Crowe Horwath

Final Draft Report to

PSI
CUMANN CÓGAISEOIRÍ NA hÉIREANN
The Pharmaceutical Society of Ireland
AN RIALTÓIR CÓGAISÍOCHTA
THE PHARMACY REGULATOR

Review of Current Outsourcing Arrangements with respect to the Irish Institute of Pharmacy

5th May 2017

Contents

1 Introduction

1.1 Background to the Project

Crowe Horwath were commissioned by the PSI at the end of January 2017 to undertake a review of the outsourcing arrangements in place to date with respect to the Irish Institute of Pharmacy (IIOP), with a view to informing future structures.

1.2 Terms of Reference

The PSI's invitation to tender (ITT) document stated that:

The purpose of this review is to consider the experience to date since the commencement of the IIOP's operations in August 2013 to inform the ongoing development of the CPD model. The review must examine, evaluate and assess the governance, operational, functional, contractual, management and delivery arrangements in place in respect of the IIOP outsourced service arrangement; and consider the experience in the context of quality, effectiveness, efficacy and value-for-money."

The principal elements of the review include the following:

- Review of Current Governance Arrangements;
- Analysis of the Current Operational Methodology;
- Functional Analysis;
- Pharmacy Practice Development;
- Value for Money Analysis.

The ITT indicated that *"the review outputs should be summarised in comprehensive final report to include the review findings and recommendations to be presented to the PSI Council to inform decision-making in respect of the future development and next iteration of this contracted service".*

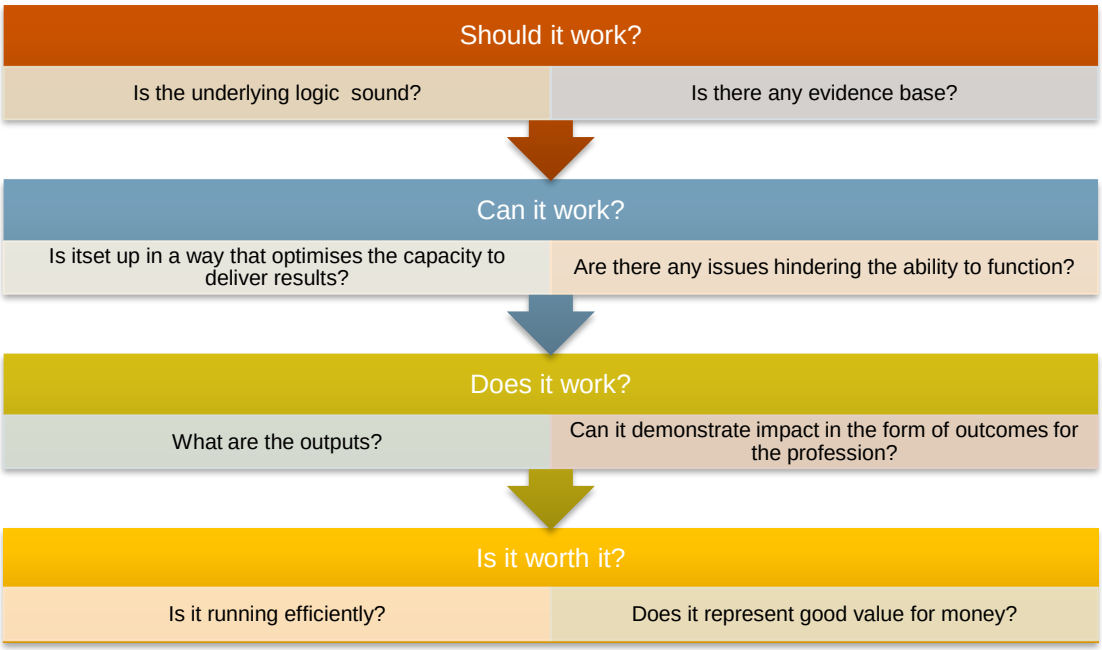
1.3 Methodology and Approach

Crowe Horwath commenced the assignment in early February 2017, and agreed a timetable with the PSI which involved the vast majority of the fieldwork and analysis being undertaken within February and March, leading to the final report being signed off by the PSI Council in May.

The key elements of the review have comprised:

- Stakeholder consultation with a wide range of key stakeholders, including the PSI, the IIOP, the Steering Group, RCSI, the Department of Health, training providers, pharmacists, and others (a full list of stakeholders consulted appears in Appendix 2);
- Review of key documentation relating to the establishment and functioning of the IIOP;
- Functional analysis of the operation of the model;
- Consideration of the financial model in terms of sustainability and value for money;

- Comprehensive analysis of the IIOP against the terms of reference, using the following key questions within a “logic model” structure:



2 Current Position

2.1 Context / History

Under the Pharmacy Act 2007, the PSI is required "to ensure that pharmacists undertake appropriate continuing professional development, including the acquisition of specialisation". Following the recommendations of the Review of International CPD Models (2010) – it was decided to implement a CPD framework by means of an outsourced model.

The Review of International CPD Models (2010) recommended the establishment of "an Institute overseeing the management and delivery of CPD, funding and supporting appropriate provision and ensuring outcomes are generated by providers and assessing the practice standards of pharmacists". It also recommended that the model to be adopted should be a self-reflective CPD model rather than one based on points or hours.

2.2 Establishment of IIOP

The Irish Institute of Pharmacy was established by the PSI in August 2013 in response to the recommendations of the above report which was commissioned by the PSI.

It was intended that the Institute would have two core roles:

- the development of a CPD system for pharmacists in Ireland and ensuring its effective ongoing operation; and
- the development of the practice of pharmacy in line with international best practice and evolving healthcare needs.

Following a national procurement process, the Royal College of Surgeons in Ireland (RCSI) was appointed as the managing body of the IIOP in August 2013, under a four-year contract. This contract was extended by agreement between the PSI and the RCSI to run until the end of the calendar year 2017, and it is expected that a fresh procurement process will be commenced by the PSI during 2017 to conform with these timescales.

2.3 Status of IIOP and Functional / Legal Relationship with Stakeholders

The financial and governance arrangements for the IIOP are managed under a contractual agreement between the PSI and the RCSI: under this agreement, the IIOP is not a separate legal entity but rather a contractual construct. The IIOP is intended to operate "at arm's length" from the PSI: the PSI is responsible for the setting of standards and guidelines to ensure compliance with legislation, with the IIOP's role intended to support and enable pharmacists to meet these standards and to establish a quality assurance system relating to the maintenance of competence within the profession.

The governance arrangements are examined in further detail in Section 3 of this report.

2.4 Main Areas of Work

According to its strategy, the IIOP has two roles in relation to the competence of the pharmacy profession:

- Enhancing capability within the profession to meet the emerging needs of patients in an evolving and complex healthcare system;
- Providing quality assurance about the competence of the profession.

The key activities of the IIOP are as follows:

- The provision of support, information, and training to pharmacists in relation to the CPD model, the ePortfolio, and the review processes: this comprises the IIOP website; newsletters; helpdesk function; the peer-support pharmacist network; conferences; and information and training events.
- Development of the ePortfolio as an infrastructure to facilitate the recording and reporting of engagement in CPD by individual pharmacists;
- Development and roll-out of the ePortfolio review to validate engagement by pharmacists on an ongoing basis, examining the development and maintenance of competencies in line with the competency framework defined for the profession;
- Development and roll-out of a CPD practice review process, a peer-developed process which recreates patient facing scenarios to assess competency along with other assessment methods;
- Commissioning of CPD training programmes from external providers;
- Accreditation of CPD courses and programmes developed by training providers.

2.5 Resources

2.5.1 Funding

Core funding for the IIOP comprises two key funding sources: a commitment of €500,000 annually from the PSI as part of the contract for the outsourcing of the CPD model, and funding from the Department of Health. The latter comprises an annual stream of €600,000, which is a legacy of the original Health Service Executive (HSE) funding to the Irish Centre for Continuing Pharmaceutical Education (ICCPE), which was disestablished on the formation of the IIOP.

The PSI approved additional yearly funding of €275,000 and €320,000 respectively in Years 3 and 4 of the IIOP's operation.

Further consideration of the IIOP's funding arrangements is set out in Section 7.

2.5.2 Staffing

The IIOP has an establishment of nine staff:

- Executive Director
- Operations Manager
- Operations Co-ordinators (2)

- Operations Assistant
- Quality Assurance Pharmacists (3, including one current vacancy)
- Learning Technologist.

2.5.3 Peer Support Pharmacists

A key resource for the IIOP is the network of 37 peer-support pharmacists (PSPs), who were appointed to provide assistance and support to pharmacists in relation to the new CPD model. PSPs facilitate local information meetings and provide training via webinars to inform and update pharmacists on the development of the CPD model and the roll-out of ePortfolio review and practice review, to ensure pharmacists are trained and supported to engage with the ePortfolio, and to act as a conduit for feedback from the profession on their CPD needs and issues in respect of their engagement with the CPD model and tools.

3 Current Governance Arrangements

3.1 Description of Current Arrangements

Governance arrangements at the IIOP are unclear and somewhat confusing. The primary governance vehicle for the IIOP is its Steering Group, which has 16 members appointed by the PSI, including representation from the following:

- PSI Council;
- Department of Health;
- Health Service Executive;
- Hospital Pharmacists Association of Ireland;
- Pharmaceutical Society of Northern Ireland (members of Council);
- Pharmacists in Industry, Education and Regulation (PIER);
- Royal College of Surgeons in Ireland;
- Trinity College Dublin;
- University College Cork;
- Hospital pharmacist (1);
- Community pharmacists (2 – 1 from large pharmacy groups and 1 from independent/small groups);
- Health Products Regulatory Authority;
- Irish Pharmacy Union.

The Chair of the Steering Group is a nominee from the HSE. The IIOP Executive Director attends all meetings. Executive staff from the PSI do not regularly attend the Steering Group, but may be requested to attend its meetings for certain items of business.

3.2 Analysis and Findings

On a positive note, Steering Group members were proud and very supportive of the work that had been done by the Institute and the commitment shown by its Executive Director and staff.

However, the prevailing view amongst members of the Steering Group was that they were typically unclear of the Steering Group's purpose. Members expressed a view that their skills were vastly under-utilised, and that the name 'Steering Group' was inaccurate as they were not involved in setting the work plan for the IIOP and were not privy to any operational/ financial information about the organisation. Minutes of the Steering Group meetings and stakeholder interviews indicated that attendance at Steering Group meetings had been variable, with some members attending every meeting, and others attending infrequently.

The 90-minute length of the Steering Group meetings was reported as being very focused, but sometimes did not offer the opportunity to discuss topics in-depth. Steering Group members expressed frustration with the situation, and disappointment that their expectations of involvement had not been met.

There was a strong perception amongst Steering Group members that the real governance of the IIOP happens elsewhere, and a sense that the role of the Steering Group is marginal. This is very understandable, as the primary governance channels are between IIOP and the PSI for contractual matters, including performance of the contract, and between the RCSI and IIOP (staffing, finances, operations, legal matters, and so forth). There are various other channels of communication which operate either continuously or ad hoc.

Crowe Horwath's assessment is that it is difficult to see what real value the Steering Group adds at present. Having said that, we can understand the original rationale in establishing the Steering Group to oversee IIOP during the period of its establishment (e.g. for the first 2 to 3 years), particularly in view of the need for multiple stakeholders to be kept advised and to engage with their respective constituencies during the early days of the IIOP, but the value of having such a group now that the IIOP is fully up and running is less clear.

3.3 Issues for Resolution

Effective governance is absolutely fundamental to the future of the IIOP. As we noted elsewhere within this report, the IIOP is widely seen to be doing a good job and have made a significant and lasting contribution to CPD within the profession of pharmacy in Ireland over a relatively short time period, and it enjoys significant support from a wide range of stakeholders, as has been the case since its establishment. Nonetheless, it must be recognised that the four most central stakeholders (the PSI, the Department of Health, the HSE, and the RCSI) all have very different roles with regard to pharmacy and, as a consequence, the relationships between these stakeholders and the IIOP, and the expectations they hold of it, are somewhat different.

Our assessment is that the IIOP now needs a different governance model to reflect the fact that it is no longer in its infancy as an organisation, and to help it to become more established as a managing body. We believe that the Steering Group has served its purpose well, but should now be thanked for its contribution and should not continue beyond the end of the current contract. The ideal governance structure for the IIOP would, in our opinion, be a small Advisory Group of perhaps six or seven individuals whose prime responsibility would be to advise on the annual work plan, review and advise on performance and financial matters, and generally advise the Executive Director on relevant matters pertaining to the execution of the work plan and achievement of performance targets.

This body would be advisory in nature and would not perform any executive role, and as the IIOP is not a separate legal entity the Advisory Group would not be a board of directors as defined within the Companies Act. We would envisage the Advisory Group including one or more representatives from the host institution, perhaps three representatives from the pharmacy profession, and one or two independent persons with relevant business experience (e.g. accountancy or the legal profession). The appointment of Advisory Group members should be based on a competency framework to ensure the right balance of skills and expertise can be maintained.

The Advisory Group would be appointed by the host organisation, with input from the IIOP, perhaps with a designated number of Advisory Group members to be appointed on foot of IIOP nominations. (We assume that under the next contract, the IIOP would continue in some shape or form, under the auspices of its host organisation.)

Should the next contract be of a similar duration as the current contract, i.e. five years, we recommend that the Advisory Group be appointed for same period in a coterminous fashion. However, if the contract were to be for a substantially longer term, such as ten years, we would recommend that mechanisms to refresh the Advisory Group with rolling retirements and nominations be established.

The PSI would not be represented on the Advisory Group: its principal role is to set policy in respect of CPD requirements for pharmacists, to procure the services provided by the IIOP, and to monitor and control the contract, and as such it would not be appropriate for the PSI to have a role in the Advisory Group. For similar reasons, the Department of Health and the HSE would also be conflicted.

