme.”

Mrs Harvey outlined the results from some of the measures used in the programme, using figures from different trusts as examples. She pointed out, however, that collaborative is not about statistical data collection, but is about measuring for improvements.

Delays to discharge The number of times a patient’s discharge from hospital was delayed because of a medicines-related problem was measured. Over the course of the programme, 66 per cent of trusts in the first and second waves of the programme and 37 per cent of trusts in the third wave reported an improvement in this area.

Missed doses The number of times a patient’s medicine dose was missed when it should have been administered was analysed. At Calderdale and Huddersfield NHS Foundation Trust 16 doses out of 100 were recorded as being missed at the start of the programme. Mrs Harvey explained that they have now reduced these incidences to between zero and two missed doses per 100.

“I am sure that self-administration of medicines has contributed to that improvement,” she said. In total, 56 per cent of trusts in the first wave of the programme and 72 per cent in the second wave reported an improvement in this area. Mrs Harvey noted that more work still needs to be done in this area to improve patient care.

Patient drug policies To be considered compliant with this measure, trusts were required to have policies in place for self-administration of medicines, use of patients’ own drugs and dispensing for discharge. The number of wards that did not have all three of these policies in place was recorded. During the course of the programme, 50 per cent of trusts in waves one and two and two achieved an improvement in this measure. Of the trusts in wave three, 9 per cent reported that all of their wards operated these policies, and a further 32 per cent reported an improvement, Mrs Harvey said.

Information at transfer of care At the start of the programme, measurements from one particular trust showed that complete information was not provided in any of the cases studied when a patient was transferred to the next point of care. “From information they received through participating in the programme, this trust soon realised that they could put something into place quite easily to ensure that information was passed over correctly, timely and with the detail that was required,” Mrs Harvey said. Within eight months this trust managed to transfer all of their patients from ward to ward with complete sets of information. Overall, an improvement in this area was seen in 69 per cent of trusts in wave one of the programme and 22 per cent of trusts in wave three.

Clinical reviews Overall, 31 per cent of trusts in waves one and two and 19 per cent of trusts in wave three reported that all of their prescriptions were already reviewed by a pharmacist before being dispensed. Of the remaining teams, 50 per cent of trusts in waves one and two and 24 per cent of trusts in wave three reported a reduction in the number of prescriptions that had not had a clinical review by a pharmacist at the point of dispensing.

“Beyond the collaborative”

Mrs Harvey acknowledged that the results from the collaborative only reflect the 44 trusts that took part in the three waves of the programme, which is a small percentage of the number of acute and mental health trusts across the country. She described current and future work the NPC is undertaking to ensure that their messages spread further than the collaborative.

The NPC has now started its Integrated Medicines Management Programme for Long Term Conditions. Teams from secondary care and a mental health team are taking part alongside their primary care colleagues. The NPC is also aiming to produce a package towards the end of the year to help trusts achieve better medicines reconciliation.

Mrs Harvey also said that a cohort of medicines management facilitators are soon to be appointed, one in each strategic health authority area. These facilitators will come from primary care to begin, but they also intend to provide a pilot of this initiative with a secondary care model.

“Top tips”

In conclusion, Mrs Harvey described what the trusts participating in the HMMMC considered to be the main messages for improving medicines management (see Panel). As a final thought, she asked attendees to consider which of these points they would take back to their trusts, if they were to implement just one.
Incorporating patient expectations is one of the key medicines management features of the annual health check, according to Julia Sonander, acute hospital portfolio topic lead at the Healthcare Commission.

For the mental health trust report, “Talking about medicines: the management of medicines in trusts providing mental health services”, published in January, a group of patients using mental health services were invited to the Commission’s offices and their opinions sought, Mrs Sonander explained. Discussions revealed that patients were uncertain about the role of pharmacists in medicines management. For example, when talking about a situation in which a hospital pharmacist had optimised a patient’s medicines, one group of patients said: “We don’t really expect the pharmacist to stand up for us against the psychiatrist about our medicines.” Mrs Sonander said she was surprised by this misconception, that undermines the pharmacists’ role in providing a vital safety check. She said that she was pleased that other patient groups had disagreed with this opinion and said that they did expect pharmacists to sort out their medicine regimens.

