NHS hospital staffing: *Status quo* or Ebb and flow?

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Note: The author has co-ordinated national surveys by the NHS Pharmacy Education and Development Committee over the last 6 years and much of the data and opinions in this article are drawn from those surveys unless otherwise stated. The opinions expressed here, however, are those of the author and not necessarily those of the Committee. Copies of the reports published by the Committee have been widely distributed to hospitals but are also available from the author. They have been abstracted in the Pharmaceutical Journal.

Opinions and statistics, often contradictory, have been bandied around for years concerning hospital pharmacy and the state of recruitment and retention of staff. Despite being at one level a national organisation, the NHS has always functioned as a large number of smaller units and for many years there were no centrally collated data that were reliable regarding pharmacy staffing. It was not surprising therefore that opinions differed on whether or not there were shortages. In 1996 the NHS Pharmacy Education and Development Committee decided that its work was being hampered by the contradictory opinions being expressed and took the step of conducting a comprehensive national survey to establish the true facts. These surveys have continued and the 4th was recently completed. Taken together, the surveys show consistent trends and confirm that there are indeed problems with pharmacy staffing in NHS hospitals.

There are, of course, other sources of data and these point to the same conclusions. For some years, there have been surveys in London, in the North-east, and in Wales which, by concentrating on a smaller geographical area, have been able to add detail and insights that are not available from the national survey. The Department of Health collates figures from human resources departments but their accuracy has often been questioned and they present a particular measure of vacancies which some people feel under-estimates the real problems that departments face. Recently, the Audit Commission produced a head count over several years that confirmed other data.

What then can we say about hospital pharmacy staffing? Firstly, there is a clear and consistent vacancy rate for pharmacists which is around 14 per cent if taken as a snapshot on 31st July. 8.5% of posts have been vacant for 3 months or more. The Department of Health calculates a 3-month figure, up to the end of March, of 5.3% and unpublished Audit Commission data show a snapshot vacancy rate of 11% on 31st March. Clearly, which of these figures is more important could be debated but it is probably not helpful to do so; the trends are clear and consistent. The July figure is probably the low point of the year but it's still a time of the year which matters greatly especially as it is at a time of increased annual leave. It used to be the case that hospital workload was deliberately diminished during the main holiday periods but that is no longer the case and hospitals are expected to provide the same level of service 24 hours a day, seven days a week, 52

weeks a year.

Such vacancy levels might be expected to affect the level of service that departments can offer and this is indeed the case. The surveys have shown that in any one year 50 to 60 per cent of hospitals have had to refuse some pharmacy services because of staff shortages. This simple statistic is probably the most important information that any of the surveys have produced because it indicates that the staff shortages are important and have a real impact. Those of us who advocate radical measures to deal with the problem are not doing so out of self-interest or protectionism but are doing so because of the effect on the service to patients.

Pharmacy departments around the country have tried various strategies to cope with the shortages. Apart from withdrawing or refusing services, many staff have worked unpaid extra hours and departments have been restructured to make the most of whatever staff could be recruited. In many cases, managers were explicit that such restructuring was not done because of desirable changes in skill mix but simply to overcome the problems of poor recruitment. Such restructuring has produced shifts from junior pharmacist grades to higher grades (there have been falls in A-C grades and increases in D-F, especially E) and has increased the number of technicians and auxiliary staff. The biggest change is not in the staff in post but in the junior posts available. It is clear that departments who could not fill A/B posts have simply given up and converted them to something else. This process has continued for several years and it is not surprising therefore that in the latest survey the most worrying feature was the dramatic increase in the vacancy rate amongst MTOs; over 400 new posts have been created in 2 years but only 200 have been filled. This change preceded the recommendations of the Audit Commission that would be expected to increase further the demand for technicians.

A curious feature of the MTO data is that a combination of Audit Commission data on headcounts and our data on whole-time equivalents shows a marked increase in part-time working among MTOs. It isn't clear if existing full-timers are going part-time or if new part-timers are being attracted to the service. There has not been a similar shift amongst pharmacists.

