

MOVING UP THE AGENDA: MANPOWER ISSUES

Developments around consultant pharmacists and how such roles tie in with

Agenda for Change were set out to delegates at the morning session of the

Hospital Pharmacist conference held in London on 11 November. Gareth Jones reports

The consultant pharmacist title should only apply to those appointed to approved posts and who meet the appropriate level of competence, said John Farrell, principal pharmaceutical officer, Department of Health. He stressed that the title should not be conferred solely in recognition of excellence or innovative practice. He added: "A consultant pharmacist will be a champion in practice, education and research, have influence at strategic level and be recognised locally and nationally as an ambassador for the profession."

Mr Farrell was introducing the Department's developing work on consultant pharmacists which, he said, would produce final guidance in spring 2005, subject to ministerial approval. This project applies to the managed sector in England, although there will be ongoing dialogue with colleagues in the devolved administrations.

The development of the role of consultant pharmacists was announced in the Vision for Pharmacy in 2003. Earlier this year, at the Guild of Healthcare Pharmacists conference, Rosie Winterton, Minister of Health, announced the establishment of the steering group. There is also a wider reference group which will be consulted on the proposals (eg, Chief Medical Officer, Guild of Healthcare Pharmacists, Royal Pharmaceutical Society, specialist interest groups, academia).

Developing consultant pharmacist posts will retain the skills of pharmacists in the NHS for the benefit of the patient and also recognise these skills appropriately, he added. The guidance will cover a definition for the title of consultant pharmacist, said Mr Farrell. At the moment this title does not have any accepted meaning. A competency framework will be developed to differentiate between advanced level practice and the new consultant role.

In addition, an Agenda for Change job profile is being produced, ahead of the role being introduced. Mr Farrell hoped that this would give people as much guidance as possible about what the role will involve. The consultation process with the unions would still be followed before sign-off as with all profiles.

Mr Jones is editor of Hospital Pharmacist



John Farrell: consultant posts will create huge expectation within the service

Mr Farrell said that the benefits of registration of consultants are not immediately obvious and that any advantages would have to outweigh potential bureaucratic burdens. If registration did proceed, a decision would be made about which body is most appropriate for managing this process.

"These posts will create huge expectations within the service," said Mr Farrell. "They will [cover] varied roles with demands coming from different directions," he added. Mechanisms need to be put in place to support those individuals who become the first to take up the posts.

"Patients have a right to expect that when they are presented with someone bearing the title consultant pharmacist, they are getting the highest standard and quality of care available. These standards of care should be uniform across the country," Mr Farrell said. Post holders should be able to move with relative ease from one part of the country to another. Although clinical pharmacy is the forerunner of the consultant pharmacist project, the intention is to make the work inclusive and include other areas of work.

There will be no targets for the number of posts that will be created. The number of posts will be determined following an examination of service need at the local level.

Consultant posts will only be set-up when there will be patient benefit. The consultant

will be expected to undertake clinical practice at expert level, and this is likely to constitute about 50 per cent of the role. This practice could involve direct patient care or work involving populations or groups of patients. Consultant pharmacists will have a strong leadership role and will focus on succession planning and bringing forward the next generation of consultants. Consultants will also be expected not only to participate in research and development, but also to initiate innovative approaches and promote evidence based practice.

In terms of approving a consultant pharmacist post, Mr Farrell thought that setting up approval panels would be one way to achieve this. The geographical spread has to be determined, as these panels could function across a few primary care trusts, a strategic health authority or a cluster of strategic health authorities. They would look at the business case for the post and the person specification and determine if there is a match with the national guidance.

It is important to differentiate consultant level practice from other existing or planned roles. Firstly, advanced level practice, which is covered in more detail in the presentation by David Webb (p449). Secondly, the Faculty of Public Health and others are developing the role of a consultant in pharmaceutical public health with a separate competency framework and assessment. This qualification will be equivalent to consultants in public health medicine. The Vision for Pharmacy also made a commitment to developing pharmacists with a special interest, and this work will be taken forward separately in 2005 within the context of the new community pharmacy contract.

The specialist pharmacist interest groups are likely to be involved in the assessment panel to look at the post, and, where appropriate, the interview process to select the candidate. "We need to make sure that we get a credible specialist input into this process," said Mr Farrell. He added that work was needed on identifying where this advice would come from.

Mr Farrell reminded participants that the material presented at the conference was not finalised, and encouraged comments and suggestions.