Other patient expectations included a wish that their medicines be discussed in a non-intimidating environment (and not just on a ward round, where many people are present) so that they are given a proper opportunity to consent to changes to their medication. Open access clinics and free telephone support are also valued, because patients feel that they, or their carers, are often the first to detect signs of deterioration in their health. Patients also believe they should be made aware that there is an element of trial and error in optimising medicines and want advice about how they could ensure a good outcome. Receiving drugs in packaging that looks the same as the packaging they have previously received is also important to patients. They also want trusts to provide them with yellow cards (as, for example, the charity, MIND does) to report side effects, Mrs Sonander said.

Despite the differences between mental health trusts and acute trusts, Mrs Sonander expects that many of the aspirations of mental health patients are shared by those in acute trusts.

The two reports detail that which is achievable, rather than just that which is aspirational, Mrs Sonander continued. She explained that it can be difficult to choose appropriate medicines-related indicators. The aim is to provide trusts with a means of assessing their performance against that of other trusts, to drive improvements. To this end, the clinical pharmacy audit process used to compile the data for the reports has been turned into a tool so that trusts can re-enter their data and get back the results relating to the various indicators to evaluate their performance over time. A register for users is to be included with this tool, Mrs Sonander explained, so that trusts can be informed of any upgrades — the tool is newly developed, so there could well be glitches in the software.

As well as driving improvements, Mrs Sonander said that she hoped the information from the health check could be used to show how the services provided by pharmacy staff benefit patients. Further work could include looking at how to measure different outcomes and how to improve our understanding of interventions. “Drilling down” into the benefits to patients of the education provided to them by pharmacists was another option, she said.

Mrs Sonander’s thoughts about what might be monitored regularly included, for acute trusts, the percentage of wards where a risk assessment has been completed for the preparation of the parenteral products used, clinical pharmacy time per admission and the percentage of wards where full self-administration is occurring. For mental health trusts, clinical pharmacy time given per bed day and the number of people cared for by community teams who have had a medication review in the past year are among the possibilities, Mrs Sonander said.
The trust has developed a rigorously managed stock list for each area where CDs are kept, and authorised signatures are required for ordering them. Mrs Mellor explained that they have tried to link signature management into the three-monthly CD check. This process has also enabled mandatory engagement of senior staff within the area.

Benefits of the system

Describing the benefits of the new system for the management of Controlled Drugs, Mrs Mellor said that working relationships have improved now that staff have a better understanding of the issues surrounding these drugs. Senior nursing staff are now more receptive to thinking about their wider responsibilities for medicines stock, but also for medicines use within the organisation. She said: “It has been a big awareness-raising process which has been uncomfortable at times, but has enabled us to reinforce good practice and develop and share good practice.”

Standardising the way discrepancies are documented and reported has also improved the feedback loop and is good practice, she added.

Auditing

It is important to differentiate stock reconciliation (routine stock balancing) and audit. Mrs Mellor pointed out. She explained that the trust has standardised the way the three-monthly audits are carried out, using standard operating procedures, documentation and training programmes. The audits are led by the pharmacy but are multidisciplinary. The audits also incorporate case review, to check for clinical appropriateness. The new CD reports look at the following four aspects of good practice:

- That the stock and register of CDs has been checked
- That the security of CDs has been reviewed
- That the range of CDs stocked on the ward and quantities supplied have been discussed with the ward manager/senior nurse
- That the list of authorised signatures has been updated and returned to pharmacy

Monitoring tool

Mrs Mellor described a computerised tool that is being used by the trust to monitor CD supply. The tool, which is still under development, uses transaction data from the pharmacy management system (JAC) to highlight any changes in the use or supply of selected medicines. Reports are then formatted to help identify patterns of use that deviate from the norm.

