

NHS hospital staffing Status quo or ebb and flow?

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Staff vacancies in hospital pharmacy are continuing and have a major impact on services to patients; there are also worrying shifts in grade patterns. This article discusses the current state and trends in hospital recruitment



Recent surveys confirm that fully staffed hospital pharmacies are few and far between

Opinions and statistics concerning hospital pharmacy and the state of recruitment and retention of staff are often contradictory and have been bandied around for years. 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 facts. These surveys have continued and the fourth was recently completed (PJ, 4 May, p599). 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, 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 also 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 underestimates the real problems that departments face. Recently, the Audit Commission produced a head count over several years that confirmed the other data, and which was cited in their "Spoonful of sugar" report.

HOSPITAL STAFFING

What, then, can we say about hospital pharmacy staffing? First, there is a clear and consistent vacancy rate for pharmacists which is around 14 per cent if taken as a snapshot on 31 July. Posts that have been vacant for three months or more stand at 8.5 per cent. The Department of Health calculates a three-month figure, up to the end of March, of 5.3 per cent, and unpublished Audit Commission data show a snapshot vacancy rate of 11 per cent on 31 March.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 is 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. However, this 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

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indeed the case. The surveys have shown that in any one year, 50 to 60 per cent of hospitals have had to refuse to provide 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 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 in many parts of 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 have been 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 to C grades and increases in D to 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 is the dramatic increase in the vacancy rate among medical technical officers (MTOs); over 400 new posts have been created in two years but only 200 have been filled. This change preceded the recommendations of the Audit Commission which 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 head counts and our data on whole-time equivalents shows a marked increase in part-time working among MTOs. It is not 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 among pharmacists.

FUNDING OF TRAINING

Training new staff is one obvious way to overcome the shortages. Often, however, 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 training levy has been cut or clawed back in the past 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 preregistration 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 is not the solution. This year, after a fallow year with 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 can only guess. Although the Secretary of State for Health, in answer to a parliamentary question, announced and supported the increase in the training of pharmacists, the money comes from existing training funds and does not represent new money for the service. The same number are being recruited for preregistration schemes in 2003 but it is not 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 preregistration salary has significantly risen; budgets were set based on the former salaries and some confederations may not wish to make up the difference.

CHANGING SECTORS

If training new staff is not an adequate solution, then staff must be recruited from other sectors of the profession. There is an urban myth which suggests that community pharmacists could not face the cut in salary required to work in hospital, nor could they cope with the type of work required there. Both aspects of this myth are untrue. In the past year, about 150 pharmacists made

the switch and perhaps more would do so if the myth was debunked more publicly. Similar myths may prevent women coming to work in hospital after a break for family responsibilities; we need to create good "welcome back" publicity, and induction and training courses that last longer than a few days.

RETENTION

So far, I have referred mainly to staffing shortages 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 past two years the hospital service recruited about 750 to 800 pharmacists but 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 months, we plan to investigate this matter further but it raises serious concerns. We need to address why we do not retain more of our trainees and why we do not 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 primary care groups, primary care trusts 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 augers well for primary care, and for joint working with secondary care, but is a blow to hospitals.

SALARIES

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 past 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 improvement.

Many departments have implemented their own pay rises for certain posts or members of staff, sometimes as

enhanced salary but more often as an 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 past five years. This is 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.

— JOB SATISFACTION

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 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 then we should not only consider pharmacists and MTOs but join other professions in seeking solutions for auxiliary staff.

— PASSING ON SKILLS

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 time but 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 explicitly fund trainers.

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 past 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 multiprofessional education and training levy, and of the new workforce confederations, but it has so far not extended much beyond the existing preregistration 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.

— INCREASING THE POOL

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 univer-

sities and the A-level 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. For that reason, the Department of Health has included pharmacy in its high-profile advertising campaigns. Students often say that they were influenced strongly by experiences on vacation or work experience placements. It may be a pain to have school children around when we are busy but it may also be the secret of future recruitment success.

Is the situation one of total gloom? Of course not. Looking back, we can see that there have been some important developments in the world of hospital pharmacy over the past few years, the skill-mix is better than it was, overall numbers of pharmacists have increased, and let us hope, MTOs will soon follow suit.

In addition, the picture appears brighter when we consider that 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 the tides will continue to ebb and flow and we need to be alert to make sure they flow in the direction we want.