Learn lessons from nursing and allied health professional consultants

Consultant allied health professionals (AHP) already exist said Jackie Turnpenney, project lead, consultant pharmacist project. These posts were introduced to improve services to patients, provide new career opportunities, retain experienced staff, strengthen professional leadership and drive the changes in the modernisation agenda. The Government announced a strategy in November 2000 to create 250 consultant AHPs by 2004.¹ Recruitment has been slower than expected, with only 47 post holders appointed. Ms Turnpenney shared some of the experiences of setting up these posts which maybe useful when considering the consultant pharmacist role.

PROBLEMS

The biggest single reason for the shortfall of appointments is the lack of finance, said Ms Turnpenney. This has occurred because of difficulties in pooling the money needed to fund a consultant post. However, more creative solutions, like skill mix, may be an answer. Another option is that more than one organisation employs a consultant (eg, primary care trusts, acute trusts, higher education institutions), and therefore the cash requirement for each individual trust is more manageable.

When the posts were announced, there was major structural change occurring in the NHS. Some groups were fragmented and new management structures were not highlighting consultant AHPs as an immediate target for their new organisations.

Ms Turnpenney added that a further challenge is that setting up consultant posts is not simply a matter of upgrading existing posts. Some service managers seem reluctant to introduce the posts, suggested Ms Turnpenney. This may be because they are not comfortable employing someone who will earn more than them. This has been a problem for both nursing and AHPs. She thought that it was important that service managers do not see the consultant role as a threat to themselves, as these roles should complement and not replace the existing senior roles.

As a result of the slow uptake, consultants are currently working in only the five biggest AHP professions. However, posts had been established across a wide range of specialties (eg, musculo-skeletal disease, pain, respiratory/critical care, diagnostic radiography, diabetes, oncology). Of the people that have moved into a consultant AHP role, only one person has moved out of the post (to take



Jackie Turnpenney: consultant posts must be designed with a realistic workload

another role) and therefore no-one has left because the role was not achievable.

“Those people who are thinking of creating consultant pharmacist posts in the future should be creative about the roles that are developed. Hopefully in a year or two we will be able to see a range of different roles created in pharmacy across a range of specialties,” she said. National guidance does not precisely define what consultants will do.

The government also announced a target of 1,000 nursing consultant posts by 2004. There was a high turnover rate because some of the processes set-up were not quite right. Changes have been made following the early learning with consultant nurses.

CREATING THE POSTS

Ideas for nursing and AHP consultant posts are conceived at a local level. A submission by a trust or group of trusts to employ a consultant is then assessed by a panel at strategic health authority level. There are two roles for the panels: maintain the minimum criteria of the national guidelines on consultant posts and ensure that the posts are achievable.

The panels check that the finance is in place to pay the salary of the consultant and also that the right infrastructure is available (office space, secretarial support, access to IT, etc). They also check for explicit stakeholder support for the posts. Ms Turnpenney said that an audit of consultant AHPs found that some had no office and were working from a treatment couch — highly specialised staff with a complex role cannot be expected to

function in these conditions. The place of the consultant within their organisations should be clear, so that there is accountability, she said.

Fifty per cent of time should be spent on clinical practice and the remainder split between education, research and professional leadership. Some of the proposed consultant posts had seven or eight clinical sessions per week which does not allow the consultant the opportunity to complete the rest of their role. An example of this was seen in some of the consultant radiographer roles, which were set up with as high an amount of clinical practice as would be seen in a consultant radiologist post. These posts are intended to be broader based than medical consultants and it is important to negotiate the clinical component at the beginning, said Ms Turnpenney. When these posts are designed they must be “doable”. “Experience for both nurse and AHP consultants shows that the research element can be at risk if the requirements of the post are too large,” she said.

It is particularly important with the first consultants to provide leadership training. This helps the post holders deal with their highly visible role. Many different organisations may attempt to call on their time and the expectations of the post holders and employers should be realistic, she thought.

SUCCESESSES

A presentation on the lessons learned from a programme inevitably focuses on things that did not go as well as was hoped. Ms Turnpenney emphasised that the implementation of AHP consultants had been a positive process. A lot of the work done so far has been on service re-design, which has benefited from the great experience of these practitioners. They are now beginning to increase research capacity. They are also finding that doors are opening at a strategic levels.

There is anecdotal evidence that the existence of consultant posts is supporting recruitment. Where a consultant is in post, people want to work there and learn from them, particularly if their own aspiration is to be a consultant.