Internal audit programme

An annual audit from each pharmacy department includes stock checks on a variety of CD lines, transaction checks on purchases and issues within the pharmacy, and an audit trail checking the documentation for CD transport, receipt, ward register entry and use.

“It gives us a full view of what sort of systems we are managing. Although it is a snapshot, it is helpful in identifying where things are beginning to drift or change,” Mrs Mellor said.

She explained that they also undertake audits within the pharmacy, “We do not think that the stock of Controlled Drugs in pharmacy is any different to the stock of controlled drugs on a ward” she said. The trust now uses independent pharmacy managers to audit pharmacy activity in other trust locations, as well as using pharmacy staff to audit wards and other departments.

Mrs Mellor described some of the benefits from this new way of working (see Panel).

Workload balance

Mrs Mellor said that the trust is now starting to measure the impact of the new CD management system on workload. Such systems require the investment of a lot of time, and it is important to analyse whether this is producing value and directly benefiting patients, she explained. A balance must also be achieved between monitoring CDs and maintaining patient care. “We do not want to take away effective patient contact and become policemen of the organisation to such an extent that we forget our prime role,” she said.

Mrs Mellor explained that putting new procedures in place to manage medicines liable to misuse can cause confusion among staff who may not fully understand why this is necessary. The trust has now developed a series of leaflets about good practice in medicines management within the organisation that is also being developed into an e-learning tool. So far about 10,000 leaflets have been distributed within the organisation for training and to help staff understand the different issues.

Turning to the requirements for CD accountable officers, Mrs Mellor said that some of the work they have done on CD management will go towards helping trusts comply with these requirements. “We are beginning to put that out in the public domain. We are working with the stakeholder group, the Department of Health and the Society on the guidance for CD management in secondary care,” she said.

In conclusion, Mrs Mellor emphasised that these new ways of working must not be detrimental to the effective clinical care of patients. The next step for the trust is to identify ways to differentiate sloppy practice from intentional misappropriation, she said.
Establishing a successful self-administration scheme

Over 80 per cent of patients at Calderdale Royal Hospital take part in self-administration schemes, Karen Guy, specialist pharmacy nurse for medicines management at the Calderdale and Huddersfield NHS Foundation Trust told conference attendees. Mrs Guy outlined the schemes in place at the trust that have led to such a high uptake of self-administration of medicines.

Before patients come to hospital, they are made aware that they should bring in their own medicines. A prominent notice is displayed on the home page of the trust’s website and ambulance staff are issued with green pharmacy bags in which to carry patients’ drugs.

Patients in hospital for elective treatments are assessed for their ability to self-administer before they attend hospital and those otherwise admitted are assessed “when the time is right for them”, Mrs Guy said. Several factors are included in the assessment, including the nature of the patient’s illness, his or her motivation to self-medicate, knowledge of medicines and ability to read and understand instructions and manage packaging. Based on this assessment, patients are assigned into one of three levels:

- Level 3, where a patient manages his or her medicines during their stay and has control of his or her medicines locker key
- Level 2, where a patient is supervised to self-administer his or her medicines
- Level 1, where nursing staff administer medicines to a patient

Mrs Guy pointed out that even when patients are assessed as level 3, they are not ignored during the drug round. Nurses will stop and talk to them when they would otherwise be administering their medicines, particularly if there has been a change to the patient’s drug regimen.

Strategic changes

On a more strategic level, key to the successful implementation of self-administration has been having a pharmacy nurse in post. Mrs Guy said that part of her role has involved being a self-administration “champion”, communicating the benefits of the scheme to nurses in a way that they understand and respect. She currently works in the pharmacy department and has several years of nursing experience, so is aware of the perspectives of both pharmacy and nursing staff.

