The role of the multi-professional consultant practitioner in supporting workforce transformation in the UK

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Multi-professional consultant practice | career capability framework | systems leadership | embedded researcher | practice expertise | workforce transformation | people centred systems | co-production

ABBREVIATIONS
AHP – Allied health professional
CGA – Comprehensive geriatric assessment
HEE – Health Education England
ICS – Integrated care systems
MPCP – Multi-professional consultant practice
PCN – Primary care network
WHO – World Health Organisation

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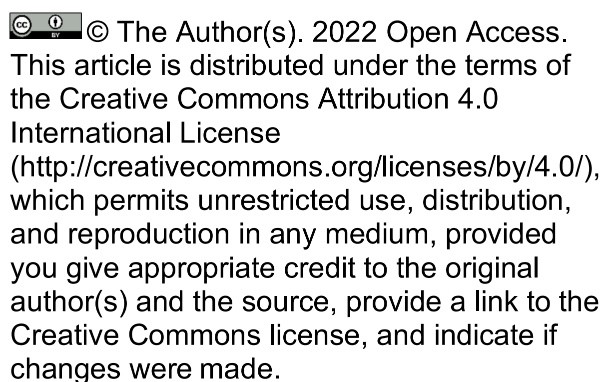

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What this paper adds: This paper illustrates the impact of different multi-professional consultant practitioner posts in England through case studies, highlighting the impact of the role as a systems leader on population health outcomes. As the multi-professional consultant practitioner capability framework is only recently released in England it provides a practical application and consideration of workforce development and transformation priorities for integrated health and care systems. Key enablers and priorities are identified to optimise the benefits these roles bring to system and workforce transformation and to accelerate their establishment where they are absent.

Abstract: There is an urgent need to transform health and social care to take a whole systems approach to meet health and social care need and address health inequalities in partnership with citizens and communities to focus on what matters to them. Pivotal to this is transformation of the healthcare workforce to develop the capabilities required and offer career progression and development opportunities to attract and retain staff.

The contribution that multi professional consultant practice roles can make as system leaders to this challenge is highlighted across the five domains of multi-professional consultant level practice: 1) strategic and enabling leadership; 2) learning, developing, improving practices; 3) embedded research and inclusive evaluation; plus 4) process consultancy combined with 5) the credibility of professional expertise.

The interdependence of these domains is a crucial part of the role, and its inbuilt flexibility is an asset which enables changing priorities and community needs to be addressed in partnership with people.

The multi-professional skillset also contributes to developing effective cultures of learning at every level of the health and care system. This feature enables change to be embedded sustainably through drawing on and valuing the contribution of all and developing good places to work – instrumental in both workforce retention and innovation.

Multi-professional consultant practice roles are an invaluable resource that needs to be at the forefront of system transformation

and recognised as catalytic for achieving strategic priorities by commissioners.
This paper provides three consultant level practice case studies in pharmacy, nursing, and allied health practice to illustrate impact and outcomes on population health priorities.
There is an urgent need to invest in workforce education and development if the future vision for people centred integrated health and social care is to be realised and sustained in the longer term.

This requires investment in commissioning consultant practitioner roles as systems leaders and creating attractive career progression and development frameworks for practitioners to progress from enhanced to advanced to consultant practitioner level roles.

Introduction: Health Education England (HEE) has co-created a new career capability framework for Multi-professional Consultant level Practice (MPCP) (HEE, 2020), a term used to describe the role, capabilities and impact expected from this level of practice as system leaders and embedded researchers.

Capability is defined as *'the attributes (skills, knowledge, and behaviours) which individuals bring to the workplace. This includes the ability to be competent and beyond this, to manage change, be flexible, deal with situations which may be complex or unpredictable and continue to improve performance.'* (Health Education England, NHS England and Skills for Health 2020, p. 9).

The purpose of the MPCP role is to provide integrated expertise in the four domains necessary for enabling quality care to be delivered and evaluated at all levels of the health and care system[1] (Box 1), where credibility in one's own professional practice is a pre-requisite (Manley *et al.,* 2016).

Box 1: Working definition of multi-professional consultant practice is defined by integrated expertise in the four domains necessary for enabling quality* care at all levels of the health and social-care system:

- Expert practice (the consultant's main health / social-care profession)
- Strategic and enabling leadership
- Learning, developing, and improving across the system
- Research and innovation as an embedded researcher

This embraces the key skillset for systems leadership and systems transformation aided by clinical credibility in the consultant's own professional practice and underpinned by consultancy approaches that sustain quality.

*Quality is defined as person-centred, safe and effective care with continuity

Adapted from Manley and Crouch (2020)

The domains are underpinned by a consultancy foundation which focuses on enabling self-sufficiency in problem solving

[1] The integrated care system (ICS) is the term for new structures in England for bringing all partners together with citizens in England to provide integrated care services across a specific place to meet population needs.

