PHARMACY MENTAL HEALTH WORKFORCE MODEL 2022

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Regional Mental Health Pharmacy Group July 2022

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Introduction

There has been limited investment regionally into pharmacy services in mental health and staffing levels are substantially below that required to meet the standards outlined in this document and vary across the five Healthcare Trusts.

In light of the Mental Health Strategy 2021-2031 which incorporates the NI Medicines Optimisation Quality Framework (MOQF) as a core principle, this paper aims to review recommended standards set out by national and local guidance, collate information on current pharmacy activities, bench mark against expected standards and identify the workforce gap.

Scope of review

Scope of review is limited to HSC Trust employees and will not include mental health pharmacy resource requirements in general practices or community pharmacies.

Evidence and Standards

NHS England Lord Carter's report review into unwarranted variations in mental health and community services illustrated that for every £1 spent on clinical pharmacy services; this led to a savings of £5 within the healthcare system. To achieve this, the provision and efficiency of community health services will have to be significantly strengthened and the key challenge for mental health services is meeting this unmet need.

The role of the pharmacist and pharmacy technician can contribute considerably to the safe management of medicines within mental health by working with patients, prescribers and the wider multidisciplinary team. This approach has been endorsed by NICE, Royal College of Psychiatrists, Royal Pharmaceutical Society and Health Education England. The Royal College of Psychiatrists have Standards for Mental Health In-patient Units, Crisis Resolution Home Treatment Teams and Psychiatric Intensive Care Units; all of which highlight the need for a pharmacist to be a core member of the MDT.

Evidence of shortage of psychiatrists and increased waiting lists means pharmacist non-medical prescriber (NMP) could take on caseloads to reduce burden by titrating and reviewing medication, de-prescribing medication, providing patient education and completing specialist medication reviews. The optimum use of medicines in partnership with patients/clients, families and / or carers is central to the management of mental illnesses. Evidence indicates that psychoactive medication is often used inappropriately.

NICE NG5 recommends medicines optimisation and structured medication reviews for adults, children and young people taking multiple medicines (polypharmacy) or with chronic or long-term conditions and for older people.

In March 2016, the NI MOQF was published which introduces a national model for medicines optimisation (MO). The MOQF promotes multidisciplinary working, recognising the role of pharmacists in integrated teams optimising patient's medicines. The MOQF contains 10 quality standards, addressing the priority issues for medicines optimisation in NI. Within this are three overarching quality domains of safety, effectiveness, and patient/ client focus, describing the best practices that should be delivered in each setting, including mental health. Medicines remain the most commonly used therapeutic intervention in the NHS and yet up to 50% of patients do not take their medications as prescribed. Patients with a mental health illness for example, schizophrenia, may have altered thinking and beliefs about medicines and their illness which may affect adherence. The pharmacy workforce however, is insufficient with respect to the recommendations outlined in the current Medicines

Optimisation Quality Framework, NICE practice standards and is not equitable with the clinical pharmacy service provided within other areas of secondary care e.g. acute hospital services.

Inpatients the Northern Ireland Clinical Pharmacy Standards from 2005 recommend one pharmacist for 40 beds +/- 10 beds within acute psychiatry. All of the trusts work below this standard. Mental health pharmacists should also provide a pharmacy service to specialist MH beds e.g. CAMHS, LD, medium secure and addictions. Furthermore, the Royal college of Psychiatrists recommends 1 WTE band 7 pharmacist for a mental health liaison service providing service to an Emergency Department and 1000 bedded general hospital. Staffing needs to accommodate both the number of patients in beds, and patient turnover, therefore we would highlight the standards do not reflect the LOS or turnover which influences capacity of staff to see all patients.

Psychiatric Intensive Care Unit Standards outline duties to include performing medicine reconciliation on admission; applying medicines optimisation and evidence based criteria to ensure a person centred approach and the best possible outcomes from their medicines; contributing to guideline development, audit of high risk medicines and staff training on the use of medicines. With additional post- graduate qualifications (including independent prescribing or mental health related diploma) and mental health experience, an advanced clinical pharmacist supports the inpatient team to achieve defined standards of care.

Home Treatment Crisis Response teams provide an acute service to patients remaining in community. Staffing for these services needs to accommodate both the number of patients in service as a virtual ward and patient turnover, therefore we would highlight the lack of standards to identify resource needed. Pilot work in local trusts would suggest the staffing level should reflect that of acute inpatients.

