

# NHS pharmacy staff numbers continue to rise significantly

Numbers of qualified staff employed within pharmacy in the NHS in England have increased 7 per cent in the year to September 2004, according to the results of the latest workforce survey, published by the Department of Health in March.

This continues a trend which has seen the number of qualified pharmacy staff grow 50 per cent over seven years. Whole time equivalent numbers of qualified pharmacy staff increased from 7,591 in September 1997 to 11,375 in September 2004. Pharmacy support staff numbers also grew from 1,111 to 2,802 over the same period (see Panel below). Pharmacy growth was ahead of that for qualified nurses (23 per cent), doctors (29 per cent) and all NHS staff (27 per cent). The split between staff employed by hospital and primary care trusts was not given.

Peter Sharott, pharmaceutical adviser, London Regional Public Health Group, said that "Modernisation requires more staff to offer near patient services and deliver the recommendations of 'A spoonful of sugar' and other initiatives. My view is that not all trusts are growing staff numbers at the same rate, and those trusts that fall behind will struggle to deliver services."



Pharmacy staff numbers have increased 50 per cent in the past seven years

The increased workload is thought to be in both clinical and technical services. A conference report on p149 details some of the other reasons for growth in the pharmacy workload.

□ In a separate development, the results of the 2004 NHS staff survey by the Healthcare Commission suggest that over half of NHS staff regularly work unpaid overtime, with 12 per cent generally working six or more hours over their contracted hours per week.

A quarter of staff have been harassed or abused by patients or patients' relatives. The percentage of staff who reported having seen at least one error

that could have hurt either staff or patients in the previous month was 44, down from 47 in the 2003 survey. Over 200,000 staff from the NHS in England were surveyed to compile the results, which are available via [www.pjonline.com/links/hp](http://www.pjonline.com/links/hp)

## Pharmacy staff in England

Year	Qualified	Unqualified
1997	7,591	1,111
1998	8,120	1,156
1999	8,404	1,260
2000	8,657	1,465
2001	9,372	1,766
2002	10,083	2,052
2003	10,630	2,515
2004	11,375	2,802

## Neurology framework is published

The National Service Framework (NSF) for Long-term Conditions was published in March. It focuses on neurological conditions, setting out 11 quality requirements for the NHS and social services to provide within 10 years.

One requirement is for services to be person-centred. For example, patients are to have a single point of access to services via a named contact, so that they can refer themselves quickly back to services as their needs change. According to

Claire Reed, neurosciences pharmacist at Queen's Medical Centre, Nottingham, there is a potential role for pharmacists in this requirement. "Pharmacists who run specialist clinics, for instance those working with epilepsy, multiple sclerosis and Parkinson's disease patients, could be the named contact and so the first point of call for patients," she said. Joint working, including closer links between GPs, local hospitals and specialist neuroscience service provision, is advocated.

Other requirements relate to prompt diagnosis, appropriate referral and treatment, providing well co-ordinated life-long care and support for patients and their families and carers, and encouraging patients to adjust to their condition and socially integrate.

The framework can be accessed via [www.pjonline.com/links/hp](http://www.pjonline.com/links/hp) and a good practice guide that suggests how the quality requirements in the NSF can be implemented locally is also available.

## brief

■ The impact of the clinical trials directive one year on is the subject of a symposium organised by the Hospital Pharmacists Group and the Industrial Pharmacists Groups of the Royal Pharmaceutical Society, the Joint Pharmaceutical Analysis Group and the Academy of Pharmaceutical Sciences of Great Britain, to take place on 19 May at the Society's headquarters in London. Further information is available from [www.jpjag.org](http://www.jpjag.org)

■ Candidates are sought to fill three vacancies (two for England, and one for Scotland) on the committee of the Royal Pharmaceutical Society's Hospital Pharmacists Group. Nominations are to be made by 15 April. Further details at [www.pjonline.com/links/hp](http://www.pjonline.com/links/hp)

■ Prescription charges in England and Scotland rose 10p per item to £6.50 on 1 April. In Wales, they reduced by £1 to £4 per item.

■ Amended job profiles for pharmacy technicians have now been cleared for release and are expected to be published shortly. The entry point for pharmacy technicians is now band 4 (and not band 3). There are minor technical amendments to the band 4, 5, 6 and 7 profiles, although the Association of Pharmacy Technicians UK does not expect re-evaluation to be necessary for those who have already been matched.

■ Having lead pharmacists as part of the management structure in cancer networks is good practice, according to the National Audit Office's progress report on the NHS Cancer Plan published last month. However many lead pharmacist positions remain unfilled. The report is available via [www.pjonline.com/links/hp](http://www.pjonline.com/links/hp)

# Children's medicine network announced

A new network to develop better medicines for children is to be set up as part of the Department of Health's paediatric strategy.

The UK Medicines for Children Network will be co-ordinated from a centre based at the Royal Liverpool Children's NHS Trust, and run in partnership with the University of Liverpool. It will comprise eight research centres situated throughout the UK, and represents a £20m investment. Tony Nunn, clinical director of pharmacy at the Royal Children's NHS Trust is to be assistant director at the co-ordinating centre and each centre is likely to include a hospital pharmacist.

Mr Nunn told *Hospital Pharmacist* that research centres in the network will carry out clinical trials in accordance with a portfolio of work on children's medicines that needs to be done. Formulation issues feature prominently, including research on the stability and quality of existing formulations, such as specials and extemporaneously-prepared medicines. Bioavailability is also key, according to Mr Nunn, with about half the preparations currently made in children's hospitals not having



PHOTOHISC

Developing more medicines for children is the task of new network

bioavailability data associated with them.

There will also be a focus on using new technologies and formulation techniques. Melt-formulations and multi-particulate formulations are to be looked at where appropriate, rather than just liquids, Mr Nunn added.

The network is looking to collaborate with European centres, together with established UK institutions such as the Centre for Pharmacy Practice Research.

Other aspects of the Department of Health's paediatric strategy include the development of the British National Formulary for Children, set to be launched in July.

## Obtaining consent could compromise paediatric database

Having a requirement to obtain signed consent for the collection of patient-identifiable information to be entered onto the national paediatric intensive care audit network database would significantly reduce the amount of information stored on the database, and could therefore compromise it. This is the view set out in a study published on *BMJ online* (available from [www.bmj.com](http://www.bmj.com)). Researchers from the University of Leeds (McKinney PA, *et al*) set about obtaining consent by giving the parents or guardians of children admitted to five intensive care units a short explanation of the database, together with an information sheet. They then asked parents or guardians to fill in a signed consent form 24 hours later. Although there was only one active refusal (ie, the parent or guardian indicated on the form that they did not want information about their child being included on the database), only 182 out of 422 signed forms giving consent were returned. Signed forms were more likely to be returned for younger children and for those who had longer hospital stays. If obtaining consent to add information to audit databases becomes necessary, then resources will need to be dedicated to finding new ways of doing so, the researchers conclude.