The proposed new arrangements as described above are presented in Figure 3.3 below:

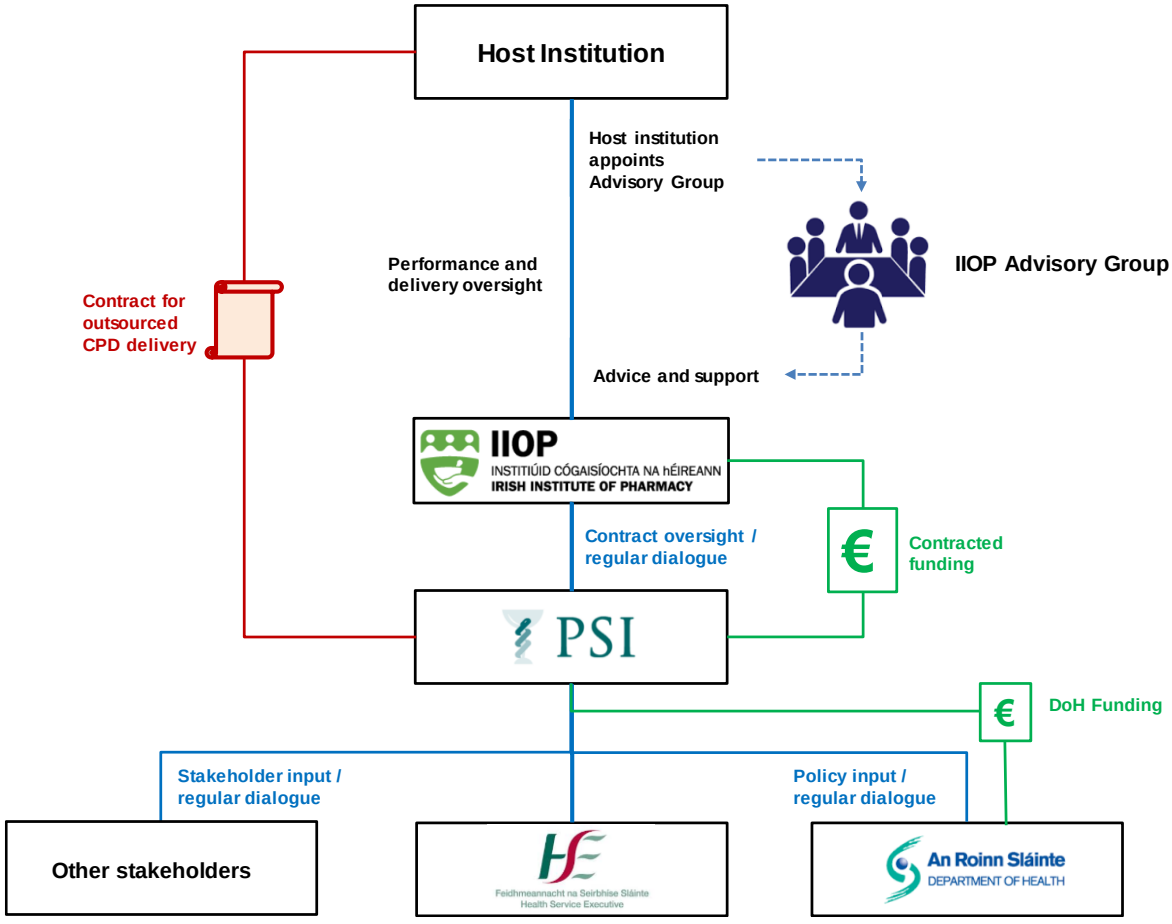


Figure 3.3: Proposed New Governance Structure for the IIOP

3.4 Recommendations

We therefore recommend the following:

- the IIOP and its host institution should establish a new Advisory Group to oversee the work of the IIOP;

- the terms of reference for the Advisory Group should be drawn up by the IIOP / host institution and should be agreed with the PSI in advance of its commencement;
- an independent chair should be appointed to the Advisory Group;
- the existing Steering Group should be thanked for its contribution but should not be re-established within the next contract;
- IIOP should continue to engage with the wide range of stakeholders who have an interest in pharmacy CPD, but not through a formalised model of a steering group with a series of standing meetings as a present;
- the PSI should continue to work closely with the IIOP through regular contract management meetings, maintaining regular dialogue to address emerging issues and resolve emerging problems;
- the interests of the Department of Health and HSE should be channelled through the PSI.

We believe that these arrangements would be much neater and clearer to all concerned, and would enhance the ability of all parties to focus on the critical issues affecting the IIOP and pharmacy CPD generally.

4 Current Operational Methodology

4.1 Background

2011 and 2012 saw the initial establishment of the IIOP as an organisation within the RCSI. In 2013, key organisational features of IIOP were put in place and the establishment phase drew to a close. Major appointments were made, office space was established and refurbished, and technical requirements started to develop. A work plan from the PSI and Department of Health was agreed, as IIOP operational funding would be dependent upon this activity. Some aspects of service delivery from IIOP were delayed until the Executive Director came into post in March 2014. Whilst an operational team had been set up within its RCSI base, a Steering Group was appointed by the PSI, Peer Support Pharmacists (PSPs) were recruited for training, and a holding website and branding were started in 2013, any significant amount of engagement or promotion with the profession was deferred until 2014.

4.2 Service Delivery to Date

Completion of the implementation phase of the IIOP was contractually agreed between the PSI and the RCSI at the end of 2013. In 2014, the pharmacist engagement programme began in earnest, using a combination of face-to-face meetings and webinars to communicate the CPD message to PSI registrants across the country. The IIOP estimated that 1,200 pharmacists engaged through these mechanisms in that year (IIOP Annual Report for 2014). Six educational programmes were launched – 2 face-to-face (F2F) and 4 online – to support topics including superintendent training (F2F) and seasonal influenza vaccine refresher level 2 training (online). The IT-based system incorporating the website, virtual learning environment (VLE) and ePortfolio (incorporating the Core Competence Self-Assessment Tool CCSAT) was developed, piloted and in place by the end of 2014.

In 2015 the legislation relating to CPD for pharmacists in Ireland: Pharmaceutical Society of Ireland (Continuing Professional Development) Rules 2015, S.I. 553 was published. A phased roll-out of the IT system to pharmacists took place over the first quarter of the year. Sixty ePortfolio information engagement events delivered by the PSP network took place, with over 960 pharmacists attending and a recording of one then being made available on the IIOP website. Five educational programmes were accredited and launched, including pharmacy addiction services (F2F) and effective communication skills (online) (IIOP Annual Report for 2015).

In early 2016 the ePortfolio Review pilot process was completed, with 130 pharmacists participating in the pilot. The first ePortfolio Review process commenced in Autumn 2016 and is due to conclude in May of this year. 40 Peer Support Pharmacists information events were held in 2016, with 438 pharmacists attending these events. Eight training programmes were accredited and launched, including a variety of courses to facilitate the implementation of the Medicinal Products (Prescription and Control of Supply) (Amendment) (No. 2) Regulations 2015, which permitted pharmacists to supply and administer medicines in emergency situations and extended the range of vaccinations that can be administered by pharmacists. Work commenced on the piloting of the Practice Review process, with 89 pharmacists participating in the development of the Practice Review pilot.

In March 2017, the IIOP website shows 13 available online courses and three live face-to-face courses in different venues around the country.

4.3 Advantages and Disadvantages of the Multi-Provider Training Model

4.3.1 Analysis and Comment

Pharmacists in Ireland need choice and variety in their CPD resources. Whilst about 80% of the profession work in community pharmacy, their population needs may differ and there may be special interests among community pharmacists including different long-term conditions or pharmaceutical public health. The 20% of pharmacists who work in hospital, industry and non-patient-facing roles will require even more diverse opportunities to keep updated. For these reasons, the multi-provider model helps all pharmacists to be able to access resources appropriate to their needs, in the context of their identified practice improvement and maintenance requirements. It recognises informal learning, non-formal learning and formal learning as valid CPD resources. In contrast, the single provider model would demand a core curriculum and one accredited provider of all the material that pharmacists need to practise. Thus the multi-provider model is really the only model that offers sufficient diversity and choice for pharmacists in all sectors and at all stages of their careers.

Rather than creating courses itself, IIOP commissions others to create and provide online, face-to-face and blended courses. Given the constrained resources of IIOP and its primary objective to oversee the CPD process as a whole, this approach seems sensible. However, our stakeholder engagement programme has shown there are challenges in respect of the capacity and willingness of the market of training providers to provide the range, quality, and choice of courses and content the IIOP and the PSI envisaged.

The review encompassed consultation with training providers as well as considering the perspective of the IIOP, the PSI, the Department of Health, and the Steering Group in relation to the implementation of the multi-provider model.

Training providers had concerns about the ***accreditation process***, examined in more detail in Section 5. From their perspective, this process was lengthy, detailed, not always appropriate to the course or content, and represented a deterrent to their continuation with the IIOP in future.

In addition, the ***timelines allowed for the development and submission of courses*** were universally agreed to be too tight to deliver a high quality resource. Training providers reported high pressure that resulted in work that they would have liked more time to optimise – not in terms of accuracy of content but in, for example, the level of interactivity that they could achieve in online courses. Tight timelines also made course production more expensive because they often had to use short-term agency staff to supplement their in-house workforce.

Concerns were expressed by a number of stakeholders about the ***uptake of these resource-intensive courses***. There were reports of workshops aimed at 10 participants being run for far fewer participants, against the advice of the training provider. Inevitably, the provision to date has been skewed towards community pharmacy, as the majority sector of the profession. It was recognised, however, that some more generic courses had wider appeal, e.g.

leadership. Stakeholders appear to be unclear regarding who is setting the agenda / work programme.

The staff of IIOP have expressed some interest in developing and adapting courses within the unit, but their very limited capacity may be better deployed as an 'information hub' for existing courses.

4.3.2 Recommendations

We therefore recommend the following:

- Development of a more collaborative approach to the creation of other courses, including a revision of the copyright clause to allow more partnership with other pharmacy providers;
- Allowing training providers more flexibility to optimise the learning objectives for the course and to deliver online packages as self-contained modules;
- Allowing a minimum of 8 weeks from confirmation of provider to the accreditation submission date;
- To constrain plans for IIOP to create its own courses but to concentrate on its function as an information hub.

4.4 Scope of the Work of the IIOP

4.4.1 Analysis and Comment

All stakeholders commend the IIOP team for addressing its remit with energy and enthusiasm, and for the quality and professionalism of the work done. It is universally recognised that the IIOP has brought pharmacy CPD a long way in a short period of time, with more work to be done.

The original contract scope of the IIOP is broad-ranging, and whilst the IIOP team has tried to progress all strands of the mission (CPD, leadership and research), and promote IIOP both nationally and internationally, stakeholders recognise that more clarity is needed about the primary purpose of the IIOP in order to focus its resources. The PSI contract commitments are very broad, and the resource committed is insufficient to cover them all. As the establishment of the Institute and its work progressed, a clear priority emerged in relation to establishing the quality assurance framework of the CPD model. We understand that agreement was reached to prioritise the CPD aspects of the IIOP's remit, with, for example, an agreed deferment of the appointment of a Director of Pharmacy Practice and the associated activities in relation to pharmacy practice development.

However, there does appear to be some lack of clarity, and some tension, about who should develop the policy aspects of CPD and practice development (which the PSI seems to retain), and the day-to-day operation of the profession's CPD system. If the main function of the IIOP is to facilitate CPD engagement among pharmacists, it may be prudent to restrict the current scope to the implementation of the statutory CPD obligations relating to ePortfolio and practice review. If the IIOP is seen as the *de facto* professional body of the future, then more resource and autonomy may need to be invested in it.

There has been a conscious decision by IIOP – with the support of its parent organisation, the RCSI – to pursue the broad mission of the Institute, with the understanding that some activity has stretched the staff beyond normal capacity because they have felt a strong commitment to its aims. Moreover, unplanned work from the Department of Health relating to new legislation can sometimes take urgent precedence over other planned activities. Staff work long hours and some have indicated that they voluntarily put holiday plans on hold if their work at the IIOP demands it – something which may be commendable once or twice, but is neither sustainable nor good for the staff in the long term. RCSI – which also supports the broad mission of IIOP – has contributed two extra staff to the unit beyond its contractual obligations in this first contract term, but this review anticipates that these may not be renewable in a future contract or may only be achievable with an increase in costs.

The recognition of the over-broad scope of the contract by PSI and the subsequent agreements on prioritising the CPD aspects are welcome; a similarly increased clarity and feasible scope should be built into the future contract.

There are systems-based challenges that do not assist the efficient and effective work of the team, with some fundamental changes needing to be agreed between the PSI and the IIOP that would remove some problems. For example, one member of staff spends a significant proportion of their time preparing the monthly financial returns for the PSI and Department of Health. Several members of staff, including the Executive Director, spend a significant amount of their time answering telephone calls from pharmacists, a number of whom have negative views about the CPD model and need detailed explanation before they can be reconciled to its benefit for them.

Similarly, there are features of the accreditation system (addressed elsewhere) that could be changed without loss of credibility but large gains in capacity. There have been 'crunch points' in the work of IIOP, such as the need to reorganise and reprioritise work arising from the requirement from the Department to create and accredit a course relating to the emergency administration of medicines in response to S.I. 449, and the roll-out of the ePortfolio.

The IIOP team recognised the considerable challenge to workload and staff in agreeing to undertake such work within the timeframes set out. However, the IIOP's perceived concern in relation to the possibility of funding from the PSI and/or the Department being withheld or reduced if their requirements were not met made it difficult for them to challenge a work programme even if it appeared too onerous. We note that some flexibility has now been built into the funding arrangements with the Department, which should alleviate some of these concerns.