Figure 1: The four domains of the Multi-professional Consultant Practitioner role in England

in others across every level of the system (Fig 1).

These roles represent the pinnacle of the practice career framework across all health professions (Skills for Health, 2020) and have huge potential for delivering the NHS vision and policies across integrated care systems (ICSs) (NHS Long Term, 2019; NHS People Plan, 2020; Health and Care Bill, UK Parliament, 2022), although there is a lack of understanding and appreciation of their potential for supporting system-wide transformation.
This paper outlines the role, purpose, and capabilities of the MPCP, and aims to demonstrate the impact on the system and workforce through three case studies using the professional lenses of pharmacy, nursing and allied health professional (AHP[2]) practice.

Key enablers and priorities are identified for ICSs, the new commissioning bodies in England, to optimise the benefits these roles bring to system and workforce transformation and to accelerate their establishment where they are absent.

Background: How does the Consultant Practitioner Role fit with the WHO and UK vision for future integrated health care delivery?

[2] Allied Health Professions in the United Kingdom is the term that represents 14 health care professions, making up one third of the workforce; 13 of the 14 AHPs are regulated by the Health and Care Professions Council (HCPC) with Osteopaths regulated by the General Osteopathic Council (GOC).

Achieving people centred healthcare, the key driver behind the World Health Organisation's (WHO) global strategy (WHO, 2015) outlines a fundamental paradigm shift in the way health and social care services need to be organised and delivered.

To place the person and citizens at the centre of health and care transformation requires focusing on what matters to people, addressing equity, diversity and inclusion, and developing the full potential of the workforce in partnership with communities to address population health needs.

The WHO (2015) identify sixteen principles for people centred integrated health systems (Box 2) and these principles underpin the development of the Multi-Professional Consultant Practice (MPCP) Capability and Impact Framework relevant to all health professions across the United Kingdom (HEE, 2020).

Multi-professional consultant roles are aligned to expertise in the skills required to enable collaborative place-based system wide transformation for people with health and care needs based on person and people centred values (Box 3).

The NHS Long Term Plan (2019) sets out to improve the lives, health, and wellbeing of people who live and work in their localities and neighbourhoods through formalising the establishment of integrated care systems (ICSs). MPCP therefore defines and possesses the skills and expertise required to address the challenges posed by health and care systems in the UK, but also other countries where there may also be the need for more integrated systems and/or priorities with improving the capability and capacity of the workforce.

Box 2: The sixteen principles underpinning people centred integrated health systems (WHO, 2015).

Comprehensive, equitable, sustainable, coordinated, holistic, preventative, empowering, respectful, collaborative, co-produced, endowed with rights and responsibilities, governed through shared accountability, evidence informed, led by whole systems thinking, and ethical.

The aim is to provide 'joined-up' health and care services to improve outcomes, tackle inequalities, enhance productivity - social and economic, and collaboratively address complex challenges through enabling place-based organisations to work in partnership with residents and service users (NHS 2022). This aim will be thwarted if the workforce cannot be retained, grown, and developed to deliver this vision.

What is the Multiprofessional Consultant Practitioner Career Capability Framework and why is Systems Leadership so important?

The MPCP Capability and Impact Framework has built on research extending over twenty years (Manley *et al.,* 2019), and has been co-created with over 1000 participants and key professional bodies across the United Kingdom (UK). Launched in 2020, by Heath Education England (HEE) it comprises the four integrated domains (Fig 1) aligned with

core values, key capabilities, and an impact framework to emphasise role expectations across pathways,

Box 3: People and Person-centred definitions and values

‘Person-centred care supports people to develop the knowledge, skills, and confidence they need to more effectively manage and make informed decisions about their own health and health care. It is coordinated and tailored to the needs of the individual. And, crucially, it ensures that people are always treated with dignity, compassion, and respect’ (Health Foundation, 2016).

It is the core values of dignity, compassion and respect for preference, choices and relationships that are fundamental to the experience of person-centred practice (McCormack *et al.,* 2021).

People-centred care: an approach to care that consciously adopts individuals’, carers’, families’, and communities’ perspectives as participants in, and beneficiaries of, trusted health systems that respond to their needs and preferences in humane and holistic ways. People-centred care also requires that people have the education and support they need to make decisions and participate in their own care. It is organized around the health needs and expectations of people rather than diseases (WHO, 2015).

communities, and populations. It places emphasis on systems leadership and embedded researcher functions. These functions are combined with workforce transformation through developing effective person-centred workplace cultures where everyone can flourish (Cardiff *et al.,* 2020), drawing on the workplace as a key resource for learning, development, and improvement (Manley *et al.,* 2016).

Workforce transformation is ‘*a process, driven by improving the way we recruit, retain, deploy, develop and continue to support the healthcare workforce, to meet the growing and changing needs of local populations – ensuring high quality care for the patients of today and the future’* (HEE, 2022, para two).