Community mental health teams, the NI clinical pharmacy standards do not include timings however the Sainsbury report from 2007 gives guidance for WTE staff required for a population of 250,000. Based on its recommendations, it suggests:

- 2.25 pharmacists and 2 technicians for CMHTs,
- 0.5 pharmacists and 0.3 pharmacy technicians for Early Intervention teams and
- 0.5 pharmacists and 0.3 pharmacy technicians for Assertive Outreach Team.

However the report from the Mental Health Medicines Management pilot suggested that 1.0 WTE would be required to cover the clinical activity with a caseload of approx. 500 patients. This would be a better reflection of the type of work required rather than based on population data from the Sainsbury report.

The number of patients prescribed Clozapine has substantially increased over the last 10 years without additional pharmacy investment to manage this. The safe provision of this service as well as the most recent implementation of Point of Care monitoring for clozapine patients into some trusts continues to be a significant strain on the minimal pharmacy staffing presently resourced. Patient services staffing provision to manage the supply of clozapine to patients has been included in the workforce table.

Perinatal Mental Health Services, the Royal College of Psychiatrists made recommendations for the provision of services for childbearing women; under workforce guidance it recommends a minimum of 0.5 B8a/8b pharmacists per 10,000 births. The report outlines the extensive role of a perinatal pharmacist.

Inpatient and community rehabilitation services for people with complex psychosis, NICE Guidance and the Royal College of Psychiatrist/Quality network recommends

multidisciplinary teams comprising a range of professionals with skills and competence in mental health rehabilitation, including a specialist mental health pharmacist. It specifically recommends that patients should have a comprehensive biopsychosocial needs assessment by a multidisciplinary team within 4 weeks of entering the rehabilitation service and part of this assessment must include medicines reconciliation by a specialist mental health pharmacist and physical health checks including monitoring of drug levels.

Education and Training

Consideration should be given to inclusion of this speciality within pharmacy undergraduate and post graduate training whilst also providing opportunities and support for pharmacy staff in all sectors (community, GP, secondary care) to develop their skills within the field of Mental Health. Time required for training must be taken into consideration for all new posts. Mental health pharmacists also provide education and training at a multi-professional level. This is a critical role and is included in all specialist mental health pharmacist job-plans.

Workforce development/recruitment

Without foundation career experience opportunities in mental health clinical pharmacist roles, it is difficult to attract new staff. With insufficient staffing levels, training provision for new pharmacists and technicians is limited. Pharmacy technicians have a wide range of skills to help release pharmacist time to focus on more complex and clinical issues. Pharmacy technician recruitment will need to be phased and introduced to the services they have been identified for once pharmacist funding is replete and may need to incorporate training pharmacy technicians' lead-in time.

Recommendations for Pharmacy Workforce Development

Additional pharmacy resource is required for mental health services to support the implementation of the Mental Health Strategy.

Two consultant pharmacist posts should be commissioned ahead of phase 1 to lead the implementation of the Mental Health Strategy and facilitate the roll out of the mental health pharmacy workforce.

Individual trusts will allocate resources in a phased approach as follows and there will be some variance given differences in baseline mental health pharmacy staffing provision:

a) Phase 1: To provide a clinical pharmacy service to acute mental health service so adherence to relevant service standards are achieved. Prioritise roll out of a blend of band 6 & 7 pharmacists, 8a pharmacists and some of the pharmacy technician workforce. These posts will ensure staff gain experience in mental health and lead to development of a robust career development framework.

b) Phase 2: To provide clinical pharmacy services to acute services/sub-acute inpatient services that are not available in all trusts e.g. CAMHS/LD/medium secure

c) Phase 3: To provide a clinical pharmacy service to community mental health support and recovery teams and ensure relevant service standards are achieved

Ongoing re-assessment of pharmacy resource requirements as new services are developed and/or reviewed to react to emerging understanding of needs. Additional pharmacy support for our dispensary and supply function has also been built into this paper.