4.4.2 Recommendations

We therefore recommend the following:

- fundamental changes needed to the systems of work, principally between the IIOP and the PSI but also involving the Department and the host organisation, should be negotiated before the implementation of the next contract;
- the mission scope should be reviewed, and should be constrained or pursued according to capacity;
- the PSI and DoH should work collaboratively with the IIOP to develop a sustainable revised structure and scope that can be achieved within the resources available to the Institute.

5 Functional Analysis

5.1 Accreditation

5.1.1 IIOP Accreditation Process

The multi-provider training model means that courses commissioned by the IIOP are provided (with a small number of exceptions) by external providers, and accredited by the IIOP. The objectives of this accreditation are:

- To assure the quality of individual CPD programmes against criteria including:
  - PSI accreditation standards;
  - Programme specifications;
  - Compliance with contractual terms and conditions and legal or regulatory requirements;
- To ensure that all approved CPD programmes have an appropriate risk and quality management system in place to identify potential risks to pharmacists, patient safety, and programme quality on an ongoing basis;
- To ensure that CPD programmes are responsive to the needs of patients, address relevant risks to patient safety associated with current pharmacy practice, and are focused on improving patient outcomes.

The stages in the IIOP process are as follows:

- ***Internal Review by the applicant:*** This is where the applicant completes a detailed application form identifying how the programme meets the specified accreditation criteria and referring to the evidence which supports this. The application form refers to and maps directly to the PSI accreditation standards.
- ***Validation of the application by the IIOP:*** This is an administration stage, conducted internally by the IIOP. The purpose of the validation is to ensure that the provider's application has been completed fully and that all required documentation has been submitted.
- ***Individual peer review:*** Following the validation exercise, the reviewing members of the ART are required to conduct an individual peer review of the submitted training material.
- ***Accreditation Review Team (ART) meeting:*** Subsequent to the completion of the individual peer review stage, the IIOP provides a forum for ART members to discuss the application. In the majority of instances, this forum is a face-to-face meeting attended by the applicant team. The meeting will be chaired by a Chair appointed by the Executive Director (ED) or nominee and will be run in accordance with an agreed agenda.
- ***Creation and dissemination of reports:*** Following the accreditation meeting, a formal report is produced by the appointed rapporteur, which includes the overall determination of the ART. The ART is invited to provide any feedback on the report, which should be an accurate reflection of the team meeting. In the event that accreditation is provisional on the provider meeting specified conditions and/or recommendations, the applicant is usually given a defined period by which they must respond.

- ***Sign-off:*** Following review of the applicant's response by the appointed person(s) in the ART, and subject to the approval of the Chair, the report is then issued to the Executive Director of the IIOP, for sign-off. Subject to the agreement of the Executive Director, the report is then submitted to the PSI for approval of the decision to accredit.

A key part of the process is the use of accreditation review teams (ARTs). Membership of the ART is formed through the identification of suitably experienced professionals, drawn from the Peer Review Panel. ARTs consist of subject matter experts (SMEs), who may or may not be pharmacists. A Chair of the ART is appointed by the Executive Director. The composition of an ART depends on the nature of the programme being accredited, but must contain the following members:

- At least one peer reviewer with expertise in relation to the subject matter content;
- At least one peer reviewer who is a pharmacist with practical experience related to the subject area;
- One reviewer with an appropriate level of competence in quality and risk management to enable assessment of Standards 6 & 8 (PSI Accreditation Standards);
- A patient advocate and public interest member, as appropriate.

The remit of the ART is to make a determination on the CPD programme, as submitted by the applicant, against certain criteria, where applicable. These criteria include:

- Compliance with the relevant accreditation standards for CPD programmes, as set down by the PSI;
- Compliance with the required programme specifications, as appropriate;
- Compliance with any other criteria as specified by the IIOP.

5.1.2 Stakeholder Views on the Accreditation Process

Most stakeholders with involvement in the accreditation process considered it complex, bureaucratic, and onerous for the purpose. Key concerns included the level of administration required of both training providers and the IIOP; the lack of flexibility and proportionality; its unsuitability for certain types of course (e.g. leadership courses); and the role it may be playing in reducing the pool of training providers and the challenges this poses in a multi-provider outsourced model.

The full process of commissioning courses – from tender to final accreditation – reflects a tension between meeting robust standards and a complex bureaucratic process. A number of stakeholders expressed their concern about a diminishing number of training providers being willing to tender for courses. The IPU Academy made a decision not to submit tenders for IIOP courses as they provide all of their courses through their own IPU Academy.

Stakeholders asserted that the IIOP accreditation process is at odds with those of other professional bodies. In the IIOP system, both the content and the underpinning quality management system for the course is accredited. This is one reason that the system is very onerous – most comparable organisations only accredit the content. Significant resources were expended at the accreditation meeting in terms of people's time and travel. It was believed that the processes in other professional bodies could inform a more streamlined and proportionate system. If the quality management system continues to be assessed, however, it was suggested that this could underpin a system where training providers are accredited,

rather than individual courses. This might help to achieve a more streamlined, yet quality assured, approach.

5.1.3 Findings – Accreditation

It is unclear to this review why every course available from IIOP needs formal accreditation. Whilst the need for high quality content to be available to pharmacists is accepted, the CPD model does not demand attendance at accredited courses; rather it emphasises the value of all resources as long as they are chosen thoughtfully as part of a reflective cycle.

There are legislative requirements for some courses to be accredited to underpin a new service, such as vaccination, but using the same accreditation process may be disproportionate for more general courses like leadership. The accreditation standards were developed to meet legal requirements for the accreditation of training for a particular expansion of community pharmacy clinical service delivery, and the lack of flexibility or differentiation in the process to allow for a more appropriate accreditation system for different types of course appears to be a root issue.

There is also value in competition and choice for pharmacists, which may not be best served by this approach if it is deterring training providers and ultimately reducing the market capacity to serve the requirements of the model. Moreover, there is a risk that a course may not be accredited after a lengthy process, and then there would be no alternative provider – the process would have to start again, incurring significant delay. This has not yet happened.

Some stakeholders considered the process was very robust, and reflected a 'gold standard', but it may only be achievable at a high cost. However, it was also suggested that the focus on standards rather than design and delivery at the ART stage might mean that a course could meet the standards but might not represent a high-quality training experience for pharmacists engaging with it.

5.1.4 Recommendations – Accreditation

We therefore recommend the following:

- To consider a flexible, tailored approach to accreditation with a reduction in the administrative burden on training providers and on the IIOP;
- To reserve the full accreditation process for courses that require approval under legislation for pharmacists who wish to supply a new commissioned service;
- To consider whether any IIOP accreditation is in fact necessary for courses that are not supporting the roll-out of commissioned services;
- To review the accreditation standards with a view to identifying which should be applied in accrediting particular types of course;
- To consider an accreditation model whereby providers could go through a full accreditation process once, with shorter, simpler reviews of proposed course content following on from this (however, this may entail changes to primary legislation, which may be onerous and not achievable in the short term).

5.2 Pharmacist Experience of the CPD Model

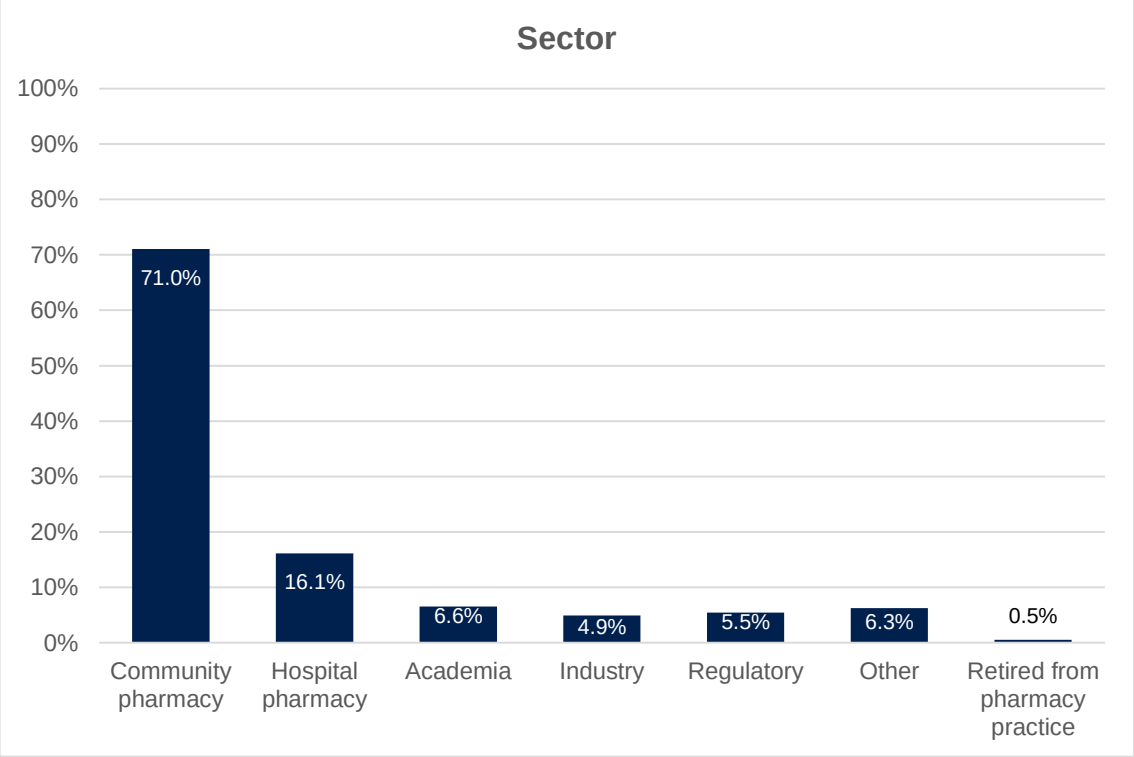
5.2.1 Survey

The review of the experience of pharmacists in engaging with the CPD model was undertaken primarily by means of an online survey. The survey link was disseminated by the PSI to all registered pharmacists by email.

More detail on the survey responses in the form of tables and charts is set out in Appendix X. An overview of the key results and findings is set out here.

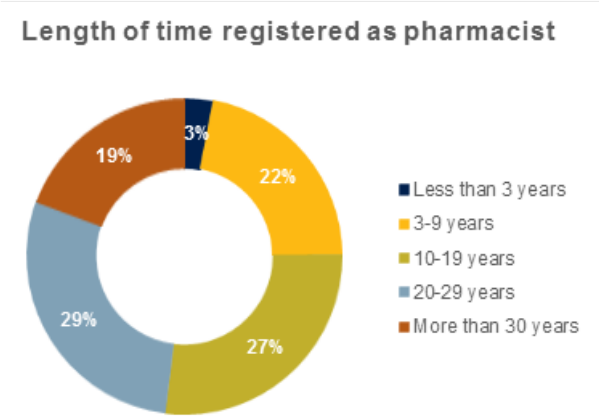
A total of 365 completed surveys were received. Given the register of approximately 5,800 pharmacists, this number of surveys indicates a margin of error of ±5%, that is, for any particular response, the true figure may be 5% higher or lower than what is indicated. So, for example, if 50% of pharmacists indicate that they have read the IIOP newsletter, the accurate figure may be as high as 55% or as low as 45%.

The profile of responding pharmacists is fairly well-distributed. Pharmacists were asked to indicate what sector(s) of pharmacy they worked in. As can be seen in the chart, 71% of respondents indicated that they worked in community pharmacy; 16% in hospital pharmacy; and a further 24% were from academia, industry, and "other" sectors or were retired from practice.



"Other" sectors included, for example, working within the HSE or in other national roles.

The respondents had varied lengths of time within pharmacy practice as per the chart displayed on the right. This suggests that the survey responses are not dominated by, for example, recent entrants to the profession nor by those who have been working for several decades, but represents a cross-section of pharmacists in terms of career stages.



The respondents were based in a range of locations around the country, with 36% from the Dublin area, 27.9% from Munster, 22.1 from Leinster (not including Dublin), 11.5% from Connaught, and 4.9% from Ulster.

5.2.2 *Pharmacists' Engagement with the IIOP*

According to the survey responses, almost all pharmacists have had some degree of engagement with the IIOP and the CPD model, with 99.7% having visited the website and 96.4% having engaged in some way with the ePortfolio. Some 11.4% of the respondents had been called for ePortfolio review. Some 20% of the respondents had been more directly involved in the work of the IIOP, for example as PSPs, ePortfolio review pilot participants, members of accreditation review teams, members of the Steering Group, and so forth.