Workforce transformation embraces all professions and staff groups contributing to health and care and aims to ensure the workforce has the qualities and capabilities required to meet the needs of local communities using person centred approaches to reflect the values of equality, diversity and inclusion ensuring services provided to everyone are fair and accessible and by addressing collectively inequalities that influence health status (Williams *et al.,* 2020).

At the heart of this is the use of co-production principles and approaches that enable all stakeholder voices to be heard, respected, and valued in shaping future plans (NHS, 2021; Graham *et al.,* 2022). MPCP is underpinned by systems thinking that recognises the dynamic interdependence between every part of the health and care system (Swanson *et al.,* 2012). This approach involves facilitating the complexity of cross boundary working and adopting processes that enable the development of shared vision, creativity and learning in action and supports the long-term development of people and institutions enabling them to adapt, change, prosper and grow (McCormack *et al.,* 2008).

Core to facilitating this cross sectoral working is systems leadership broadly defined as:

'a set of skills and capacities that any individual or organization can use to catalyse, enable, and support the process of systems-level change. It combines collaborative leadership, coalition-building, and systems insight to mobilize innovation and action across a large, decentralized network' (Dreier *et al.,* 2019b, p. 13)

In the context of health and care the role of clinical credibility has been identified as an essential enabler when transforming health care for different groups across systems, defined as:

'The leadership approach that drives integration across boundaries based on specialized clinical credibility working with shared purposes to break down silos and deliver person-centered, safe and effective care with continuity' (Manley *et al.,* 2016, p. 5).

The key activities of systems leadership distilled in a concept analysis describes what system leaders do across all the domains of MPCP (Box 4) using the mnemonic 'SYSTEM'.

Systems leadership appreciates and works with the complex, dynamic changing, inter-relationships comprising health and care systems (Greenhalgh and Papoutsi, 2018; Cohn *et al.,* 2013), facilitating cross boundary working at every level (Dunn *et al.,* 2022; Manley and Jackson, 2020; Martin and Manley, 2017; Manley and Titchen, 2016), fostering a shared approach, focusing on what matters to people and communities (https://wmty.world) to evaluate and embed learning and real change collaboratively with impact linked to professional effectiveness.

Box 4: The key activities that describe what systems leaders do

(Setchfield and Manley, 2020, cited by Solman *et al.,* 2021)

Stimulating and facilitating high engagement

Yielding in practice co-created values, purpose, goals, vision, principles

System challenge to navigate complexity towards the future

Testing assumptions, fostering reflection

Enabling system improvement

Modelling and facilitating learning in and about work

System leadership therefore counters the fragmentation that exists across community and secondary care, tertiary agencies and public health, which has huge negative impact on service delivery to the detriment of people and communities, and inevitably leads to ineffective use of valuable resources. This fragmentation hinders the ability to address health inequalities and meet unmet needs through unnecessary duplication, and gaps in continuity and timeliness resulting from deficits in capability and capacity of the workforce and/or inappropriate deployment.

Complex adaptive systems have already been aligned with mobilising the natural creativity of health care professionals to adapt to circumstances and evolve new and better ways of achieving quality

(Lanham *et al.,* 2009), and is a notable feature of the pandemic where front line staff have experienced liberation to find solutions (Jackson *et al.,* 2020).

As embedded researchers, MPCP enables better insight into local contexts, the issues affecting stakeholders (including service users), and the realities of practice with the potential for improving quality and sustaining changes through practice-based research and evaluation (Vindrola-Padros *et al.,* 2017). Embedded research also addresses the key influences on the translation of research and best evidence into practice namely the contextual factors (comprising context, culture, leadership and evaluation), the blending of different evidence relevant to practice, and the holistic facilitation expertise required for successful knowledge translation (Rycroft-Malone *et al.,* 2013).

Through the consultancy function, MPCP is also a mechanism through which quality of the system can be developed and sustained. This function provides internal consultancy across the system at every level. The consultancy process, informed by Caplan's model (1970) focuses on two consultancy levels; supporting patients, citizens, and other professionals at one level associated with advanced level practice, and at the second level facilitating a system-wide focus associated with consultant level practice. MPCP also predominantly draws on a process consultancy approach, where the aim is to enable others at all levels to become self-sufficient in their own problem solving (Schein, 1988) (Box 5).

Box 5: Process consultation defined
Edgar Schein (1969) *Process Consultation: Its role in organization development,* Addison-Wesley Publishing Company, Reading: Mass.

Process consultation is the creation of a relationship with the client that permits the client to perceive, understand, and act on the process events that occur in the client's internal and external environment to improve the situation as defined by the client.

In summary, MPCP achieves system integration and addresses workforce transformation priorities through expertise and credibility in professional practice combined with expertise in its four integrated domains, its consultancy foundation, and a shared purpose, to develop cultures that provide person /people centred, safe and effective health, care, and services across systems with continuity, addressing health inequalities. Whilst MPCP is the pinnacle of the professional practice career framework where professional expertise is central to the role; the generic domains also inform career progression at all levels (i.e. pre-registration, registration, enhanced practice, and advanced practice) and there is increased recognition that capabilities in these areas are required together with the core values to enable adaptive change; innovation for solutions, cultures where all can flourish and sustainable transformation across systems (Manley and Jackson, 2020).

