Consultant Pharmacists

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What is a Consultant Pharmacist?

- Department of health approved title from March 2005

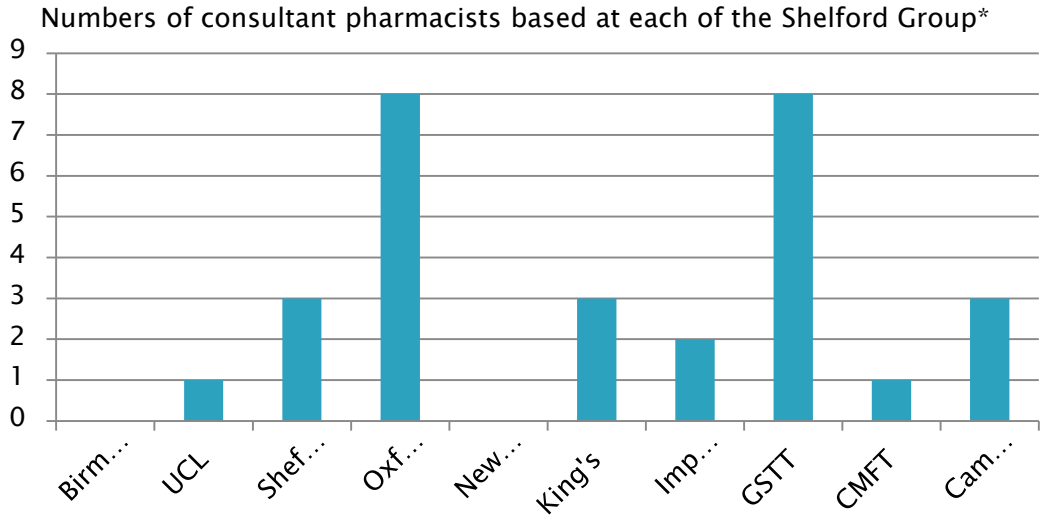
- Consultant Pharmacist title should only apply to practitioners who:
  - ✓ are appointed to approved posts
  - ✓ meet the appropriate level of competence

The title should not be conferred solely in recognition of excellence or innovative practice

- Aims of the posts
  - Ensure that the highest level of pharmaceutical expertise is available to those patients who need it
  - Make the best use of high level pharmacy skills in patient care
  - Strengthen professional leadership
  - Provide a new career opportunity to help retain experienced pharmacists in practice

The First Ten Years

- Organic growth of posts
  - Predominantly in response available individuals and organisational need
- Predominantly secondary care based focussed in large teaching hospitals but still not evenly distributed



*Ten of England's leading Academic Healthcare Organisations which are comparable

Where Are We Now?

	England	Wales	N. Ireland	Scotland
Population	54.8m	3.1m	1.9m	5.4
Consultant posts	~80	9	6	0
Specialities	28	5	2	N/A
Place of Employment	Almost exclusively secondary care, few CCG, national	All roles regional or national	Predominantly regional, one secondary care	N/A

Wales and N. Ireland were later in creating posts, have taken a more strategic approach

Key learning from Northern Ireland

Highlights

- Strategic planning for new posts (MOIC)
  - Confirmation of approval processes for posts
  - Linked strategy with workforce planning
  - Demonstrable outcome including economic health gain
- Development of advanced generalist role
  - Effective integration across “sectors”
  - Supported career structure
  - Higher Education Institutions links
  - Identification of future areas for development

Key developments from Wales

- Central approval process (all Wales)
  - Govt. panel – should it be professional (not policy)?
  - Opportunistic post creation rather than strategic
- Moving forward
  - New role, adequately resources (admin, cpd etc), aligned to country challenges/delivery plans
  - Measurable outcomes incl. research, time built in Roles should influence regionally and cross-sector
  - Work at board level
  - Contribute/influence beyond pharmacy
  - Postholders must have RPS faculty

Consultant Pharmacists in England: Creating the future workforce

- Roles need to:
  - meet population needs
  - support collaborative working across health economies
  - Be part of the pharmacy career structure to ensure growth into roles and succession planning
- Focus on **clinical pharmacy leadership** in response to:
  - Changing NHS landscape: STPs, accountable care across health economies
  - Increase in clinical pharmacy: Carter, Carter 2, GP pharmacists, urgent care, care homes
  - Clinical developments: genomics, personalised medicines, telehealth

What are we Doing to Get There?