REFERENCES

1. Department of Health. Meeting the challenge: a strategy for allied health professionals. London: The Department; 2000.

Competency framework — needed to recognise consultant practice

A competency approach to consultant pharmacist practice is probably unavoidable, said David Webb, director of clinical pharmacy, London, Eastern and South East Pharmacy Services, because the NHS is now moving to Agenda for Change. Agenda for Change is based on a competency framework — the Knowledge and Skills Framework (KSF). The advantage of this competency approach is that when people are exposed to a competency framework, their development progresses in an accelerated and sustainable fashion. At every stage someone can see what they have to achieve in order to move on to a higher level.

“Competences have their critics, with some suggesting that consultant practice is beyond the scope of a competency framework,” said Mr Webb. He added that this comment showed a narrow interpretation of competencies and demonstrated a misunderstanding of the political climate following the Kennedy report. The other



David Webb: distinguish between advanced and consultant level

school of thought is that reflective practice subsumes everything that competencies are there to achieve. He said that reflective

practice is just a part of expert professional practice.

The consultant post opens up a second, practice-based, career pathway as an alternative to working as a professional manager. This process anchors people within set periods of development, much more than was the case previously, said Mr Webb.

Mr Webb and colleagues have developed an advanced level competency framework to recognise practice at this level. A literature review was undertaken and descriptors of competencies were written. These were then put forward for consensus panels to debate. Three panels each considered two of the six clusters of competencies:

- Expert professional practice
- Building working relationships
- Leadership
- Management
- Education, training and development
- Research and evaluation

The advanced level framework consists of 34 competencies in these six clusters. When assessing an individual, they can be graded at foundation, excellence and mastery level for each competency. This framework is generic, and expert professional practice can be interpreted for each practice function and other functions are so general as to apply for everyone.

Work had been undertaken to evaluate whether this tool facilitates the recognition of competency profiles. Hospital pharmacists were invited to take part in a self-assessment of their practice level and competency. They were categorised as specialists in training, experienced practitioners or leading edge practitioners. They were also asked what sort of evidence they would use to substantiate that judgement. The first analysis has been completed on 319 pharmacists (including 68 working in oncology, 69 in mental health, 36 in paediatrics, 35 in critical care, 68 in primary care, 21 in medicines information and 22 in other areas).

Looking at the whole sample, pharmacists are most confident about their abilities in expert professional practice and building relationships. Leadership, management, and education, training and development form a middle category but research and evaluation is less well developed.

Using the self-assessment of competencies, the possible profile for a consultant would be mastery in expert practice, building relationships and leadership, and excellence in management, education, training and development, and research and evaluation. The advanced practitioner would occupy the excellence level for all competencies with the exception of research and evaluation, which would be at foundation level. "This work allows us to consider a strategy for moving people from advanced level to consultant level practice," said Mr Webb.

With the competencies to be a consultant proposed, the profiles of the 319 pharmacists were then reviewed to find out how many met the criteria. Forty-five of 319 (14 per cent) satisfied the suggested competency criteria for becoming a consultant. Nearly 50 per cent of those who scored themselves as being leading edge met the criteria for consultant status. These pharmacists have on average been qualified for 21 years and spent seven years in their current organisation. In terms of their qualifications, 61 per cent hold a diploma, 36 per cent an MSc and 9 per cent a PhD.

"The advanced level framework gives us a method to recognise practice at a consultant and advanced level. It makes it possible to understand what the development needs are to move from the specialist on entry,

through to advanced and consultant level. This makes it a key part of a sustainable development strategy," said Mr Webb. He thought that the framework could be used as a template for all specialties, but it would require re-interpreting for each specialist group, in terms of what it means to be a consultant in that area.

The framework does not outline the purpose of a consultant pharmacist and it does not identify the knowledge and experience required in different areas. Mr Webb suggested that there would need to be certificates of completion to verify that an individual had been through sufficient training. These should be issued at the end of general training and at some stage when the person is working at the advanced level.

The challenge for the specialty groups is to unite around this idea and use the specialty system to inform the knowledge, training and experiences, he said. He commented that the guidance due in the spring would focus more on the mechanism for approving the post. The issue of developing people so that they are fit for purpose is a longer term goal, he added.

This advanced level competency framework has been mapped to the KSF. The competencies were clearly recognised in the KSF, which is regarded as important if this competency framework is to be useful.