Table 1: Intermediate and Ultimate outcomes of Systems Leadership (adapted from Solman *et al.*, 2021)

Intermediate Outcomes	Ultimate Outcomes
An ethos of shared ownership, risk, responsibility and accountability across the system Better information technology to underpin shared partnerships Committed, high performing teams that are effective and innovative Integrated systematic learning, improvement and adaptability to meet system need Workforce aligned with shared vision, purpose and cultures that are person-centred, population focussed with place-based systems Patients involved in service design Employees experience high quality support	Improved patient experience Timely and appropriate care Population focussed change People taking greater responsibility for their own health and wellbeing Reduced staff turnover

Integral to these roles is the demonstration of impact, to enable commissioners and key stakeholders to understand the potential of these roles in support of system and workforce transformation.

The term "impact" describes '*any change caused in whole or in part by an action or set of actions, including research actions*' (Belcher and Halliwell, 2021, p. 2). A synthesis of existing literature on systems leadership referred to by Solman *et al.* (2021) identifies both intermediate and ultimate outcomes and impact outlined in Table 1.

The MPCP Capability and Impact Framework provides top-level impact statements (Table 2) for each domain with specific examples identified (HEE, 2020), recognising that impact is achieved through integrating capabilities across all the domains.

Case study illustrations of how the MPCP domains can impact outcomes to support system and workforce transformation

To illustrate the MPCP Impact Framework we present three case studies from the perspective of a consultant pharmacist, consultant nurse and consultant Allied Healthcare Professional (AHP).

Each case will be presented with a focus, followed by a descriptor of the role and impact written in the consultant's voice, and ends with a commentary which is intended to draw out the interrelationships

Table 2: Multi-Professional Consultant Practice Impact Framework – overarching impact statements (see HEE 2020 for examples under each statement)

DOMAIN	Broad overarching statements of impact for each domain			
Expert Practice	Demonstrates real, measurable, and lasting improvements to the quality of care and service	Demonstrates the development of innovative and effective person-centred pathways aligned with systems of care	Demonstrates that the public, service users, carers and families have been involved significantly in joint activities to improve and evaluate services	Demonstrates significantly improved person-centred, safe, effective, and combined services across the system.
Strategic and Enabling Leadership	Transforming and lasting effect on staff and people experiencing care or services	Seen as a key influential leader in helping to develop a specialist area of practice or service.	Develops the transformation and development of clinical care, and service leaders.	Demonstrates innovations put in place in changing and complex situations.
Learning, developing, improving across the system	Significantly influences the development of a learning culture across services and the system.	Demonstrates measurable outcomes on organisational learning as a skilled facilitator	Identifies learning and development initiatives that support workforce development across the system.	Actively influences and is a significant contributor to developing curriculums that allow students and practitioners to learn.
Research and Innovation	Oversees leadership on how evidence in practice is put in place and used	Creates a knowledge-rich culture. Makes sure the relevant system data is used intelligently	Identifies and contributes to knowledge and the appropriate evidence base, informing person-centred, safe, and effective care.	Inspires and helps others to be positively involved with research and clinical academic pathways.
Consultancy in all pillars across the system	Measurable and sustainable improvements that are capable of being proved and which result from expertise and advice provided to service users, their carers and families, and staff	Helps make sure expertise and advice is shared across every level of the health economy in the specialist area of practice	Contributes advice and expertise on putting in place and evaluating combined systems in the specialist area of practice.	Developing systems leaders in putting in place and evaluating joined-up systems in the specialist area of practice.

between the domains contributing to impact.

Case Study 1: Consultant Pharmacist's Illustration of Impact on Cardiovascular Morbidity and Mortality

This case study illustrates the impact of a consultant pharmacist's work on reducing cardiovascular morbidity and mortality across two London Clinical Commissioning Groups (CCGs) and the impact this had on health outcomes.

Case Study 1: Consultant pharmacists case study systems leadership for improving medicines optimisation

"When I first took on my consultant role it was to deliver face to face patient care, and I was working in community Heart Failure (HF) clinics and delivering cardiovascular disease (CVD) clinics in GP practices. However, it soon became apparent to me that the scale of the problems regarding medicine optimisation in primary care meant that, while the work I was doing was important to individual patients, it was not going to be enough.
Over time my role took on a clinical leadership role, I set about commissioning pharmacy led service across boroughs and localities, mentored pharmacists to develop their patient facing roles and provided clinical supervision to them in practice, whilst also improving the practice of our nurse and GP workforce who will remain the first port of call for many of these issues – if they can get it right first time, patient care will improve and so will outcomes."