5.2.3 *Support Services*

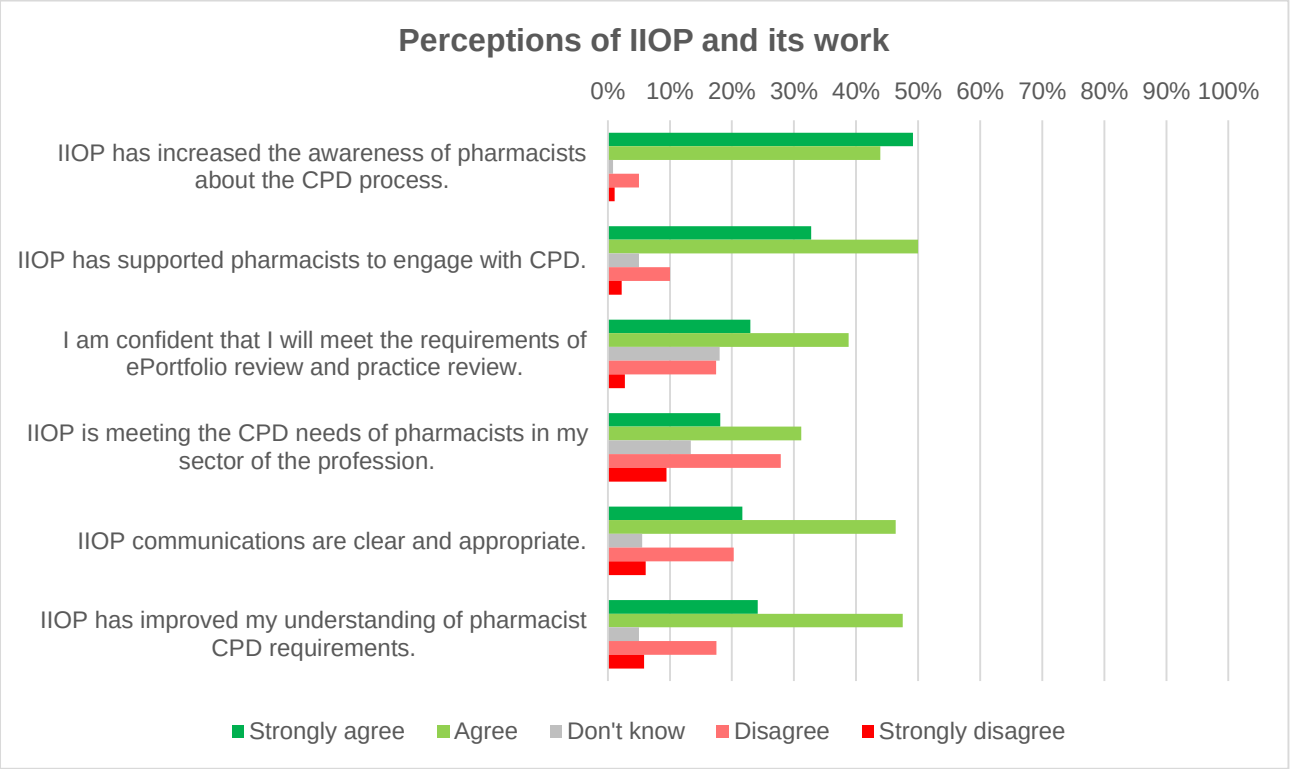
Pharmacists who responded had availed of IIOP supports to varying degrees, with the large majority (89%) having read the IIOP newsletter at the minimum. Nearly half (49.7%) had attended local PSP information events, with a further 23.1% having participated in PSP webinars. More than a third (34.3%) had accessed support via the IIOP helpdesk. Smaller numbers had attended IT workshops (11.7%) or coffee mornings (5.3%). More than a quarter (28.5%) had availed of "other" supports, although the comments indicate that these included, for example, engagement with the IPU Academy, undertaking accredited training, and getting advice from peers – this may suggest that "support" was interpreted by some to mean support with their CPD rather than direct IIOP services: this is further borne out by a high (17.4%) "Not sure" response to this question.

5.2.4 *Perceptions of the IIOP and its Work*

Survey respondents were asked to indicate their perceptions of the IIOP by rating their agreement with a number of key statements about its work and achievements to date:

- *IIOP has increased the awareness of pharmacists about the CPD process.*
- *IIOP has supported pharmacists to engage with CPD.*
- *I am confident that I will meet the requirements of ePortfolio review and practice review.*
- *IIOP is meeting the CPD needs of pharmacists in my sector of the profession.*
- *IIOP communications are clear and appropriate.*
- *IIOP has improved my understanding of pharmacist CPD requirements.*

As can be seen in the diagram below, the perceptions of respondents are broadly positive, in particular in relation to the first two and last two statements:



More than 93% of respondents either agreed or strongly agreed that IIOP had increased the awareness in the profession of the CPD process, and also endorsed (83%) the IIOP's role in supporting pharmacists to engage with the CPD model.

However, pharmacists are less confident that they will meet the requirements of ePortfolio and/or practice review, and likewise are more ambivalent about whether the IIOP is meeting the needs of their particular sector of the profession. In respect of this latter point, a breakdown of the responses to this question by sector of the respondents indicates that whilst 55% of those working in community pharmacy agree or strongly agree that their sector's needs are being met, with 32% saying they are not, 42% of hospital pharmacists feel the sectors' needs are met with 46% suggesting they are not. Industry and regulatory sector pharmacists indicated that they did not believe their sector's needs were met, with 72% and 75% respectively stating that they disagreed or strongly disagreed.

5.2.5 Perception of Independence from the PSI

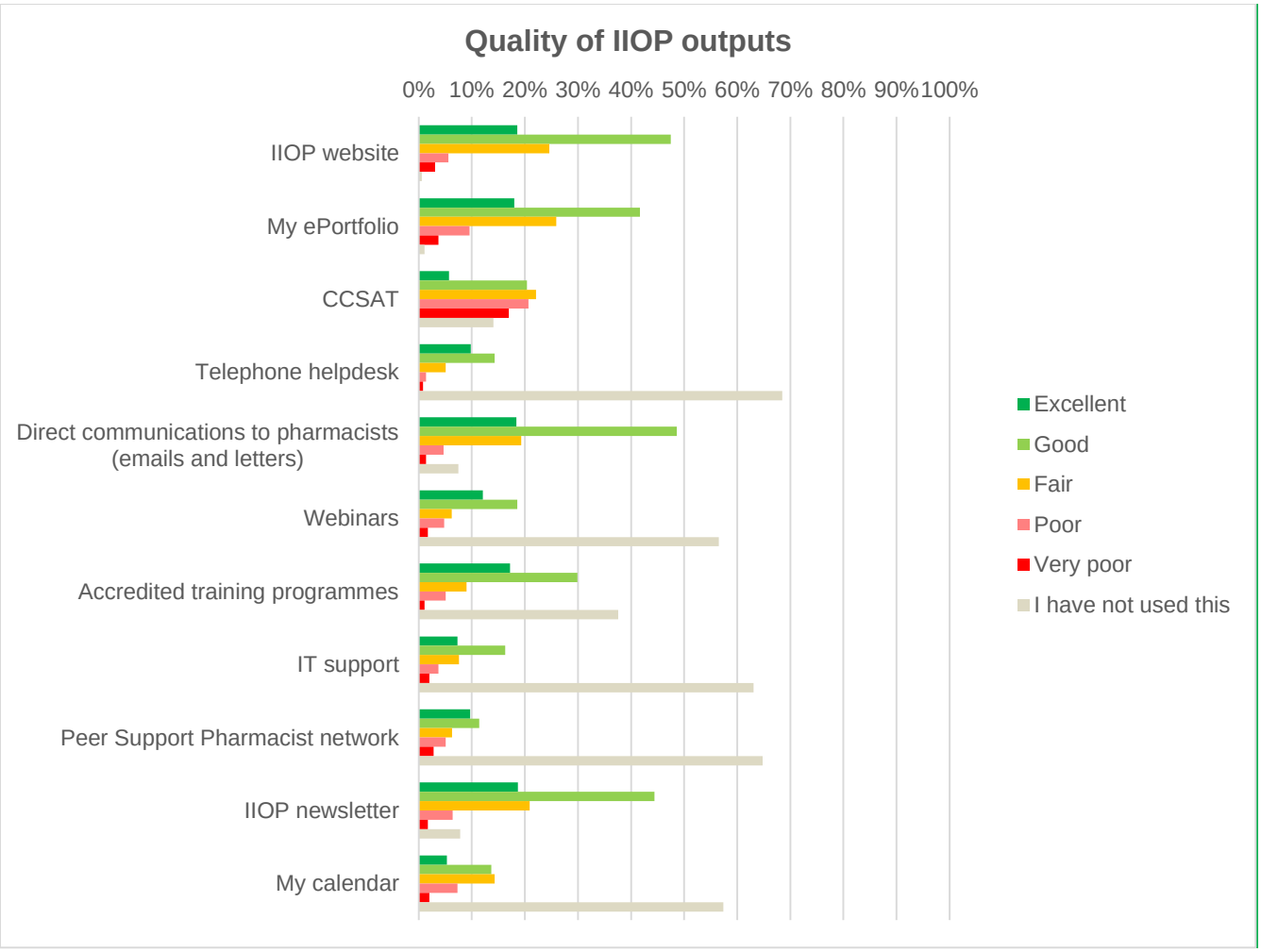
We asked survey participants to rate their perception of the IIOP's independence from the PSI. The answers were very mixed, ranging from 1 ("not at all independent) to 5 ("totally independent"), with the average rating in the middle at 3. Interestingly, only 39% regarded the IIOP as being independent, with 61% either stating that it is not independent or expressing no opinion. This is suggestive of a lack of clarity or conviction in the profession that there is a distinct separation of roles between the IIOP and the PSI.

5.2.6 *Quality of IIOP Outputs*

Pharmacists were asked their opinion on the quality of a range of outputs from the IIOP:

- IIOP website
- My ePortfolio
- CCSAT
- Telephone helpdesk
- Direct communications to pharmacists (emails and letters)
- Webinars
- Accredited training programmes
- IT support
- Peer Support Pharmacist network
- IIOP newsletter
- My calendar

As the diagram below shows, there is broadly positive appraisal of the quality of IIOP outputs; however, few are achieving consistently "excellent" ratings. A key issue appears to be the CCSAT tool, which has considerably lower quality ratings than other aspects of the IIOP's work.



5.2.7 *Qualitative Opinion*

Pharmacists were invited to give further comment within the survey, and the feedback in relation to their experience of the IIOP and the CPD model was extremely mixed, with strongly divergent and contrasting opinions: many were supportive of the IIOP and the CPD model; some had reservations about the implementation and specific aspects like CCSAT but were broadly positive about the process; and others were extremely negative about the requirements on pharmacists and the mechanisms by which they are required to engage with their CPD.

5.2.8 *Findings – Pharmacist Engagement with IIOP*

The survey responses suggest that there may be some way to go in relation to fully engaging and convincing the pharmacy profession in respect of the CPD model, although those who have engaged with IIOP supports and outputs are broadly positive about these.

From the comments submitted, it appears that particular issues with the website, CCSAT, and ePortfolio are problematic for many pharmacists, and that some find the self-reflective model challenging in an otherwise highly regulated environment; this requires good communication with and support of the pharmacy profession by the IIOP in rolling out the CPD framework. Comments relating to pharmacists' direct engagement with the IIOP team are more positive, with pharmacists appreciative of the support offered.

6 Pharmacy Practice Development

6.1 Description of Current Arrangements

Part of the contract between the PSI and RCSI on the establishment of the IIOP included a key role for the Institute in leading work on the development of pharmacy practice in Ireland to support a greater role for and involvement of pharmacists in the delivery of evidence-based integrated care to patients. The contract specified the appointment of a Director of Pharmacy Practice Development, tasked with delivering a range of activities relating to the development of pharmacy practice, including putting in place the following:

- *a means to identify and pursue opportunities around advancing the clinical practice of pharmacy and implementing the recommendations of the Pharmacy Ireland 2020 review of pharmacy services.*
- *a framework to identify and progress the most appropriate inputs required from pharmacists in implementation of HSE Quality and Clinical Care Directorate programmes.*
- *a structured approach to engagement with national healthcare policy stakeholders and also those representing other healthcare professions to ensure that the role of pharmacy in delivery of patient care can evolve in this context.*
- *a system of commissioning research to inform the development of pharmacy practice whenever appropriate.*
- *a structure to enable the piloting and road testing of protocols and initiatives to develop the practice of pharmacy within a network of teaching pharmacies and tutor pharmacists.*
- *a mechanism to ensure that CPD programmes and activities needed for the implementation of evolved roles and services are developed and rolled-out.*

With the exception of the last point, much of this activity has not yet been actioned, with the PSI and IIOP agreeing during 2015 to prioritise the development of the CPD model, tools, and review mechanisms before proceeding with the pharmacy development role for the Institute. Accordingly, the recruitment of the Director of Pharmacy Practice Development has been deferred.

6.2 Analysis and Findings

Most stakeholders recognised that IIOP could have a role in pharmacy practice development, but that this was not its primary role, particularly at present whilst the CPD aspects of its work are still being rolled out and bedded down within the profession.

The Executive Director has been undertaking some of the anticipated work of this proposed Director of Pharmacy Practice Development; this includes engaging with colleagues within and beyond the pharmacy profession to identify and pursue opportunities around advancing the clinical practice of pharmacy and implementing the recommendations of the Pharmacy Ireland 2020 review of pharmacy services, and to identify and progress the most appropriate inputs required from pharmacists in implementation of HSE Quality and Clinical Care Directorate programmes. Whilst this work is valuable, we believe that it needs to be undertaken by a senior member of staff dedicated to this area (i.e. the proposed Director post)

and that having the Executive Director hold prime responsibility for this work is not sustainable: as the contractual pharmacy practice development activity aspects of the IIOP have been deferred by agreement between the PSI and the IIOP, further pharmacy practice development work within the IIOP, other than that supported by the operation of the CPD model, should be placed on hold until the CPD framework is fully rolled out and capacity is available to undertake additional work in this area.

The report on Future Pharmacy Practice in Ireland includes a number of pharmacy practice development recommendations that could be supported by the work of IIOP. The topics are wide-ranging.

We anticipate that progressing the recommendations of the Future Pharmacy Practice report will be a key focus of the PSI, working with different stakeholders. A key aspect of the report is the need for the PSI to work closely with the Department of Health, the HSE, and other agencies and stakeholders to discuss the role for pharmacy and pharmacists within integrated health care in Ireland, and it will be following this engagement with key stakeholders that the PSI will develop specific pharmacy practice development requirements in relation to the advancement of the profession within healthcare delivery. The role of the IIOP will be crucial in this area.

In Appendix 1 we set out the recommendations of the Future Pharmacy Practice report, and indicate some current and potential work for the IIOP in progressing these.