Table 1: Summary of current and proposed mental Health Pharmacy service provision

	Current Trust Mental Health Pharmacy provision					**Future required resource for** Trust Pharmacy Mental Health *(in addition to current provision)*					
SERVICE AREA	**BHSCT 362,100**	**NHSCT 483,600**	**SHSCT 397, 800**	**SEHSCT 396,700**	**WHSCT 305,300**	**WTE/ Service from reference**	**BHSCT 362,100**	**NHSCT 483,600**	**SHSCT 397, 800**	**SEHSCT 396,700**	**WHSCT 305,300**
Consultant Pharmacist	-	-	-	-	-	5 8c (NI wide)	**Establish 2 consultant posts initially and work to 1 consultant post in each trust**				
MH Services Pharmacy Lead	1 B8b	1 B8b	0.5 B8b	-	-	1 B8b per trust (AFC)	-	-	-	1B8b	1B8b
Acute In-patient Care*	- 1 B7 1 B6 1 B4 0.1 B2	- 2 B7 - 1 B5 -	- 1 B7 0.4 B6 1 B4 0.1 B2	1 B8a - - - -	1 B8a - - - -	1 B8a 3 B6 OR B7- to create training/skill-mix 2 B4/5 tech skill-mix WTE/80 beds 1 B2 ATO (IP/CMHT)	- 1.5 B7 1.5 B6 1 B4/5 1 B2	1 B8a 2 B7 1.5 B6 1 B4/5 1.5 B2**	1 B8a 1 B7 0.6 B6 1 B4/5 1 B2	- 2 B7 1 B6 2 B4/5 1.5 B2**	- 2 B7 1.5 B6** 1.5 B4/5 1.5 B2**
Acute PICU*	Included in IP figures	-	0.25 B7	-	-	0.5 B8a WTE/10 beds	Included in IP figures	Included in IP figures	Included in IP figures	Included in IP figures	Included in IP figures
Acute Crisis Resolution Home Treatment teams *	1 B8a 1 B7	-	0.5 B8b	1 B8a	1 B8a	2.6 B6 OR B7- to create training/skill-mix WTE/50 admissions	1 B7 1 B6	2 B7** 1 B6	1.6 B7 1 B6	2 B7** 1 B6	2 B7 0.6 B6
Acute MH & Substance Misuse Liaison*	-	-	0.5 B7	-	-	0.5 B7 WTE/500 bed	1 B7	1 B7	0.5 B7	1 B7	1 B7
Acute In-patient Addictions*	-	-	-	-	-	0.5 B7 WTE/10 beds	NA	0.5 B7	NA	0.5 B7	0.5 B7
Acute/ community ID Team (includes in-patient beds)	0.6 B7 IP only	-	1.25 B7 Community & IP	-	-	1 B7 community 0.5 B7 inpatient WTE/10 beds	1.4 B7	1 B7	0.25 B7	1 B7	1.5 B7
Acute/ community CAMHS	-	-	-	-	-	1 B7 Community 1 B7 Inpatient 1 B4 Inpatient	2 B7 1 B4	1 B7	1 B7	1 B7	1 B7
Specialist sub-acute Regional Medium-secure	-	-	-	-	-	1 B7 Inpatient	1 B7	NA	NA	NA	NA
Community CMHT Adult	-	-	-	-	-	1.5 B7 or B8a Lead skill mix 500 caseload Clozapine/300 patients 1.0 B5 Pt services 1.0 B4 Pt services	2 B8a 4 B7 1.5 B5 1.5 B4	3 B8a 6 B7 1 B5 1 B4	2 B8a 4 B7 1 B5 1 B4	2 B8a 5.25 B7 1 B5** 1 B4**	3 B8a** 4 B7 1 B5** 1 B4**
Community Addictions	-	-	-	-	-	1 B8a *Buvidal excluded*	1 B8a	1 B8a	1 B8a	1 B8a	1 B8a
Community/ Sub acute Rehab Team includes inpatient rehab beds	-	-	-	-	-	0.25 B7 WTE/10 beds 0.25 B5 inpatient	Included in the CMHT	Included in CMHT/ Inpatient	Included in CMHT	Included in CMHT/ Inpatient	Included in CMHT/ Inpatient
Community Early Intervention Psychosis	-	-	-	-	-	0.5B7 WTE/ 250,000	Included in CMHT	1.2 B7	NA	1 B7	NA
Specialist Peri-natal MH team* **	-	-	-	-	-	0.5 8a (WTE/ 10,000 births)	0.5 B8a	0.5 B8a	0.5 B8a	1 B8a	0.5 B8a
Specialist Community Forensic Service	-	-	-	-	-		Included in CMHT	Included in CMHT	Included in CMHT	Included in CMHT	Included in CMHT
Total							**Establish 2 consultant posts initially and work to 1 consultant post in each trust**				
Baseline staffing does not have any annual leave uplift as per standard models in MDT.	1 B8b 1 B8a 2.6 B7 1 B6 - 1 B4 0.1 B2	1 B8b - 2 B7 - 1 B5 - -	1 B8b - 3 B7 0.4 B6 - 1 B4 0.1 B2	- 2 B8a - - - - -	- 2B8a - - - - -	**Please note that the 1.24 factor has been applied to uplift for annual leave/ training etc. in band 8a-band 2 posts**	**- 4.6 B8a 15.4 B7 3.5 B6 6.4 B4/5 - 1.2 B2**	**- 6.8 B8a 18.7 B7 3 B6 4 B4/5 - 1.8 B2**	**- 5.6 B8a 11 B7 2.1 B6 4 B4/B5 - 1.2 B2**	**1 B8b 5.5 B8a 17 B7 2.5 B6 5 B4/B5 - 1.8 B2**	**1 B8b 6.0 B8a 15 B7 2.6 B6 4.5 B4/5 - 1.8 B2**