"Upskilling the primary care workforce to do the right thing was achieved using our virtual clinic model which, through up skilling of frontline staff, has shown dramatic improvement in blood pressure (BP) control and increased uptake of anticoagulation in atrial fibrillation (AF). The AF model has now received NHSE funding for a national demonstrator program which would not have happened if I had remained wedded to a narrow view of what consultant level practice meant. In summary:

· I set up a series of pharmacist-led clinics for patients with previously poorly treated hypertension

· I developed a virtual clinic model of hypertension review through which over 1,500 patients were followed up with an average reduction in systolic blood pressure of 25mmHg, conferring a reduction in the incidence of coronary heart disease and stroke of between 40-70%.

· I delivered a virtual clinic model for increasing the uptake of anticoagulation in patients with Atrial Fibrillation (AF)

· Over 5 months, more than 1,500 patients were reviewed and almost 1,300 of them were anticoagulated which prevented 45 strokes per annum across both CCGs, preventing the associated morbidity and mortality." - Consultant Pharmacist

Case study 1 describes the consultant pharmacist's realisation that a system wide approach was required if greater impact was to be achieved across the system on health outcomes, and this eventually also led to wider national roll-out. The essential interrelationship between the domains of MPCP illustrate their interdependence in

achieving the impact. The Consultant Pharmacists expert practice embraced medicines optimisation in primary care especially linked to medication of people with cardiovascular disease and hypertension.

Through her strategic and enabling leadership role she recognised how people with these conditions were managed, was not enough to achieve major impact, so set about through her consultancy role to commission pharmacy led services; taking forward innovations through the virtual clinic model and then mentoring other pharmacists to develop their role in this area. This linked with her capabilities in providing ongoing clinical supervision of pharmacists and the wider facilitation of other professions in supporting ongoing learning, development, and improvement to strengthen their own practices whilst using indicators of improvement as an embedded researcher to monitor and evaluate impact on health outcomes across the system.

Case Study 2: The Consultant Nurse's Illustration of Impact for Frailty Services

The consultant nurse's case study is linked to providing systems leadership across frailty services with a focus on growing the workforce.
This case study illustrates that enabling commissioners to recognise and use the full potential of MPCP has been a real challenge in enabling joined up approaches across people's health and social care journeys nationally (Cashin *et al.,* 2015). Renee, through the consultancy function to commissioners, which draws on her professional (nursing) expertise and credibility in frailty, and as a systems leader, illustrates the influence that she is having working at a systems level and breaking down barriers across boundaries to focus on the things that matter to people and communities.

Additionally, her role is achieving an integrated approach to developing the workforce where strong person centred, inclusive values are the foundation. Enabling and strategic leadership at this level together with the ability to facilitate and co-create an integrated approach with others to learning, developing, and improving, using the workplace as a key resource, is her current emphasis and intent.

The relative focus on different domains fluctuates in this key role to address changing health and social care priorities. Whilst Renee's current focus is on the urgent need for developing and retaining the workforce, as a consultant level practitioner this body of work will provide her with the tools to embody being an embedded researcher, creating a knowledge-rich and inquiring culture that continually evaluates.

This in turn will enable her to demonstrate the positive impact these initiatives are having on people with frailty, their families and communities through services that improves accessibility for all and reduces inequality.

Case Study 2: Systems leadership - developing the workforce for people experiencing frailty across pathways and communities.

“As Consultant Nurse within the older Persons Services, my role focuses on the delivery of integrated care across both community and acute settings, incorporating the pillars of the Multi-Professional Consultant Level Practice Capability Framework to enable high quality person centred safe and effective care to be provided at all levels of the system. A strong emphasis of my role is developing skills and knowledge around the specialism of frailty. Therefore, I sit on the Clinical Commissioning Group (CCG) Frailty Board and have accountability for ensuring that the integrated care systems multi-professional workforce has a solid evidence-based knowledge of frailty that positively influences care delivery and focuses on what matters to people. I have used my professional expertise within frailty to collectively draw upon national directives, local population need and the shared values of the multi-professional workforce to co-produce an innovative educational resource pack that includes a bespoke online website –‘ icareFrailty’, training sessions, capability portfolio and community of practice for frailty.

All with the aim to develop, empower and enhance skills, knowledge, and capability, so that as a system we have a confident and capable multi-professional workforce delivering integrated, proactive person-centred care that supports our older population living well for longer and futuristically reducing the need for crisis management within frailty. As this work is in the early stages, impact may be anticipated and may be demonstrated by key qualitative indicators such patient reported satisfaction, staff confidence in recognising and managing frailty and a universal approach to frailty that minimizes a postcode lottery to service delivery. Key quantitative indicators may include reduction in conveyance to accident and emergency, reduction in crisis referrals, increased numbers of advanced care plans. All supporting the move away from episodic hospital-based care to community-based person centred and coordinated care. Drawing upon the skill set of a system leader has empowered me to emphasise collective enabling leadership, creating a culture of inclusiveness, shared vision and open effective communication that has not only allowed this body of work to flourish but also provided a foundation that the workforce and future workforces can build upon to continually challenge, improve, and inform how services are delivered and commissioned. Whilst this body of work is at the beginning stages of journey there is commitment and drive from the ICS, and all involved to ensure it achieves an integrated approach to growing workforce capability and proactive management of people with frailty. Whilst providing consultancy expertise directly to people, their families and other member of the health and social care team I am also working at a system level to grow the capacity and capability of other consultant and aspiring consultants across different professions through an innovative programme involving several ICS’s.” - Consultant Nurse