- Stakeholder meeting Dec 2017 identified
  - Need for new guidance
    - Flexibility in practice, needs-based for local population
    - Consistency across post holders
  - New processes for approval
    - Provide visible and robust assurance
  - Link with career structures, (RPS)
  - Embedding roles in workforce (HEE)
  - Engagement and understanding of the role (driven by CPhOs)

Survey Data

- Response from 34 Chiefs, 41 Consultants

- Variable reporting structures
  - Important that consultants are managed in a way that supports them to achieve agreed outcomes (for the organisation(s), patients, the individual and the wider NHS)
  - Consultants delivering high level autonomous direct clinical care should have a reporting arrangement with someone who understands their clinical role

Benefits and Drawbacks

- Greatest benefit of consultant pharmacists
  - LEADERSHIP as well as
    - expert resource
    - support cross boundary working
    - Innovate, lead and design services to improve patient care (individual and population)
    - autonomous direct clinical care for those with the most complex pharmaceutical needs
- **BUT……**
  - They are a relatively expensive resource
  - Seen as a resource for large teaching hospitals only

What About "Expert Practice"?

- Original DH guidance states that consultants "will normally spend about 50% of their time in practice within their area of expertise."
  - Rationale for inclusion in 2005 guidance
  - Does not define the meaning of the term
  - Has led to variation in interpretation and challenges for organisations to support the role

- Consultants and Chiefs were asked what they thought "expert practice" was……..

"Expert Practice": What we Found

- Using their extensive knowledge and skills to:
  - **Contribute to patient care at the highest level** both
    - For individuals with the highest level of pharmaceutical need
    - At a system or population level so that the maximum number of patients benefit from their input.
- Undertake activities that could not reasonably be carried out by an advanced or senior pharmacist.

BUT practice is variable and dependent on:

- Speciality
- organisational, local and national priorities
- time of postholder in post
- postholder development needs

Issues Identified by Survey

1. **Leadership**: most frequently listed benefit and component of expert practice across both groups BUT 4th largest allocation of time by chiefs (12%),
   - **Need to ensure consultants have time to lead**
2. **Cross sector work and influence** is also seen as one of the greatest benefits and contributors to expert practice BUT least amount of time allocated to external liaison
   - **How is collaborative work best supported?**
3. **Direct clinical care** allocated largest amount of time
   - **Is this best use a consultant's time?**
   - **How is it different to ACP**

How do you balance the competing priorities to ensure the best outcome for patients?

Potential use of Job Planning: Linking the Plan to Desired Outcomes

- Guidance (NHSI, AHP, BMA)
  - Determine departmental capacity
  - How does a consultant contribute to departmental capacity
    - New Consultant guidance needs a flexible approach to time allocation to allow appropriate job planning.
- Review of Job Plan at least annually (Survey showed only 51% consultants had a Job plan updated within 2 years), aligned to:
  - the priorities of the organisation(s)
  - local and national priorities
  - consultant's development needs
- Maximise use of consultant's expertise in achieving desired outcome(s)
  - Majority (80%) of time on activities that that are at consultant level and impact on patients, rather than up to 50% "expert practice"

Models for Developing Consultant Posts

How posts are developed depends on type of post

- **Very highly specialist** (e.g. organ transplant)
  - Likely to be teaching hospital based,
  - Funding from hospital (+/- national funding)
  - Need to have individual with requisite knowledge
- **Highly specialist** (e.g. critical care, cancer services)
  - Likely to be teaching hospital based (may be spread across more than one, include a DGH)
  - Funding from one or more hospital/CCG (or STP/ACS/O)
  - Could create post without specific applicant in mind
- **Expert generalist** (e.g. care of the elderly, respiratory, diabetes)
  - Could be based anywhere across the health economy
  - Funding from multiple partners (should be encouraged/the norm)
  - Should create posts based purely on need, not available candidates

In response to population health need e.g. in high priority clinical conditions, to address health inequality

Workforce to Meet the Population Need

- Need processes that allow posts to develop in response to need, rather than postholder availability
- Ability to appoint suitable individuals who may not meet all the criteria initially (training post)
  - Can develop within the post
- Build succession planning into posts
- Develop further opportunities for consultant development into clinical lead/director roles that allow them to continue to use expertise most effectively

Modern Role of the Consultant Pharmacist

1. Be **source of expert knowledge** for the profession, the MDT and patients across a health economy
2. Lead the **modernisation of clinical services** to ensure optimal care and outcomes for patients
   - Lead on the **local implementation of national programmes** aimed at improving care
   - Take the **strategic lead on aligning priorities** across their speciality, the profession and the health economy to deliver optimal outcomes for patients
   - **Lead on the uptake of emerging technologies** (e.g. genomics) for the profession and the entire NHS
3. **Educate and develop the profession** and other healthcare professionals ensuring a sustainable supply of suitable clinical staff
4. **Lead on practice based research, clinical trials** (PI)

LOOK AT OUTCOMES AS A GROUP