Karen Guy: self-administration is part of a “whole system” approach

Implementing self-administration also required many hospital systems to be changed, Mrs Guy explained. At Calderdale Royal Hospital a useful impetus for doing this was the relocation of the hospital. One-stop dispensing was also introduced at the trust, with patients now receiving a minimum of 14 days supply of their medicines. Policies to use patients’ own drugs, under-take medication reviews on admission and to improve communication between staff working at the hospital and in primary care (such as providing discharge summaries) were brought in. Policy documentation and systems for audit and feedback were also redesigned.

Advantages

Studies carried out at the trust have shown that the proportion of patients who know the name of their medicine increased by about 25 per cent after the self-administration scheme was put in place. The proportion of patients knowing the reason for taking their medicine(s), the dose to take, the duration for which to take it, the potential side effects and any special instructions that accompany their medicine regimen increased by between 25 and 30 per cent, Mrs Guy explained. Self-administration has also reduced the nursing time spent administering medicines from a mean of over 4h per day to 2h. Patients now seem to have a greater ability to seek information about their medicines, develop positive relationships with health care professionals and use health services appropriately, Mrs Guy added. They also seem to be more confident about taking their medicines.

Mrs Guy explained that she is aware of the questions that remain unanswered about self-administration, such as those highlighted in recent research from Southampton University Hospitals NHS Trust [Editor — see Hospital Pharmacist 2006;13:388]. However, she does not see such queries as a reason not to develop self-administration schemes.

Challenges

One barrier to introducing self-administration has been challenging the opinions of nursing staff who believe that drug rounds are the best way of delivering and administering medicines to patients. “Culture eats strategy for breakfast,” Mrs Guy said, but she emphasised that beliefs, values and norms do change with time. Self-administration schemes are also a big investment, in terms of finance and personnel, she said. Expenses include buying patient lockers and keys, although lost keys have not really been an issue at Calderdale Royal Hospital, Mrs Guy said.

Mrs Guy emphasised that self-administration is part of a “whole system” approach. It is not sensible to bring in such schemes in isolation, without making the necessary changes to other procedures and documentation.

Role of a pharmacy nurse

There are currently 12 nurses employed in pharmacy departments in UK hospitals. Their role generally includes:

- Working as an integral member of the pharmacy team, but also independently
- Acting as link for all health care professionals involved in medicines management
- Fostering a sense of empathy and understanding between health care professionals
- Thinking outside the “nursing box” and the “pharmacy box”
- Delivering medicines management to nurses in a way that they understand and respect
- Keeping nurses fully informed of their medicines management responsibilities
Top left: Runners-up of the Hospital Pharmacist Life-long Learning competition; (left to right) Colin Cable (Western General Hospital, Edinburgh), Bronwen Montgomery (Leighton Hospital, Crewe) and Kathryn King (Altnagelvin Hospitals Health and Social Services NHS Trust, Northern Ireland). Another prize winner, Jane Walton (Alexandra Hospital, Worcestershire) also attended. Top right and bottom left: delegates attend the sessions. Middle right and left: company representatives exhibit their stands. Bottom right: Bridget Coleman, medicines management pharmacist and Malcolm Bubb, chief pharmacist, both from the Whittington Hospital.
Top left: Jonathan Ody, vice president, commercial operations, Europe, Mayne Pharma, sponsors of the preconference dinner and the Hospital Pharmacist Life-long Learning awards 2005/06. Top right: guests at the preconference dinner. Middle left: Ray Fitzpatrick, clinical director of pharmacy at Royal Wolverhampton Hospitals NHS Trust and Hemant Patel, president of the Royal Pharmaceutical Society. Middle right: a representative from the territorial army on duty at his exhibition stand. Bottom left: Keith Ridge, chief pharmaceutical officer for England. Bottom right: delegates take part in an interactive session.
Aseptic dispensing of unlicensed drugs — balancing the risks

Aseptic dispensing of unlicensed drugs relies on a team approach to optimise products, processes and priorities to safeguard patient care, Tom Gray, chief pharmacist, Derby Hospitals NHS Foundation Trust told conference attendees.

Although ward preparation of injectable medicines is well established, the Healthcare Commission found that a risk assessment of this practice is being conducted in less than 40 per cent of trusts.