Case Study 3: The Consultant Allied Health Professional’s (AHP) Illustration of Impact to Support People in Crisis through Community Urgent Response Services

Case study 3 illustrates a strong emphasis on growing a team to operate across systems, to support people in crisis as well as drawing on expertise as an embedded researcher to demonstrate impact and to growing others to develop the capabilities of advanced and then consultant practice.

Case Study 3: Systems leadership, evaluating effectiveness and growing the workforce

"As a consultant practitioner leading a community urgent response team, my role within the community trust is primarily in clinical leadership.
We have three consultants in the team responsible for two primary care networks (PCNs) each, supporting the wider community team of nurses and therapists to ensure we are providing high-level clinical diagnostics and interventions for all our population. We undertake Comprehensive Geriatric Assessment (CGA) for people in a crisis with decompensated frailty. We are constantly up-skilling our workforce with formal Advanced Practice training and are currently working on the personalised care agenda (https://personalisedcare.hiowhealthandcare.org/our-work/wasp) through our Strategic Transformation Programme (STP). Developing a 'One Team' approach for our community services develops closer integration and supports workforce retention and better patient outcomes- with fewer unplanned hospital admissions for the nineteen general practice surgeries we work when compared with similar general practices. This innovative model is one of the few led by consultant practitioners- who may be nurses, or therapists in the country.
We have a dynamic quality improvement focus for service development within the team, which embodies the ethos of all participating in the improvement process including our patients who support us with recruitment and training. This iterative approach has supported better integrated working with our continence service and working with primary care colleagues.

The South-East faculty for advanced practice has developed a consultant training programme- of which I am a product. I have continued, as a mentor for trainee consultants, using a rigorous self-directed development approach, and annual portfolio appraisals to meet the capabilities for the consultant level practice and we have two more graduates this month. I am passionate about developing advanced practice pathways for our community facing services and am working with Winchester University to develop exactly this, as well as a module and credential for Advanced practice on Community Rehabilitation Healthy Ageing."
"Nationally I have worked with the British Geriatrics Society in a number of key areas to ensure that policy meets the needs of older people, notably in contributing to the publishing of the 'Right Time, Right Place' document to aid service commissioners in developing pathways suitable for older people (https://www.bgs.org.uk/righttimerightplace).

As Chair of the Nurses and AHP council (the first physiotherapist to hold this role), we have a number of priorities to ensure that the voices of older people are heard at policy level, and also at service delivery level, through empowering and training our members- we have developed a number of *Community of Practices* to facilitate this

development, in leadership, advanced practice and research. My own research experience as an ethnographer has significant impact on both my enthusiasm for this role and on patients, citizens and staff as an embedded researcher. My portfolio role has now extended to incorporate a clinical advisor role within NHSE Community and Discharge team."
- Consultant Physiotherapist/Allied Health Professional

In this case study, Esther demonstrates the positive influence her role has on local care services, innovation, and workforce development through collaborative partnership working at all levels in community services with stakeholders and citizens. In addition, Esther's valued expertise, in common with many MPCPs, has also influenced national policy agendas. Her commitment to the voice of the older person is evident in her narrative and echoes the collaborative values that underpin her practice, together with investment in growing and facilitating the workforce to meet the needs of communities in flexible ways. Esther demonstrates how consultant practitioners work with complex contexts across patient pathways and systems and draws on a wide range of integrated interventions, informed by all the domains, to positively impact on patient and staff outcomes through the medium of enabling person centred cultures for both those providing and experiencing care. As an embedded researcher, consultant practitioners are well placed to collaboratively evaluate workplace cultures, team functioning, and relationships at all levels of the system, integrating research co-production (Graham *et al.,* 2022; Oye *et al.,* 2021).

In summary, published literature has identified systems leadership as having positive impact on improving patient experience (Welbourn *et al.,* 2012; Fealy *et al.,* 2013), providing more timely and appropriate care (The King's Fund, 2017), and responding to changing population needs (Caro, 2016). It has also been associated with people taking greater responsibility for their own health and wellbeing (The King's Fund, 2017; Vize, 2017). From a workforce perspective, improvements in staff turnover have also been identified (Young *et al.,* 2015). However, the literature does not identify how such outcomes have been achieved or how the professional expertise of practitioners makes a difference as a key enabler.