In the long-term, the role of IIOP as envisaged in the contract in respect of "*engagement with national healthcare policy stakeholders and also those representing other healthcare professions to ensure that the role of pharmacy in delivery of patient care can evolve in this context"* could be developed. This role is currently undertaken by PSI but might be more appropriately taken on by IIOP in future when its role in leading pharmacy practice development is fully established.

A key aspect of the pharmacy practice development role, if any, envisaged for IIOP within the next contract should be the specification of clear, achievable actions by PSI for the IIOP, rather than a more aspirational, wide-ranging role that is difficult to implement with limited resources and in "competition" with the development of a new CPD model for the profession.

6.3 Recommendations

We therefore recommend the following:

- That the IIOP continues to contribute to pharmacy practice development primarily through information-sharing about training resources to underpin practice development unless/until capacity is available to appoint a Director of Pharmacy Practice Development;
- That pharmacists are able to share information about courses they have undertaken from different providers through an information hub and discussion facility on the IIOP website;
- That an advanced practice framework be developed between the PSI and IIOP in the longer term, but that at this stage of the development of the IIOP, this may not be prioritised in the forthcoming contract;

- That the recommendations of the Future Pharmacy Practice report be translated into clearly specified requirements by the Department of Health and the PSI to be taken forward by IIOP at the appropriate time.

7 Value for Money

7.1 Description of Current Arrangements

Under the current arrangements, funding for the IIOP is provided by both the Department of Health and the PSI. The basis of the funding is different for the two funders, with the PSI working on a milestones basis while the Department funding is provided based on costs incurred.

(Department of Health funding was previously given through the HSE to the Irish Centre for Continuing Pharmaceutical Education [ICCPE] to develop courses for community pharmacists. This funding had been secured in 1996 from a community contract negotiation to provide continuing education courses for community pharmacists and qualified assistants. The ICCPE was established in 1998 for this purpose, and was disestablished in 2012 when its funding transferred to the IIOP.)

The IIOP does not appear to produce a single set of monthly management accounts. This makes it difficult to understand the full costs of running the Institute. Financial results are produced for each of the funding streams individually.

All invoices in relation to the IIOP funding are issued monthly from the RCSI to the PSI. Where the IIOP is claiming funds from the Department of Health, non-pay expenditure must be accompanied by the relevant invoices as back-up. Any differences in the pay costs must also be explained.

All of the day-to-day financial functions are undertaken by the centralised finance department in the RCSI. This provides the IIOP with access to appropriately trained and qualified staff to administer the finances. Salary confirmations are required by PSI annually for all staff where their pay is funded or part-funded by the Department. Where staff are appointed during the year into Department funded posts, salary confirmations should be provided.

The IIOP prepares a budget for the Department on an annual basis showing the expected timing of expenditure. The actual timing of expenditure can differ from this depending on when activity takes place.

7.2 Analysis and Findings

The dual funding stream ensures that the IIOP is financed to provide both the ePortfolio and course accreditation and training. There is a significant level of administration required each month to provide the necessary backup for the expenditure related to the Department funding. The uncertainty regarding the Department funding also creates issues for the IIOP. The Department funding is provided on an annual basis to the Institute; this funding is usually confirmed in January each year, but the 2017 funding was only confirmed in March. We believe that this uncertainty regarding confirmation of funding is not helpful to the IIOP in terms of trying to plan delivery of its contracted services.

The funding uncertainty delays the planning and procurement of courses for accreditation until there is confirmation that the funding is in place. The effect of this is that the IIOP cannot plan for activities in the first half of the year until funding is in place.

The IIOP does not prepare a full set of management accounts showing the full cost of operating. This creates a vacuum in regard to the information available to the funders. By providing full accounts on a bi-annual basis, the IIOP would be in a better position to justify the costs incurred.

7.3 Financial Management Issues for Resolution

The backup for expenditure that the IIOP are required to provide for the PSI and the Department creates a significant administrative burden for staff at all levels within the process. Whilst the Department does need assurance that the expenditure claimed does relate to the services funded, a balance needs to be agreed between the PSI and the IIOP regarding the level of backup required. The question of materiality is important here, and it would appear that some of the detail required which the IIOP must produce is excessive. We understand that the terms of the allocation letter from the Department of Health demand a considerable level of detail and that PSI must comply with these requirements. In future contract iterations, it may be useful for key stakeholders to consider the terms and conditions attached to funding from the point of view of materiality and reporting requirements, to balance the need to have accountability for public funding with the level of administration required within a small organisation.

7.4 Assessment of Value for Money

Ordinarily, an assessment of value for money would involve comparison of the service under review with similar comparators elsewhere, alongside a more general analysis of how resources are assigned and how money is spent within the context of the type, nature and quality of services delivered.

With regard to the latter, our assessment of the IIOP and our review of its expenditure to date would not provide us with any concern with regard to the efficient and economic use of resources. Two important aspects to consider are, firstly, the high regard in which the work of the IIOP is held by all of the stakeholders with whom we engaged and by a majority of the pharmacists who responded to our survey, which would suggest that the IIOP is undertaking its work to a high degree of quality; and secondly, the fact that the RCSI has contributed additional resources to assist the IIOP in its current work programme, ensuring that this work is completed without further financial impact on the PSI or the Department of Health.

In relation to the former, there are no direct comparators against which the IIOP can be compared in order to ascertain whether the costs currently incurred are greater or lower than what might be observed in other countries in relation to pharmacy CPD. An important dimension in this regard is that the pharmacist CPD system in Ireland is funded through the fees paid to the pharmacy regulator, supported by additional State funding from the Department of Health, rather than by a separate fee-paying structure from pharmacists. This is also the case for other professions within Ireland: for example, chartered accountants (or their employers) pay significant costs in relation to CPD separately from and additional to their membership fees to the professional bodies. This makes direct comparison of costs and funding structures difficult and the consequent assessment of relative value for money very challenging.

On the basis of the above, and recognising that the financial information for the IIOP needs to be presented in a consolidated manner, we are unable to provide a definitive finding that the current funding associated with the IIOP represents good value for money for the PSI and the Department of Health. We believe that this is probably the case, but more detailed investigation would be required before any such conclusion could be drawn without qualification.

From our discussions with the PSI and the Department of Health, we recognise that there is an understandable level of scrutiny associated with the amount of funding being provided to the IIOP, within the context of many other pressures upon both the Department and the PSI. In a situation where the level of activity being undertaken by the IIOP is likely to grow in coming years, it is unlikely that this will be able to be achieved without an increase in the funding to the IIOP. Accordingly, we believe that serious consideration must be given to a CPD funding model which involves a separate and direct contribution from pharmacists.

7.5 Recommendations

We therefore recommend the following:

- The funding for the IIOP from both sources should be ring-fenced from the outset of the contract and should be agreed for the full length of the contract, subject to any variations which may need to be introduced in response to specific changes required. The IIOP should not have to try to plan for a situation where more than half of the funding is subject to an annual confirmation, and where confirmation only arrives well into the financial year;
- The level of documentation to be supplied as part of the monthly invoice pack should be agreed at the outset of the contract. Where it is agreed that backup is no longer required the funders can review expenditure through the use of internal audit. The internal audits can either be stand-alone reviews or as part of specific topic reviews that are undertaken or commissioned by the PSI.
- The Department of Health and the PSI should give detailed consideration to future funding models related to CPD, particularly in respect of the level and scale of activity to be undertaken, and the necessity of pharmacists contributing directly to the cost of CPD (i.e. paying separately, and not just through their professional registration fees).

8 Conclusions and Recommendations

8.1 Should It Work?

When considering the question "should it work?", we aim to probe the following:

- *Is the underlying logic of the proposition sound?*
- *Is there any evidence base that it should be successful?*

The concept of an Irish Institute of Pharmacy reflects the remit of a professional body, anchored by the delegated authority of PSI to oversee the implementation of a system for CPD.

The CPD facilitation work of IIOP is based on a synthesis of international best practice commissioned by the PSI in 2010, and visits by PSI representatives to a CPD system for pharmacists in Ontario. The PSI, the pharmacy regulator, decided that the support tools and activities that could be put in place to assist pharmacists to engage in CPD system was best done at a remove from the regulator. Legislation to make CPD mandatory for all pharmacists in 2015 meant that a system had to be put in place so that all pharmacists could record CPD and have access to quality assured courses that would help them to maintain and improve their practice. A decision was taken to create a new body ‘at arm’s length’ from the PSI, funded by the PSI and the Department of Health.

The other elements of IIOP’s strategic mission centre upon pharmacy practice development underpinned by practice research.

We conclude that the underlying logic of the model is complex, but was judged by the PSI and the Department to be sound. There is no close precedent or specific evidence base for this type of CPD delivery arrangement. However, based upon the extensive work done in 2010 and the fact that decisions were made on the basis of considering international best practice, we conclude that the current model should work.

8.2 Can it Work?

When considering the question "can it work?", we aim to probe the following:

- *Is the project or initiative set up in a way that optimises the capacity to deliver beneficial results?*
- *Are there any issues hindering the project's ability to function?*

The IIOP has been given a very broad remit; in effect, it is facilitating the legislative CPD requirements among pharmacists in the context of developing pharmacy services and promoting pharmacy practice development. The two bodies that determine its work are the funders, the PSI and the Department of Health. The PSI formulated a contract with many requirements, within an implicit prioritisation of the CPD functions of the IIOP but no further guidance as to whether all requirements had to be met in full, or whether there was some understanding that not all would be achievable within the scope of the funding and capacity available.

The Department agrees an annual workplan with the IIOP that is directly linked to its funding. It also retains the right to present new work programmes to the IIOP that arise from Parliamentary legislation – an example of this was the emergency administration of medicines course. It expects the IIOP to react quickly and to make an accredited programme available within a very tight timescale, meaning that changes need to be made to its existing work programme and commitments.

The PSI chose to appoint a Steering Group reflecting many pharmacy stakeholders from different sectors. As we reported in Section 3 above, the Steering Group fulfilled a particular requirement during the establishment of the IIOP, but a different model is now required for governance.

IIOP has very limited resources in terms of staff time to devote to its broad-ranging remit. The financial reporting systems are burdensome and complex, involving almost the full-time capacity of one staff member on this function alone, including additional input from RCSI finance staff. The IIOP has chosen to pursue a broad mission, because of its strong commitment to a broad remit of pharmacy practice development, rather than the narrower activity of oversight of legislative CPD requirements.

Fundamentally, the IIOP is pulled in different directions by a number of interested parties. Specific issues that hinder the project's ability to function are the lack of clarity within the pharmacy profession in respect of the relationship between the IIOP and the PSI, the complexity of its contract and financial arrangements with its funders, the unpredictable nature of the workload, and the lack of clarity at a practical level regarding the implications of a substandard CPD review for a pharmacist in relation to any fitness to practise procedures within the PSI.

We conclude that the project is not set up in a way that optimises its capacity to deliver beneficial results, nor is it funded to deliver on all aspects of its broad remit.

8.3 Does it Work?

When considering the question "does it work?", we aim to probe the following:

- *What are the outputs for the project?*
- *Can the project demonstrate impact in the form of outcomes for stakeholders?*

The IIOP has been able to establish itself as an organisation within the RCSI and has been able to implement, partially or fully, the main elements of its CPD facilitator obligations. These include:

- a website that incorporates the ePortfolio tool and other information about CPD;
- a network of peer support pharmacists;
- information events online and in person;
- a peer review process for the ePortfolio; and
- a practice review model that is in the pilot stages.

It has also operationalised an accreditation process from PSI standards and has used it to complete a number of courses. Most of the courses are aimed at community pharmacists and early career pharmacists. There were mixed responses among survey respondents, with over

one-third of respondents disagreeing that the IIOP was meeting the needs of pharmacists in their sector of practice.

Attendance at accredited courses has been variable, which is not surprising: some have been compulsory elements of the accreditation of new community pharmacy services, others have been more general in their contribution to personal development.

The accreditation process has polarised stakeholders; some regard it as a 'gold standard' that others should follow, but others feel that it is far too onerous for its purpose.

The decision by the IIOP to pursue its broad mission as far as possible put considerable strain on its resources, in particular the staff; the commitment of the staff is excellent but it is unsustainable in the long-term to maintain the level of activity of the past number of years.

The pharmacist survey shows that the IIOP has performed well in terms of raising awareness about the new CPD requirements and providing support to pharmacists. There were more mixed results in terms of whether pharmacists thought they could meet the new CPD requirements, and whether pharmacists in sectors other than community pharmacy were catered for by the Institute.

We conclude that the project has worked well to a significant extent, but has incurred costs beyond the funding of the PSI and the Department. It has achieved much in its short life to date, but it is not clear whether its success is sustainable long-term, in the absence of greater clarity regarding its scope and priorities, and without a more effective governance structure.

8.4 Is it Worth It?

When considering the question "is it worth it?", we aim to probe the following:

- *Is it running efficiently?*
- *Does it represent good value for money?*

As noted in Section 7, it is difficult to present a definitive finding on whether the current funding associated with the IIOP represents good value for money for the PSI and the Department of Health, although we have stated that it probably does achieve this objective and that more work is required to investigate this matter at a detailed level.

Our review has shown no concerns regarding efficiency within the IIOP, and indeed much of the IIOP's current operational functioning depends on substantial effort and long hours being put in by IIOP and RCSI staff.

Answering the question "is it worth it?" is not just about the financial aspects, it is also about the overall investment of time, commitment and support to the CPD initiative of which the IIOP is a central component. In that regard, and particularly considering the lack of any such CPD infrastructure in position prior to 2010, we do conclude that the establishment of these arrangements and the creation of the IIOP have been worth the effort contributed by a wide range of stakeholders, including the PSI, the Department of Health, the RCSI and the IIOP itself.