Licensed products and facilities offer the greatest degree of assurance of product integrity and are governed by national standards, Mr Gray said. Dispensing is an altogether less regulated activity and therefore prone to greater degree of risk. “This can be offset by placing unlicensed dispensing under the control of pharmacy — can’t it?”

The Healthcare Commission has shown that the quality assurance of aseptic dispensing facilities in pharmacy is regularly inspected. However, Mr Gray pointed out that there are no national standards for the ward-based preparation of injections, and there are widespread variations in practice. Guidance from the Royal Marsden Hospital and the Royal College of Nursing has been published but it is not universally adopted or routinely audited, he added. Publication of good practice statements by NHS Scotland have gone some way to address this but, again, it is unclear if they have been nationally adopted.

So can the ward be considered a safe, effective and appropriate environment for the preparation of injectable medicines?

“Observational studies of ward-based preparation of injectable medicines consistently demonstrate deficiencies in the environment with high risks of contamination and poor aseptic technique being routinely employed,” Mr Gray said.

In some trusts up to three quarters of injectable medicines may be prepared in ward areas, where cramped conditions allow little segregation of duties or products and may lead to selection errors. Use of the wrong diluent to reconstitute injections is well known, in some cases with tragic consequences. Inappropriate vial sizes encourage multiple use and carry a contamination risk, and should be reserved for pharmacy use, he said.

“The administration of injectable medicines carries perhaps the highest risk with little opportunity for intervention, and often poor checking and accountability,” Mr Gray added.

So which is the safer environment, the pharmacy or the ward? “Undoubtedly I think that pharmacy is ideal for the preparation of injectable drugs, but only where it demonstrably meets the high standards required for aseptic practice, where the staff are trained and regularly assessed and both operational and process qualifications assured,” Mr Gray said.

Risk reduction

A number of risk reduction tools and guidelines have been published, and a safer practice alert from the National Patient Safety Agency on the preparation of injections in near-patient areas is due to be published imminently. Mr Gray said that, whichever tool is chosen, risk assessment must be given a high priority in the NHS.

Tom Gray: risk assessment must be given a high priority in the NHS

He outlined a number of ways to balance the risks, as described by the NHS Scotland guidance. These include using ready-to-administer products (although not all commercial products are suitable) and bolus injections. Mr Gray said that bolus administration may offer the most simple approach to patient safety but, given the pressures that ward staff are under, it may result in inappropriate rates of administration.

There is a universal call to procure ready-to-use, licensed products and to encourage standardisation from the royal colleges. “It is sound advice”, said Mr Gray, “but I believe there is much work still to do to ensure that these meet safe practice standards and are actually fit for purpose.”

Centralised intravenous additive (CIVA) services are well established and the evidence from the Healthcare Commission appraisal suggests that they are subject to regular quality assurance inspection. However, Mr Gray asked whether pharmacy input stops with the provision of a sterile, appropriately presented and ready-to-use product. “One criticism of CIVA services is that they are so remote from patients and the multidisciplinary team, including clinical pharmacists, that they are often unresponsive to urgent patient needs and they rely overly on verbal orders which can lead to errors,” he said.

Nevertheless, Mr Gray pointed out that ward preparation remains the norm in most UK hospitals. Despite the shortcomings, ward preparation maintains direct access to the patient, the prescriber and other members of the multidisciplinary team. Therefore, it is important that ward-based clinical pharmacists and medicines management technicians are closely involved in parenteral therapy, ensuring that products are stored, administered and disposed of appropriately. “We can’t get away from the ward preparation of IV drugs, but we can make it safer,” he said.

Opportunities

Strategies have been introduced to centralise the procurement and production of injectable medicines and to provide consistency in their safe management, such as the purchasing for safety collaboration, Mr Gray said. Another example is the modernising of the NHS hospitals medicines manufacturing service, launched in 2002/3. However, he questioned whether we are seeing the benefits of this yet.