Training new staff is one obvious way to overcome the shortages but often departments have found it difficult to obtain funding for training posts especially as training of pharmacists has been separated from training of technicians in terms of funding sources. That has now changed but it is too early to see the impact of the unification of training budgets under the aegis of Workforce Confederations. There are certainly worries that while the combined budgets could be of great assistance to pharmacy, the increased demands from other parts of the hospital service could decrease the sums of money available to pharmacy, especially as the top-sliced national levy has been cut or clawed back in the last year. There are rumours that politicians, anxious to be seen to put money into clinical areas and not into bureaucracy, have not realised that training is essential to clinical service delivery. If so, they are only making the mistake that NHS staff made, and repented, a few years ago.

For some years the hospital service in England and Wales has trained about 350 to 400 pre-registration graduates but it seems that only about two-thirds of those entered the service as pharmacists. In the face of some 600 pharmacist vacancies across the service it is clear that this level of training was not the solution. This year, after a fallow year with very few qualifiers, and as a result of serious local lobbying of Education Consortia for more funds, we expect about 500 to qualify as pharmacists, though how many will stay in hospitals we cannot guess. Although the Secretary of State for Health announced and supported the increase in the training of pharmacists in answer to a parliamentary question, it comes from existing training funds and does not represent new money for the service. The same number are being recruited for pre-registration schemes in 2003 but it isn't clear if this level of recruitment will continue once the fallow year has eased from memory. There is also a short-term problem in paying for the planned number of training posts now that the pre-registration salary has gone up so much; budgets were written on the old salaries and some Confederations may not wish to make up the difference.

If training new staff is not an adequate solution, then staff must be recruited from other sectors of the profession. There is a well-known urban myth which suggests that community pharmacists could not face the cut in salary required to work in hospital and that they would not be able to cope with the type of work required in hospital. Both aspects of this myth are untrue. In the last year about 150 pharmacists made the switch and perhaps more would do so if the myth were debunked more publicly. Similar myths may prevent women coming to work in hospital after a break for family responsibilities and we need to create good "welcome back" publicity and induction and training courses that last longer than a few days.

So far, I have referred to staffing shortages mainly as a recruitment problem and in many senses that is true. The latest data, however, suggest that as well as a recruitment problem there is a serious retention problem. It has been estimated that over the last two years the hospital service recruited about 750 to 800 pharmacists but we know the total number in service increased by only 90 or so. This indicates that a large number, around 20 per cent, of pharmacists left the service in those two years. At the moment there are no centrally collated data on why those pharmacists left. Some will have retired, some will have taken a break for family reasons, some will have decided to spend time travelling, and some will have switched to another sector of the profession or left the profession entirely. In the coming year we plan to investigate this matter further but it raises serious concerns. We need to address why we don't retain more of our trainees and why we don't provide sufficient satisfaction for junior and middle-ranking pharmacists to stay.

Anecdotes about staff leaving hospitals have focused on staff moving into supermarket pharmacies and into primary care organisations such as PCTs and GP practices. The 2001 survey, however, showed that while such primary care organisations have certainly recruited disproportionately from hospital pharmacy the total number would only account for around 20 per cent of leavers. The more worrying aspect is that the staff who have moved to Primary Care are the more experienced middle grades. That augurs well for Primary Care, and for joint working with Secondary Care, but is a blow to the hospitals.

Salary rises have been a favourite tool for attempting to retain or recruit staff. The received wisdom from employment research is that low salaries are a strong cause of dissatisfaction but high salaries do not necessarily produce satisfaction in an otherwise unsatisfactory job. The definition of a low salary will clearly depend upon an individual's circumstances and on what they perceive they could earn elsewhere. The differential that has always existed between hospital and community salaries has varied from time to time and over the last three decades there have been several attempts to close the gap. Each time there appears to have been a temporary improvement in hospital staffing but then the gap has widened once more. Following the 1999 survey, which was favourably received by the parliamentary Health Select Committee, there was an appreciable increase in junior pharmacists' salaries. It is clear from the 2001 survey that if this had an impact then it was one of stabilisation rather than an increase.