8.5 Overall Conclusion

Our overall conclusion in relation to the terms of reference set by the PSI is that **the current model for CPD as delivered through the IIOP has achieved much in a relatively short time and has generated a substantial amount of positive opinion among stakeholders**, albeit that a number of pharmacists have not yet seen the full benefits which the model might be able to deliver for them.

As it currently operates, the IIOP and the overall CPD model face several critical challenges. Firstly, **clear decisions are needed in respect of the precise remit and priorities of the IIOP**, as it is unable to deliver fully on all aspects of its remit within its current resources. The additional (unfunded) support provided by the RCSI is very welcome, but unlikely to be sustainable beyond the short term.

Secondly, the **current governance structure has outlived its usefulness and should be replaced by a governance model more suited to a maturing business entity**. In many ways, the IIOP is similar to a start-up business which has come through its initial establishment (the "visionary" phase) and is entering a period of consolidation which requires a different style of governance and a different operational approach. This sequence, leading to a third "developmental" phase, aligns with three contract periods for this outsourcing arrangement, as depicted in Figure 8.5 below:

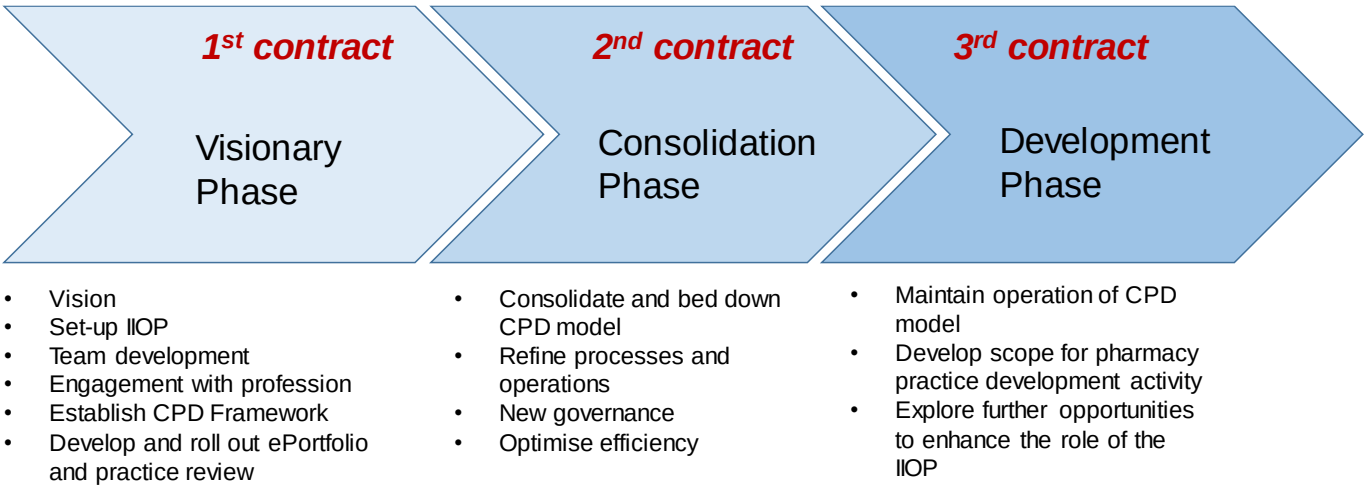


Figure 8.5: First three contract periods for CPD outsourcing

The nature of the relationship between the IIOP and the PSI should change, becoming focused on a collaborative, dialogue-based approach governed by the contract, and should not be characterised by overly burdensome reporting or immaterial financial scrutiny, as has been the case under the current arrangements. This relationship should no longer be considered or termed "arm's length": whilst this arrangement was necessary at the time of the establishment of the IIOP, the future relationship should operate on the basis of a clear contractual separation between the two entities (commissioner and provider).

Thirdly, **the PSI (in consultation with the Department of Health) should give detailed consideration to the means by which the next iteration of this contracted service is put out to tender**. We believe that the tender approach should reflect the collaborative model referred to above, and this will have an impact on the nature and type of the specification to

be developed, the length of contract (four years may be too short), the budgeting arrangements and payment/reimbursement conditions, the monitoring and governance structures, and all other relevant matters relating to how the new contract will work in practice.

Finally, **the PSI and the Department should consider actively whether the costs of the CPD model as delivered through the IIOP should continue to be borne by the PSI and the Exchequer, whether pharmacists should be asked to pay directly for their CPD, or whether some other funding model may be more appropriate**, given the probable increase in costs as the IIOP takes on more responsibilities in line with its original remit.

9 Recommendations

9.1 Overview

We have set out in the preceding sections a number of recommendations arising from our findings over the course of this review. For ease of reference, we set out all the report's recommendations below.

9.2 Governance

The governance recommendations are as follows

- the IIOP and its host institution should establish a new Advisory Group to oversee the work of the IIOP;
- the terms of reference for the Advisory Group should be drawn up by the IIOP / host institution and should be agreed with the PSI in advance of its commencement;
- an independent chair should be appointed to the Advisory Group;
- the existing Steering Group should be thanked for its contribution but should not be re-established within the next contract;
- IIOP should continue to engage with the wide range of stakeholders who have an interest in pharmacy CPD, but not through a formalised model of a steering group with a series of standing meetings as a present;
- the PSI should continue to work closely with the IIOP through regular contract management meetings, maintaining regular dialogue to address emerging issues and resolve emerging problems;
- the interests of the Department of Health and HSE should be channelled through the PSI.

9.3 Current Operational Methodology

The recommendations in respect of the operational methodology are as follows:

- development of a more collaborative approach to the creation of other courses, including a revision of the copyright clause to allow more partnership with other pharmacy providers;
- allowing training providers more flexibility to optimise the learning objectives for the course and to deliver online packages as self-contained modules;
- allowing a minimum of 8 weeks from confirmation of provider to the accreditation submission date;
- to constrain plans for IIOP to create its own courses but to concentrate on its function as an information hub.
- fundamental changes are needed to the systems of work, principally between the IIOP and the PSI but also involving the Department and the host organisation, should be negotiated before the implementation of the next contract;
- the mission scope should be reviewed, and should be constrained or pursued according to capacity;

- the PSI and DoH should work collaboratively with the IIOP to develop a sustainable revised structure and scope that can be achieved within the resources available to the Institute.

9.4 Functional Analysis

The recommendations arising from the findings in relation to the functional analysis of the IIOP are as follows:

- To consider a flexible, tailored approach to accreditation with a reduction in the administrative burden on training providers and on the IIOP;
- To reserve the full accreditation process for courses that require approval under legislation for pharmacists who wish to supply a new commissioned service;
- To consider whether any IIOP accreditation is in fact necessary for courses that are not supporting the roll-out of commissioned services;
- To review the accreditation standards with a view to identifying which should be applied in accrediting particular types of course;
- To consider an accreditation model whereby providers could go through a full accreditation process once, with shorter, simpler reviews of proposed course content following on from this (however, this may entail changes to primary legislation, which may be onerous and not achievable in the short term).

9.5 Pharmacy Practice Development

The recommendations in relation to pharmacy practice development are as follows:

- That the IIOP continues to contribute to pharmacy practice development primarily through information-sharing about training resources to underpin practice development unless/until capacity is available to appoint a Director of Pharmacy Practice Development;
- That pharmacists are able to share information about courses they have undertaken from different providers through an information hub and discussion facility on the IIOP website;
- That an advanced practice framework be developed between the PSI and IIOP in the longer term, but that at this stage of the development of the IIOP, this may not be prioritised in the forthcoming contract;
- That the recommendations of the Future Pharmacy Practice report be translated into clearly specified requirements by the Department of Health and the PSI to be taken forward by IIOP at the appropriate time.

9.6 Value for Money

The recommendations in respect of value for money are as follows:

- The funding for the IIOP from both sources should be ring-fenced from the outset of the contract and should be agreed for the full length of the contract, subject to any variations which may need to be introduced in response to specific changes required. The IIOP should not have to try to plan for a situation where more than half of the

funding is subject to an annual confirmation, and where confirmation only arrives well into the financial year;

- The level of documentation to be supplied as part of the monthly invoice pack should be agreed at the outset of the contract. Where it is agreed that backup is no longer required the funders can review expenditure through the use of internal audit. The internal audits can either be stand-alone reviews or as part of specific topic reviews that are undertaken or commissioned by the PSI.
- The Department of Health and the PSI should give detailed consideration to future funding models related to CPD, particularly in respect of the level and scale of activity to be undertaken, and the necessity of pharmacists contributing directly to the cost of CPD (i.e. paying separately, and not just through their professional registration fees).

9.7 Conclusions

The key conclusions are as follows:

- The current model for CPD as delivered through the IIOP has achieved much in a relatively short time and has generated a substantial amount of positive opinion among stakeholders;
- Clear decisions are needed in respect of the precise remit and priorities of the IIOP;
- Current governance structure has outlived its usefulness and should be replaced by a governance model more suited to a maturing business entity;
- The nature of the relationship between the IIOP and the PSI should change, becoming focused on a collaborative, dialogue-based approach governed by the contract, and should not be characterised by overly burdensome reporting or immaterial financial scrutiny, as has been the case under the current arrangements;
- The PSI (in consultation with the Department of Health) should give detailed consideration to the means by which the next iteration of this contracted service is put out to tender;
- The PSI and the Department should consider actively whether the costs of the CPD model as delivered through the IIOP should continue to be borne by the PSI and the Exchequer, whether pharmacists should be asked to pay directly for their CPD, or whether some other funding model may be more appropriate.

Appendix 1 – Recommendations of the Future Pharmacy Practice in Ireland Report

Recommendation	
1.	As the health system in Ireland continues to be reformed, policy makers should consider the role that pharmacists, with their unique expertise in medicines, could play as part of an integrated solution to patient and healthcare demands.
2.	The resource that the pharmacy sector, both hospital and community, provides within the health system should be capitalised on for the enhancement of patient care.
3.	The role of pharmacists as an integral part of the health sector delivering on the goals of Healthy Ireland should be strengthened and expanded. This includes the delivery of national information and awareness campaigns, prevention and early intervention initiatives, as well as initiatives supporting and empowering people to look after their own health and wellbeing.
4.	The role of pharmacists in supporting self-care and health behaviour change should be expanded to capitalise on their high level of contact with patients and the public to ensure prevention of and early intervention in illness. Pharmacists should be included in the training and development on health and wellbeing interventions and skills rolled out by the health service. Furthermore, community pharmacies should be considered as a possible provider of national screening services, where appropriate.
5.	The existing role that pharmacists play in supporting patients treating minor and self-limiting conditions, in the community should be further expanded.
6.	Pharmacists should be integrated into building the capacity for patients' self-care and self-management of chronic diseases, including helping patients manage their medicines. This could be provided through structured education and medicines management programmes to at-risk chronic disease patients.
7.	Pharmacists should provide a structured patient education and adherence programme for newly diagnosed chronic disease patients to improve adherence and their health outcomes.
8.	Where monitoring of patients with a chronic disease can be appropriately managed in the community, consideration should be given to establishing advanced pharmacy services for this purpose.
9.	As integrated programmes of care are rolled out, mechanisms should be explored to enable pharmacists and GPs to work more closely together to support patients in the management of their chronic conditions. This could include supplementary prescribing activities such as dosage adjustment or therapy continuation by the pharmacist in line with agreed protocols.
10.	Pharmacists should provide enhanced support to patients with complex medicines needs in the community. This could be provided using targeted medicines review and medicines management strategies for at-risk patients. These reviews should be in collaboration with other professionals including GPs.
11.	Patients in formal care settings, such as residential care, would benefit from targeted structured medicines review conducted by pharmacists and in collaboration with the patient's doctor or GP.
12.	In keeping with government policy to manage patients at the lowest level of complexity and as close to home as possible, consideration should be given to provide for pharmaceutical domiciliary care for at-risk patients.
13.	In line with HSE Integrated care guidelines, patients should receive pharmacist-led medication reconciliation and medicines review upon entry to and discharge from hospital, which should involve the community pharmacist when returning to primary care.
14.	A wider range of patients in acute hospital settings would benefit from having their medicines screened for pharmaceutical and therapeutic appropriateness by the pharmacist. Standards for clinical pharmacy should be developed to support this process.

15.	Patients with illnesses that require treatment with complex medicine regimes should have access to trained specialist pharmacists (e.g. palliative care). The specialist expertise should be used effectively throughout the new hospital group structure.
16.	In order to enhance patient outcomes and increase medication safety, multidisciplinary teams, which include pharmacists should be used to develop collaborative models of medicines management. This includes development of appropriate pharmacist prescribing models. Supplementary prescribing by pharmacists in the first instance would aid the patient management process and should be developed. Longer term consideration should be given to giving pharmacists independent prescribing rights.
17.	The leadership potential of the pharmacy profession should continue to be a focus of development.
18.	The CPD system for pharmacists as delivered through the Irish Institute of Pharmacy (IIOP) should continue to be used to deliver quality assured CPD to enable pharmacists provide the patient care and practice developments as identified.
19.	As a system of integrated care is developed within Irish health and social care services the opportunity for pharmacists to further develop shared care with other healthcare professionals, especially doctors, should be explored.
20.	To maximise the benefit to patient care, an advanced pharmacy practice and specialisation framework should be developed to further enhance the skills of pharmacists in all settings.
21.	Pharmacy practice research should be used to provide an evidence base focusing on and informing health policy. The optimal model for co-ordinating this research should be explored with the relevant stakeholders, including the pharmacy academic institutions and IIOP.
22.	Monitoring, audit and regulatory functions should underpin the implementation of these recommendations to ensure that professional accountability, clinical governance and delivery of improved health outcomes for patients are achieved.
23.	Greater structure in pharmacy teams, with delegation of operational roles to appropriately trained staff members, would facilitate the increased clinical role of pharmacists in clinical practice. Regulation of pharmacy support team members would facilitate greater involvement of pharmacists in enhanced roles.
24.	Technology should be used to enable sharing patient care, realise work efficiencies, and facilitate safe transitioning of care. In the development of national IT systems, opportunities should be explored to incorporate the pharmacy element. In the development of pharmacy IT systems provision for integration with wider health system functionality should be considered.