* Please note priority is to achieve 5 day service. Aspiration for acute services would be to achieve a 7 day model of staffing in line with other trust services. Staffing to achieve 7 day services would need to be evaluated with consideration for any additionality of resource.

** Additional provision to account for geographical spread

*** Perinatal (PN) pharmacy provision best practice as per UK PN Pharmacist Working group lead = 0.5 8a/PN team to ensure meaningful provision of service.

Appendix 1: The Role of Pharmacy within Mental Health

Medicines Optimisation: It is vital that prescribers are aware of potential interactions between medications for physical health and mental health, to avoid preventable harm to our patients and to ensure adequate physical health monitoring is carried out as needed. Pharmacists are best placed to manage high risk medications, physical health monitoring, medication monitoring, drug interactions, side effects and de-prescribing whilst reviewing adherence to NI formulary to promote cost effective prescribing. Pharmacists working as independent prescribers have the potential to reduce waiting lists in community teams, assist medical staff in dealing with complex cases' medications and reduce admissions to hospital.

Structured medication reviews: As experts in medicines, pharmacists are well placed to conduct structured medication review clinics, promote shared decision making and develop self-management plans with patients. Within mental health, structured medication reviews are additionally complex due to the need to review previous treatments and records over many years to successfully individualise a treatment plan for patients.

Medication Adherence: WHO states the effectiveness of adherence interventions may have far greater impact on the health of the population than any improvements in specific medical treatments. Non-adherence is common in all long-term conditions including mental health disorders. The impact is worse outcomes including relapse in people with Serious Mental illness (SMI) and depression. In order to optimise the use of medicines, it is important that patients are involved in decision making about their medicines and educated about their medicines to allow them to use their therapy appropriately and with maximum benefit. To improve adherence and reduce relapse rates, pharmacists can use clinical and motivational interviewing skills to deliver interventions specific to individuals to address needs and concerns around medication.

Medication Safety: In hospitals (including Mental Health Trusts), the General Medical Council EQUIP study reported a 9% prescribing error rate. With the reduced pharmacy resource within Mental Health across all settings, the risk of medication errors may be increased. The process of Medicines Reconciliation has been identified as a high-risk area across the primary-secondary care interface and within Mental Health, incidents involving high-risk medications such as Lithium, clozapine or Methadone may be serious. As pharmacists become part of multidisciplinary teams, they increase awareness of incident reporting, proactively prevent, identify and report medication-related adverse events; particularly those associated with high-risk drugs, which improves learning and drives changes to improve safety for patients. Pharmacists also contribute to quality improvement initiatives through research and audit, in addition to the development, implementation and review of guidelines.

Medication Education for Staff and Patients: Specialist mental health pharmacists are involved in the training and education of other healthcare professionals, up-skilling and promoting awareness of medications in mental health.

Recovery College supports people's recovery from mental health difficulties through learning and education that is co-produced by people with lived experience and health care professionals.

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