New career path — more options, but slower progression up the ladder

Agenda for Change and the proposed introduction of consultant pharmacist posts will lead to more options to develop and obtain higher salaries, but progression to these new posts may take longer. This was the assessment of the changes to the career path for hospital pharmacists given by Richard Cattell, director, South West Medicines Information and Training, and a member of council of the Guild of Healthcare Pharmacists.

There will be three different types of role at the top of the career ladder: professional manager, regional specialist and consultant pharmacist. The professional manager is the traditional role for pharmacists to aspire to. The consultant pharmacist would spend 50 per cent of their time on expert patient care and would have responsibilities for research and development, education and training and professional leadership. The regional specialist role would involve providing expert advice across a range of organisations (network, strategic health authority, etc.). Some roles might contain elements of two or three of these types of work.

The band at which a graduate trainee would join the health service under Agenda for Change is yet to be announced. On qualification, they would apply for a role in band 6. Once recruited, the newly qualified pharmacist and their manager would agree an outline for the post using the Knowledge and Skills Framework (KSF). Part of this process will include an agreement about what levels the employee should have reached at the two gateways on the band (the first is reached after one year in post and the second is reached towards the top of the scale). Pay progression through a band is automatic, except at the two gateways, where it can only occur if the employee has met the requirements of the KSF. The employee and manager will meet for development reviews at least annually. "The KSF could be seen as the first step towards performance related pay in the NHS," said Mr Cattell.

If a newly qualified pharmacist progresses one point up the scale each year, they would not be eligible to apply for a chief pharmacist post until the age of 50, said Mr Cattell. However, it should be possible to accelerate progression through the bands by, for example, attending suitable training courses. If a pharmacist is able to meet the personal specification for a job in a higher band, they do not need to wait to pass the second gateway before applying for this role. "We may be able to move between bands quicker than we initially thought," he said.



Richard Cattell: we must decide what constitutes a specialty within pharmacy

Initially, training should encompass all areas of NHS pharmacy. After about three years in band 6, and having completed broad competency based training with a higher education qualification, a pharmacist could be in a position to apply for a band 7 role. The decision about what role to apply for will be an important one, as this is the first decision which will affect the final career decision. These roles will be more in-depth, covering narrower areas and be specialty based. Pharmacists are likely to spend four or five years in this role.

Band 8a roles will be organisational leads in that area. These will be specialist roles, which will be done for four or five years. If a pharmacist wants to move above band 8a at the moment, they have to be lucky to find a role that does not involve management. Consultant pharmacists will be able to hold jobs in higher bands without needing to take on management responsibility. At the moment, the only option is to move to the role that will be re-named pharmacist team leader in band 8b or 8c (see Panel 1).

Mr Cattell said that the consultant pharmacist role opens up a new way for reaching the top of the career ladder. In terms of the job evaluation under Agenda for Change, the consultant will have the highest level of "knowledge and skills" in their professional group. They will also have the highest level for "analytical and judgement skills" and "freedom to act". The manager would have more human resources, finance and information responsibility than a consultant pharmacist. A consultant pharmacist would have more research and development responsibility than a manager. They may have similar responsibility for patient care, although the description of that responsibility may differ (ie, relate to a specific area rather than organisationally). Perhaps the emotional stress of dealing with distressed patients may be higher for the consultant.

The competencies for a consultant pharmacist role will be defined by the individual specialty. The role outline will be standard as there will be consistency throughout the NHS.

Mr Cattell then posed the question: "What is a specialty within pharmacy?" He thought this was something which should be identified. Could paediatric pharmacy, for example, be the specialty that the consultant will work in, or should the role be more specialised, ie, paediatric cardiology. "We need to think about these specialties to make them more real and pertinent," he said.

Mr Cattell thought that it is also important to establish who decides on the standards. One view is that pharmacists will need to obtain a certificate confirming that they are eligible to apply for a consultant pharmacist role, but someone will have to decide if these certificates are valid. "A band 6 pharmacist needs to know where they are going [in their career]. There needs to be the same structure across NHS pharmacy. Specialists in one area need to do the same thing as specialists in another area," he said.

Panel 1: How a pharmacy career might develop

Band 6

3-year role for a newly qualified pharmacist
Broad competency based training
Higher education qualification undertaken

Band 7

4-5 years with more in-depth training
Narrower specialty-based training
First decision made about final career destination

Band 8a

4-5 years in specialist post, lead in that area

Band 8b/c

Team leader with increasing organisational responsibility

Consultant pharmacist (band unknown)

Expert patient care role
Research, education and leadership role