The case studies we have presented offer a unique insight into how the professional expertise of the MPCPs illustrate the relationship between process and ultimate outcomes for patients and staff. These roles provide a crucial catalyst for workforce development and investment, realising benefits from working differently to achieve better outcomes, staff wellbeing, staff retention, and recruitment.

Discussion of the enablers for increasing adoption of these roles to support system and workforce transformation

Why the role is important: The multi-professional consultant practice role brings the required capabilities and expertise to address the challenges and current policy context in the UK, to meet the health and care needs based on person centred

values, collective leadership, and co-production with people in communities across systems. The full potential of communities and the workforce remains untapped in the contribution they could make to social capital, as well as how they influence the system about what matters and how it is evaluated through co-production and leadership (Best *et al.,* 2012; Stromgren *et al.,* 2017; NHS, 2021).

System-wide challenges include 1) an increasing number of failing services in need of urgent transformation, alongside increasing evidence of staff burnout particularly in front line practice (Chaudhry and Raza, 2020) and 2) rapid change in times of crisis highlighted by the Covid-19 pandemic and the impact on the health and wellbeing of staff, services, organisations, and systems delivering health and social care (Ford, 2020; Jackson *et al.,* 2020).
Workforce challenges include 1) developing the capabilities required for sustainable person-centred workforce transformation (Manley and Jackson., 2020), and 2) developing the healthcare workforce at all levels of the career framework (Kings Fund, 2018) to act as a pipeline to ensure that senior positions such as MPCP positions at the pinnacle of health and care practice careers also reflect the populations they serve (Skills for Care, 2022). It is vitally important that the new integrated care systems in England recognise the importance of MPCPs as system leaders to deliver the vision for transformed health and care models for the future.

What it means in terms of systems leadership: The capabilities required for inclusive systems leadership include: working with communities and stakeholders to facilitate people centred cultures (HEE 2020); implementing, embedding, and evaluating people centred, safe and effective care with continuity across communities (Manley and Jackson, 2020; Atsalos *et al.,* 2014); and developing workforce capability to meet the health and care needs of different population groups such as the priorities identified for ICSs across England (*Box 6*).

Systems leadership needs to be collaborative, inclusive, and participative, but also challenging of the patterns that drive thinking and behaviour across systems to enable rather than disable transformation (*Box 7*).

Box 6: NHS Integrated Care System Priorities (National Health Service, 2022)

- improving the health of **children and young people**
- supporting people to **stay well and independent**
- acting sooner to help those with **preventable conditions**
- supporting those with **long-term conditions** or **mental health** issues
- caring for those with **multiple needs as populations age**
- getting the best from collective resources so people **get care as quickly as possible**.

It is therefore critical to success that health and social care systems leadership roles are based on both relevant professional expertise and the generic capabilities identified in the MPCP Framework (HEE 2020) to aid the breakdown of silos across

healthcare systems (Manley et al; 2016); facilitating partners across complexity, especially in ICS's where there has been no history of partners working together (Dunn *et al.,* 2022); and embed positive patterns of thinking and behaving (*Box 7*).

Box 7: Five Patterns that drive thinking and behaviour in support of transforming complex systems
(After Plsek - website http://www.directedcreativity.com/pages/PatternsOnePage.pdf)

1.Relationships: Interactions among the various parts of the system that generate energy and innovative ideas for change, rather that drain the organisation

2.Decision-making: Change made rapidly and by the people with the most knowledge of the issue, rather than change bogged down in a treacle of hierarchy and position authority

3.Power: Individuals and groups acquire and exercise power in positive, constructive ways toward a collective purpose, rather than power coveted and used mainly for self-interest and self-preservation

4.Conflict: Conflicts and differences of opinion embraced as opportunities to discover new ways of working, rather than seen as negative and destructive

5.Learning: The system is naturally curious and eager to learn more about itself and about what might be better, rather than viewed mainly as potentially risky and threatening to the status quo

The importance of having a single integrated impact framework for all professions:

The need to develop a single impact/outcome framework across each system to reflect population priorities and address the health and care needs of people and communities is essential for each ICS in England (Dunn *et al.,* 2022).

Impact frameworks tailored to the needs of different ICSs would inform ongoing evaluation of services, innovations, and commissioning of continuing professional development. A joined-up approach to evaluation that enables what is learned to be constantly built on, will generate real return on investment of valuable resources.

As demonstrated in the case studies, the MPCP role has more impact than can be achieved by only providing direct care and consultancy to service users and colleagues through facilitating effectiveness and workforce development, to develop cultures of effectiveness and learning with impact (Manley *et al.,* 2009; Manley *et al.,* 2016). For this reason, the development of an impact framework aligned with MPCP capabilities was imperative (HEE, 2020).