Mr Gray said that pharmacy needs to take the lessons learned from the centralisation of aseptic services back to near-patient areas.

He described how a £350m private finance initiative in Derby has allowed the development of decentralised pharmacy services, working on each floor of the hospital, using modern facilities. He said that the decentralised intravenous additive services combine state-of-the-art aseptic and oral dispensing facilities linked with pneumatic tubes to the wards and the pharmacy.

“Decentralisation of facilities and integration of effective multi-skilled teams does offer safe, efficient sustainable services that are responsive to patient and staff needs,” he said.
Medicines management services within mental health trusts (MHTs) are “absolutely dire”, according to David Branford, chief pharmacist at Derbyshire Mental Health Services NHS Trust.

There is a perception among many pharmacists that mental health is an area of “slow movement”, Dr Branford explained, generating few interventions and requiring less pharmacy support than other services. Only one third of mental health wards are visited by a pharmacist on a daily basis. Just what level of support is needed is not really known, Dr Branford added, but it is more than that currently given.

Consistency of services is also an issue. Many MHTs have outsourced their pharmacy services to others, generally to acute trusts, under the terms of service level agreements (SLAs). For many MHTs (about 58 per cent), all their medicines management is provided in this way, because they have no pharmacy services of their own. Moreover, it is often more than one third-party organisation that provides services to MHTs — almost 50 per cent of MHTs have two or more organisations providing pharmacy services to them and one MHT, known to Dr Branford, has six different SLAs in place, each with different terms and conditions. Only 17 per cent of MHTs provide all their own pharmacy services, Dr Branford added.

Services to community sites (which provide the bulk of mental health services) are no better, Dr Branford said. There is a perception that community pharmacists, usually with no specialist training in mental health, will “look after this”. Dedicated pharmacy services are delivered to the community teams of only six MHTs, he added, and only three MHTs have a pharmacist as a member of their crisis intervention and home treatment teams.

Workforce is another real issue for MHTs, Dr Branford said. Documents such as the UK Psychiatric Pharmacy Workforce Survey and the Healthcare Commission’s report have highlighted the fact that there is no clear association between the size and complexity of MHTs and the number of staff they employ. It is normal to have fewer than five specialist mental health pharmacists per million population (around 15 to 20 might seem to be a more appropriate number, Dr Branford suggested).

Pharmacy technicians are another area of concern, with 60 per cent of mental health technicians currently being over the age of 40. At about 450 pharmacists and 350 technicians, the mental health pharmacy workforce in England needs to treble over the next five years to provide effective medicines management services, Dr Branford said.

However, it is not clear where this increased workforce is going to come from. As well as issues around funding, few pharmacists and technicians seem to be motivated to take up careers in mental health pharmacy. Psychiatric pharmacy is generally not covered in clinical diploma courses and so pharmacists wanting to specialise in this area are being asked to undertake an additional masters qualification in psychiatric pharmacy, which adds to their workload. There is also a lack of exposure to mental health during preregistration training. Where psychiatric pharmacy is introduced to preregistration trainees, there is evidence that this encourages them to go on and specialise in mental health, Dr Branford said.

On a positive note, governance of MHTs has undergone significant improvement, Dr Branford said. Over the past ten years, chief pharmacists have been appointed to most MHTs and are now seen as “big fish”. This provides an opportunity to set about controlling medicines management across an MHT, but the process is fraught with difficulties when there are few staff to support chief pharmacists and services are provided purely under the terms of SLAs.

Where to now?

As a result of mergers, MHTs are now large enough to consider setting up their own pharmacy services, Dr Branford said. In addition, a specification for SLAs should be drawn up, so that, where services are still brought in, terms and conditions are standardised and staff at MHTs know what levels of service they can expect.