The first recommendation asks policymakers to consider the role of pharmacy in an integrated solution to patient and healthcare demands. In order to engage properly with health policymaking, leadership capacity within the profession must increase. Communication skills with different audiences (the public, other health professions, policymakers and government) must also be honed. IIOP delivers courses about communication skills and personal development. The Executive Director reports requests from other bodies now to propose roles for pharmacists in new policy and practice developments.

The network of pharmacists and organisations represented by the Steering Group members could be better utilised to help IIOP to scope out its role, and to plan a prioritised programme of work that engages pharmacists from all sectors in this endeavour.

The management of chronic diseases is the subject of most of the report's recommendations (6-13, 15-16). IIOP has already commissioned programmes relating to chronic diseases, including the following topics:

- Acute asthma attack

- Anticoagulation
- Diabetes
- Hypertension
- Hyperlipidaemia
- Medicines management for older people
- Mental health
- Supply of high risk medicines

Many of the programmes are aimed at community pharmacists. Hospital pharmacists commented that generic courses about chronic diseases may be useful to newly qualified hospital pharmacists, but that more senior hospital professionals were not likely to benefit.

There are some community pharmacy-based recommendations about illness prevention, screening, early intervention and minor illness management (3-5). Relevant topics covered by IIOP courses to date include mental health and vaccination, but pharmacy public health and minor illness management could be areas for development. Some courses have been commissioned and accredited at the request of HSE in order to underpin a service e.g. seasonal influenza vaccination.

There are a group of recommendations that refer to the establishment of future pharmacy services (3-16), including:

- Structured education and adherence service for at-risk chronic disease patients
- Monitoring chronic disease
- Pharmacist prescribing
- Targeted medicines review to patients with complex medicines needs in the community
- Targeted medicines review for patients in formal care settings
- Pharmaceutical domiciliary care
- Medication reconciliation and medicines review at hospital admission and discharge
- Medicines review within acute hospital care
- Specialist pharmacists in hospital

The IIOP long-term condition courses would support pharmacists seeking these roles. The courses on medicines management in older people and the quality improvement courses would also allow pharmacists to acquire generic medicines review skills. As progress is made on scoping out the details for specific new services, it would be worth commissioning associated courses. IIOP is not going to be able to service the many different needs of specialist pharmacists, but the website could function as an ‘information hub’ where pharmacists can find out about relevant courses in their field from a number of different providers. This may be enhanced if pharmacists are encouraged to give feedback from courses they have undertaken.

Several recommendations refer to collaboration of pharmacists with other health professionals to optimise patient care (1, 9, 10, 11, 16, 19). Inter-professional learning could facilitate such collaboration, and is an aspiration of IIOP, but no progress has been made on this target as yet.

Recommendation 23 refers to optimising the skill mix in the pharmacy team so that pharmacists can take an increased clinical role. One stakeholder talked about the possible role of the IIOP in the CPD of other members of the pharmacy team, such as pharmacy technicians. This would be a new

programme of work needing extra capacity, and would have to be linked to the PSI if delegation of pharmacists' responsibility were involved, but would help to progress this recommendation.

A minority of recommendations relate very closely to the function of IIOP, not least the very specific recommendation 18 about the IIOP CPD system. Developing the profession's leadership potential (17) and pharmacy practice research (21) are part of the strategic for IIOP, but as yet the activity in these areas has been constrained by the attention needed to develop the CPD systems. It is likely that, unless significant new resource is made available to IIOP, this postponement will persist for the next few years until the priority of the combined ePortfolio and practice review system is rolled out.

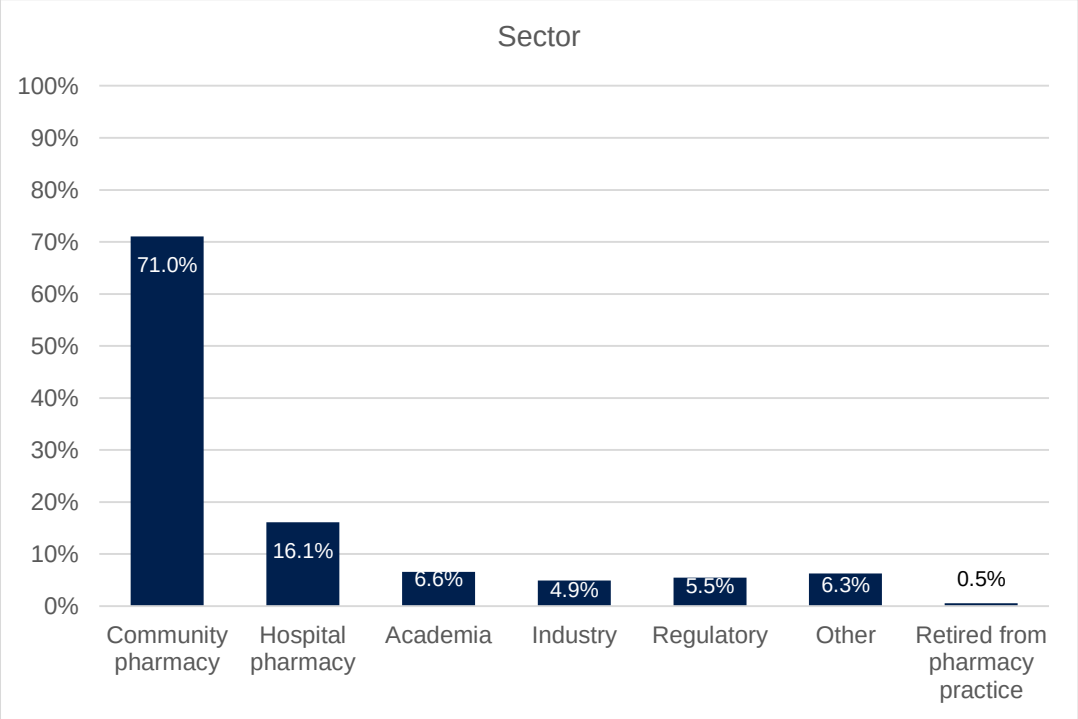
Recommendation 20 requests an advanced pharmacy practice and specialisation framework. Whilst IIOP uses the CCSAT as the basis for some CPD cycles, a senior hospital pharmacist expressed the view that this tool was far too basic to be truly useful to them. The development of an advanced practice framework should be a priority in the next period of operation for IIOP.

Appendix 2 – Stakeholders Consulted

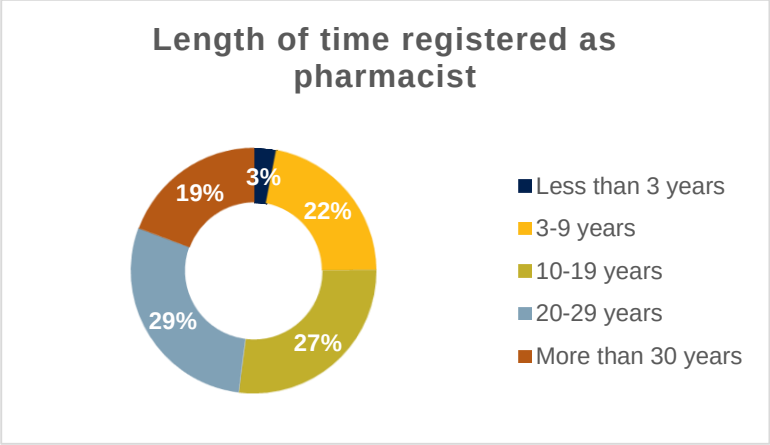
Name	Organisation
Eugene Lennon	Department of Health
Christine Brennan	Department of Health
Catriona Bradley	IIOP
Bernard Duggan	IIOP
James O'Hagan	IIOP
Sonya Saralegui Saenz	IIOP
Katherine Morrow	IIOP
Frank Bourke	IIOP
Sarah Drumm	IIOP
Michelle Scott	IIOP
Niall Byrne	PSI
Conor O'Leary	Formerly with IIOP
Aisling Reast	Formerly with IIOP
Damhnait Gaughan	PSI
Caroline Mellows	PSI
Lorraine Horgan	PSI
Cora Nestor	PSI
Eileen Troy	PSI
Cathal Kelly	RCSI
Dónall King	RCSI
Padraig Barry	RCSI
Barry Holmes	RCSI
John Michael Morris	Steering Group
Margaret Doherty	Steering Group/Community pharmacist
Eugene Renehan	Steering Group/Community pharmacist
Eamonn Quinn	Steering Group/Department of Health
Maria Creed	Steering Group/Hospital pharmacist
Claire Keane	Steering Group/HPAI
Kate Mulvenna	Steering Group/HSE
Liz Hoctor	Steering Group/Irish Pharmacy Union
Jack Daly	Steering Group/PIER
Fintan Foy	Steering Group/PSI Council
Paul Gallagher	Steering Group/RCSI
JJ Keating	Steering Group/UCC
David McLean	Training Provider: CPD Sessions
Alan Moran	Training Provider: Hibernian Healthcare
Caroline Waldron	Training Provider: IACME

Appendix 3 – Survey Results

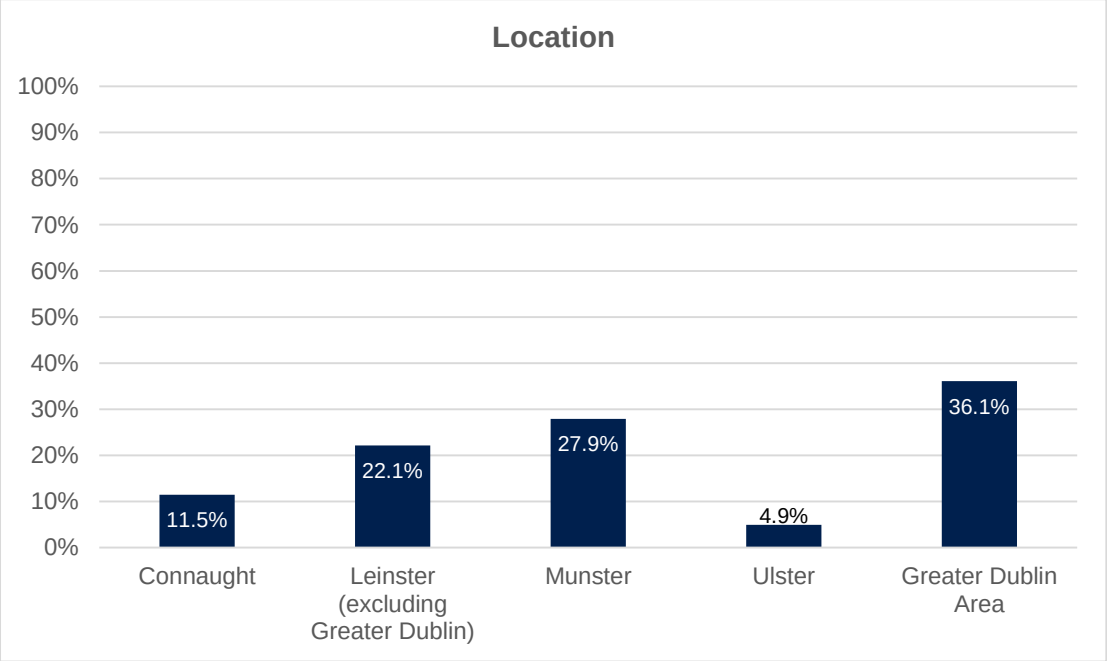
Sector	%
Community pharmacy	71.0%
Hospital pharmacy	16.1%
Academia	6.6%
Industry	4.9%
Regulatory	5.5%
Other	6.3%
Retired from pharmacy practice	0.5%



How long have you been registered as a pharmacist?	%
Less than 3 years	3.0%
3-9 years	21.6%
10-19 years	26.8%
20-29 years	28.4%
More than 30 years	19.1%

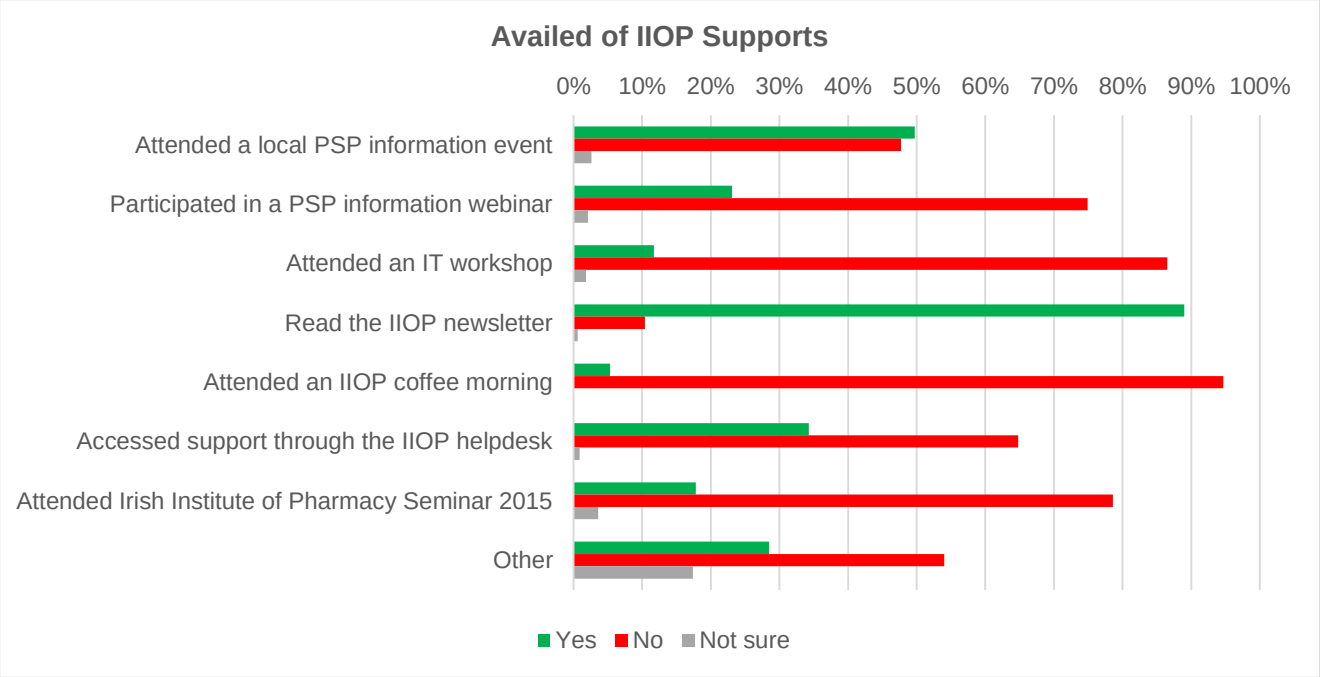


Location	%
Connaught	11.5%
Leinster (excluding Greater Dublin)	22.1%
Munster	27.9%
Ulster	4.9%
Greater Dublin Area	36.1%