There is a key opportunity for MPCP roles to work together with other stakeholders to develop a single impact framework across each ICS. Such a development will enable everyone to understand and contribute to a shared focus on what matters to people and needs to both draw on evidence of effectiveness and reflect co-production approaches with citizens, communities, stakeholders, and the workforce. Including active monitoring at every level of the system of the protected characteristics (Equality and Human Rights

Commission, 2010) will also ensure positive impact is being achieved and celebrated as diversity drives innovation and enriches the population of the communities being served.

Key recommendations for workforce commissioners to invest in these roles and career pathway progression and development:

To optimise the benefits of these roles to ICSs there are two key enablers that commissioners, systems, and employers need to address:

Appointment of MPCP roles with all the capabilities expected at systems level to provide both systems leadership and embedded research to enable effective evaluation and embedded change for different care groups.

Growing capacity in all the skills required for systems leadership, embedded research, and co-production in tandem with professional expertise through the career framework to enhance capacity and capability building, retention, and recruitment.
Commissioners need to prioritise employer supported and targeted workforce development and investment in creating opportunities for practitioners to develop in areas that are under resourced with priority given to multi professional consultant practitioners and aspiring consultant practitioners as these roles will create the cultures for growing others to address gaps in capabilities across pathways, communities, and system, as illustrated in the second and third case study.
Developing the integrated skill sets requires flexibility and investment in their development, drawing on the potential of the workplace itself for integrating learning, development, improvement, inquiry, innovation, and knowledge translation to enable the glass ceiling for career progression to be removed (Manley and Jackson, 2020; Manley and Crouch, 2022). People with these capabilities will be able to create the conditions to support the innovations and outcomes required as well as workforce development.

The second commissioning priority is investing in workforce priorities that build on the capabilities identified for systems effectiveness across the career framework, not just MPCP (Manley and Jackson, 2020) including capabilities in meeting health inequalities and health and social need. Such investment will enable greater EDI opportunities for the whole workforce so that the workforce genuinely reflects the communities being serviced, can provide evidence of working together to deliver services that meet the needs of people and communities are enriched by the diversity and innovation that such an approach can achieve.

Supporting these priorities across complex health and care systems necessitates integrated systems for support, learning, and development to enable opportunities for mutual learning, growing, and sharing expertise and place-based learning cultures (Germaine *et al.,* 2022). Also, commissioning continuous professional development (CPD) to focus on specific aspects of workforce development needed to develop health and social care across systems practically (King *et al.,* 2021; Illing *et al.,* 2018; Manley and Jackson, 2020; Jackson and Manley, 2022; Jackson *et al.,*

2015) as well as the systems leadership and embedded researcher opportunities required to work with people, citizens, and communities to focus on what matters most to them.

Other support systems need to include growing a critical mass of systems leaders and skilled facilitators through a network of critical companions who are skilled in developing person centred, creative, high support and high challenge relationships to enable mutual learning. Skilled facilitation has been demonstrated as a mechanism for enabling others to become more effective in their work (Manley and Titchen, 2016) integrates learning with multiple functions such as improvement and innovation in the workplace (Martin and Manley, 2019) and when practised holistically has greater impact than technical approaches to successful implementation of evidence into practice (Rycroft-Malone *et al.,* 2013).

Communities of Practice also assist systems leaders and others with facilitating increasing levels of complexity as well as acting collaboratively to address shared challenges and learning across different communities of care groups, citizens, and providers in the system (Struminger *et al.,* 2017).

To begin to take a joined-up approach and shared direction underpinned by equity, diversity and inclusion it is necessary to grow the MPCP expertise across all domains and health and social care professions, from pre-registration to post registration, through multi-professional learning opportunities that complement professional expertise in health and social care, with opportunities for learning that reflect everyday practice. It is essential that we encourage workforce commissioners to use the MPCP domains to map learning and development opportunities for a career development pathway for all professions from apprentice to consultant practice so that we are creating the knowledge, skills, and behaviours early, and building a platform for career progression. This also requires universities to rethink their curriculum and provide more contemporary evidence based interprofessional learning and development opportunities that reflect workforce and workplace need.

Conclusion: This paper has illustrated the potential impact of the multiprofessional consultant practitioner role as a systems leader to improve the quality of integrated health and social care services, population health outcomes and career development to aid recruitment and retention of the workforce. The four domains and consultancy foundation are key to develop, in order to:

- embed expertise across the system through strategic and enabling leadership.
- facilitate using the workplace as the main resource for learning, development and improvement.
- embed research and inclusive evaluation with people focused on what matters
- combine consultancy foundations with the credibility of professional expertise.

Recognising the interdependence of these domains is a crucial part of the role and this flexibility needs to be recognised by

commissioners as an asset which enables changing priorities and community needs to be addressed in partnership with people.

The skillset also contributes to developing effective cultures of learning at every level of the system to enable change to be embedded through drawing on and valuing the contribution of all. Employers, systems, and commissioners need to invest in people, enabling and supporting integrated skills development at every level of workforce development and education provision if the future vision of people centred integrated health and social care is to be realised and sustained in the longer term.

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