Pharmacy staff also need to become fully integrated into the workings of MHTs. It is not acceptable just to “pop up” to mental health wards in acute trusts — pharmacy staff need to be part of the ward team and be based there. Similarly, for community services, the days of “popping in for half an hour to check the cupboard” need to end — community sites require better services than that and need pharmacy staff to be part of the team, Dr Branford said. Finally, something definitely needs to be done about the number of pharmacy technicians working in mental health, Dr Branford concluded. “MHTs need similar (although not necessarily the same) medicines management technician provision as acute trusts,” he said.

Background information about mental health trusts (MHTs)

**Mental health trusts:**

- Typically comprise about 10–20 acute wards; 10–20 long-stay wards (although the numbers of these are gradually decreasing); 3–4 forensic medium secure wards, 50–100 mental health community-based teams; specialist units; and facilities for patients with learning disabilities (although the numbers of these are also gradually decreasing).
- Typically employ about 100–200 doctors and more than 1,000 nurses.
- Are currently being merged, such that the approximately 80 current MHTs will become approximately 30.
- Serve populations of about 1–2,000,000.
- Provide services to those with severe and enduring mental health problems, and not to those, for example, with minor episodes of depression and anxiety.
- Support service users over a long period of time.
- Have more than 100 sites where services are delivered in each MHT.
- Provide most treatment in community settings.
- Have devolved their pharmacy services to other organisations.

Comment about mental health pharmacy

Dr Branford is one of the authors of this month’s comment “Talking about medicines — agreeing on the way forward” (p74).
What benefits do technicians bring to medicines management?

Having medicines management technicians (MMTs) on wards prevents pharmacists from “running around like headless chickens”, according to Sarah Wilcox, president of the Association of Pharmacy Technicians UK and pharmacy technician training lead at University Hospital of Wales, Cardiff. Ms Wilcox pointed out that these are not just her words, they have been said to her on many occasions by pharmacists that she works with, particularly when wards that generally receive medicines management services from pharmacy technicians do not, for some reason, receive them.

Benefits of having MMTs

Describing in more detail the benefits of having pharmacy technicians deliver medicines management services to wards, Mrs Wilcox said that they reduce the turnaround time for discharge prescriptions, which, in turn, reduces the number of ambulances being cancelled or delayed. They also improve the education of patients about their drugs, with pharmacy technicians often having more time to counsel patients about their drugs than nurses, and having more appropriate knowledge.

Medicines management schemes have also led to income generation for pharmacy departments. For example, at Cardiff and Vale NHS Trust, funds have been allocated from the nursing budget to pay for pharmacy technicians following a pilot project that showed nursing time was saved when medicines management technicians were allocated to wards on a full-time basis. For this and other reasons, the introduction of medicines management schemes has also led to a better relationship of technicians with nursing staff, as well as with pharmacists.

Enabling patients to self-administer medicines has been another benefit of having ward-based medicines management technicians. Many patients know their medicine regimens better than medical staff and feel more in control when they are able to look after and take their medicines themselves during their hospital stay, Mrs Wilcox said [Editor — see p87 for more information about self-administration]. Pharmacy technicians themselves have also benefited from being able to take on extended roles, developing their careers in ways that would not have seemed possible as recently as ten years ago.

Other recent developments include pharmacy technicians becoming more involved in diagnostic testing services and in reporting interventions and incidents. Mrs Wilcox added. At a hospital in north Wales, it is proposed that a discharge lounge will be pharmacy technician-led, with technicians preparing prescriptions for discharge and counselling patients, maintaining electronic contact with a pharmacist in the main dispensary.

Where did we come from?

In order to recognise fully the contributions of pharmacy technicians it is important to know a bit about what technicians roles previously were and the impetuses for their development, Mrs Wilcox said. For example, in Wales, a project to introduce a higher qualification for technicians is under way. Although this is an improvement on a merely trust- or institution-based system, Mrs Wilcox wondered whether a UK-wide system might not be better.

Noel Hall report 1970. Stated that “still more effective use can be made of the technician grade if all technicians are required to possess an approved qualification, and the straightforward and repetitive jobs … are delegated …”

Nuffield report 1986. Stated that “an activity should be performed by staff at the most junior level competent to perform it”