Many departments have implemented their own pay rises for certain posts or members of staff, sometimes as enhanced salary but more often as a increased grade. Successive surveys have shown that such regrading has affected 7-15 per cent of posts in any one year and I would estimate that about 50 per cent of posts have been regraded in the last five years. This is apparently beneficial for those whose posts have been regraded but may have an adverse effect on the perceptions of those who have not had their posts regraded, perhaps because they have been in the same post for a long time. Such staff are important to the service, especially if we accept that retention is at least as big a problem as recruitment, and it is not in the interests of the service that such staff should become disgruntled. The recent pay award recognised that chief pharmacists might be in this position and rearranged the pay scales for G and H grades. It did not address the problem of E and F grades which is probably at least as important and perhaps more so.

If salary rises are not the whole answer then we must consider job satisfaction. The sense that one has done a good job, that one has achieved a successful outcome, or that one has offered a good service, is very important to most of us. Ways in which we measure job satisfaction are clearly nebulous but most of us would recognise that poor facilities, excessive demands, long hours, and seemingly irrelevant paperwork are negative features. Similarly, tasks which do not demand the skills one has might well be perceived as necessary, and perhaps on occasions a blessed relief, but do not produce job satisfaction. Surveys have confirmed what is common knowledge, namely that tasks once seen as the preserve of pharmacists are now more than adequately performed by MTOs or auxiliary staff. Skill-mix changes to facilitate the best use of all staff are therefore important and a flexible workforce is desirable. In some parts of the country a high cost of living and low unemployment prevent departments implementing all the changes they would desire. If we are to solve our problems than we should not only consider pharmacists and MTOs but join other professions in seeking solutions for auxiliary staff.

Training has often been regarded as a mix of a desirable good and a necessary evil. It is necessary for the service, we were all trained once, and there is satisfaction in passing on skills and knowledge to a new generation. But it can also be expensive in time and effort, it diverts experienced staff from doing the job to supervising trainees doing it, and there is a certain déjà vu about the mistakes of yet another greenhorn. The new regulations for

the preregistration year have highlighted the demands upon senior staff and there has been some success in various parts of the country in attracting limited extra funds to cope; and this in a service which traditionally viewed training as a part of every professional's remit and would not fund trainers explicitly.

It is easy to cut back on training at the first sign of budgetary problems, but this approach has been comprehensively demonstrated to be short-sighted and counter-productive. It is essential that we train adequate numbers of pharmacists and MTOs. The number of trainee MTOs has increased significantly in the last year but we are still training about 250 fewer students than we have vacancies. Perhaps there should be more explicit co-operation between hospitals to share the costs of training so that an adequate supply is maintained. This was the intention of the Multi-professional Education and Training Levy, and of the new Workforce Confederations, but it has so far not extended much beyond the existing pre-registration schemes, although I am aware of a few Trusts who are sharing MTO training as a private initiative. The coming requirement to train certain auxiliary staff to NVQ level 2 may also have an impact on the availability of training for other staff.

The recruitment of staff from other sectors of the profession has deleterious effects on those sectors because of the limited pool of pharmacists and we should continue efforts to increase that overall pool. The recent increases in undergraduate numbers are pleasing but in many universities they are funded by the virement of monies intended for other science degrees and must be susceptible to cut-backs. There is a recent worrying drop in applications to universities and the grades of entrants are also dropping. The advent of new medical schools can only make those trends worse unless we have a greater impact on school students. The Department of Health has included pharmacy in its high-profile advertising campaigns for that reason. Students often say that they were influenced strongly by experiences on vacation or work experience placements. It may be a pain to have school kids around when we are busy but it may also be the secret of future recruitment success.

Is the situation totally gloomy? Of course not. There have been some important developments over the last few years, the skill-mix is better than it was, overall numbers of pharmacists have increased, and hopefully MTOs will soon follow suit. The training establishment is now much larger, pharmacies are providing useful professional services they did not provide in the past, and staff are being attracted from other sectors. If I have one overall message, it would be that the staffing situation is a multi-faceted problem and addressing it requires a multi-stranded approach. We have already done many good things but as long as the winds of change keep blowing, the tides will continue to flow and we need to be alert to make sure they flow in the direction we want.