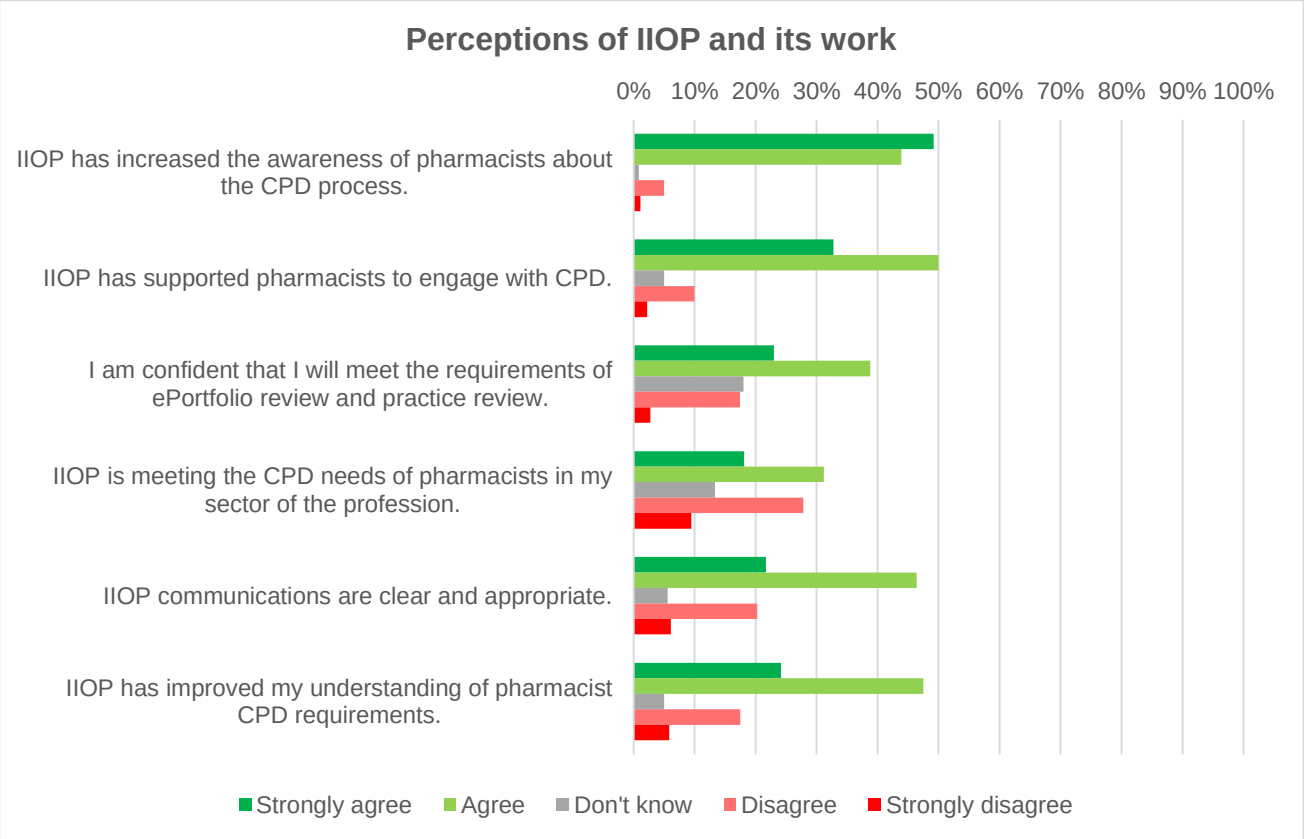


Engagement with IIOP	%
Have you visited the IIOP website?	99.7%
Have you engaged with your ePortfolio to date?	96.4%
Have you been selected for ePortfolio review?	11.2%
Have you put yourself forward to be involved in the work of the IIOP to date?	20.1%

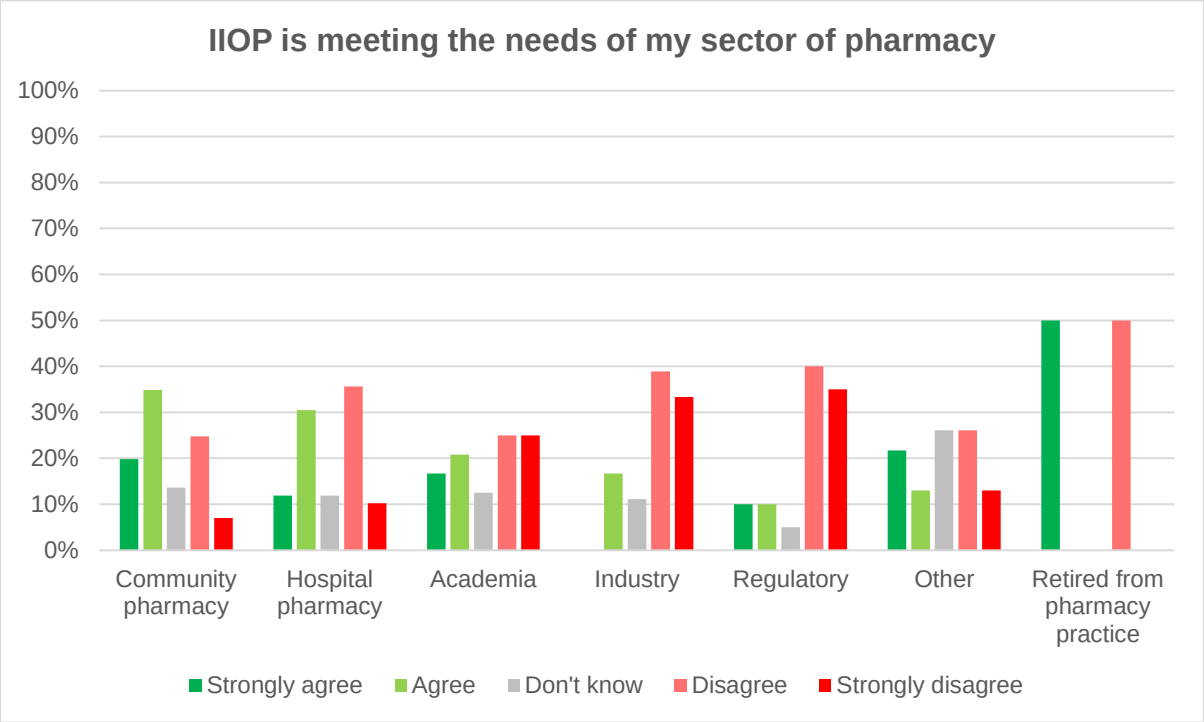
Availed of IIOP Supports	Yes	No	Not sure
Attended a local PSP information event	49.7%	47.7%	2.6%
Participated in a PSP information webinar	23.1%	74.9%	2.1%
Attended an IT workshop	11.7%	86.5%	1.8%
Read the IIOP newsletter	89.0%	10.4%	0.6%
Attended an IIOP coffee morning	5.3%	94.7%	0.0%
Accessed support through the IIOP helpdesk	34.3%	64.8%	0.9%
Attended Irish Institute of Pharmacy Seminar 2015	17.8%	78.6%	3.6%
Other	28.5%	54.0%	17.4%



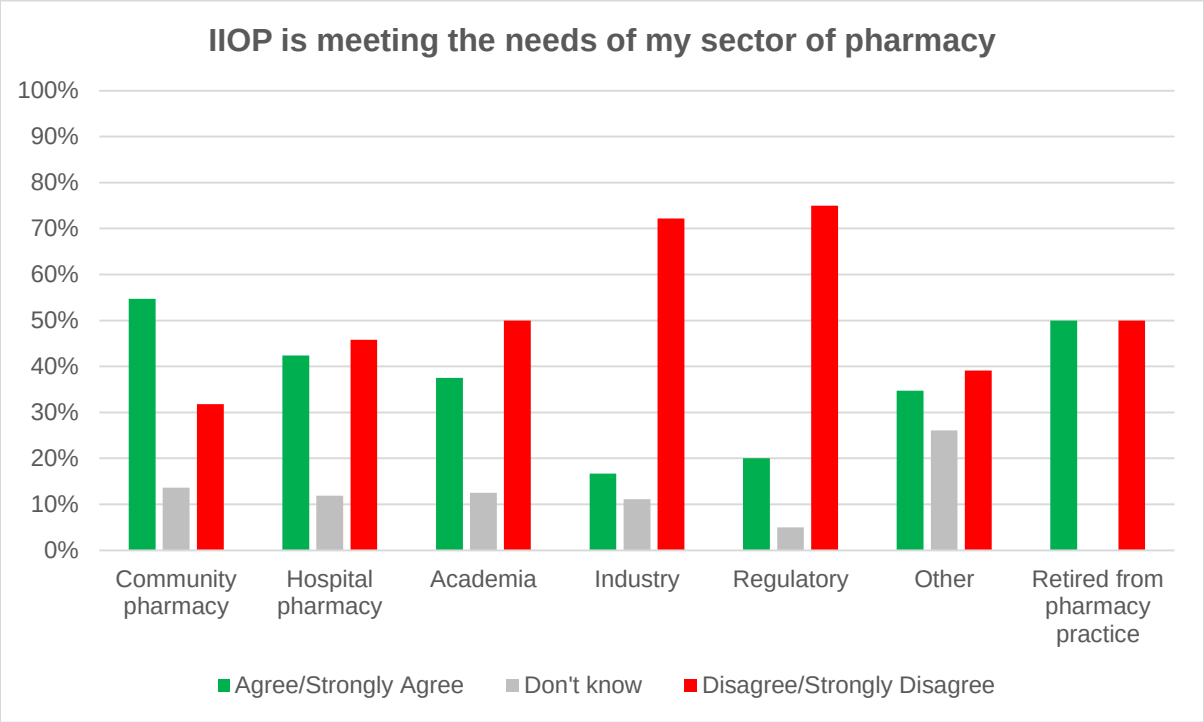
Perceptions of IIOP and its work	Strongly agree	Agree	Don't know	Disagree	Strongly disagree
IIOP has increased the awareness of pharmacists about the CPD process.	49.2%	43.9%	0.8%	5.0%	1.1%
IIOP has supported pharmacists to engage with CPD.	32.8%	50.0%	5.0%	10.0%	2.2%
I am confident that I will meet the requirements of ePortfolio review and practice review.	23.0%	38.8%	18.0%	17.5%	2.8%
IIOP is meeting the CPD needs of pharmacists in my sector of the profession.	18.1%	31.2%	13.4%	27.9%	9.5%
IIOP communications are clear and appropriate.	21.7%	46.4%	5.6%	20.3%	6.1%
IIOP has improved my understanding of pharmacist CPD requirements.	24.2%	47.5%	5.0%	17.5%	5.8%



IIOP is meeting the CPD needs of pharmacists in my sector of the profession.	Strongly agree	Agree	Don't know	Disagree	Strongly disagree
Community pharmacy	20%	35%	14%	25%	7%
Hospital pharmacy	12%	31%	12%	36%	10%
Academia	17%	21%	13%	25%	25%
Industry	0%	17%	11%	39%	33%
Regulatory	10%	10%	5%	40%	35%
Other	22%	13%	26%	26%	13%
Retired from pharmacy practice	50%	0%	0%	50%	0%



IIOP is meeting the CPD needs of pharmacists in my sector of the profession.	Agree/Strongly Agree	Don't know	Disagree/Strongly Disagree
Community pharmacy	55%	14%	32%
Hospital pharmacy	42%	12%	46%
Academia	38%	13%	50%
Industry	17%	11%	72%
Regulatory	20%	5%	75%
Other	35%	26%	39%
Retired from pharmacy practice	50%	0%	50%



Perception of IIOP's independence from PSI	
Mean	3.04
Median	3
Mode	3
Minimum	1
Maximum	5

Rating (1=not at all; 5=totally independent)	%
1	13.6%
2	23.0%
3	24.8%
4	22.4%
5	16.1%

Quality of IIOP outputs	Excellent	Good	Fair	Poor	Very poor	I have not used this
IIOP website	18.6%	47.5%	24.6%	5.6%	3.1%	0.6%
My ePortfolio	18.0%	41.7%	25.9%	9.6%	3.7%	1.1%
CCSAT	5.7%	20.4%	22.1%	20.7%	17.0%	14.1%
Telephone helpdesk	9.8%	14.3%	5.1%	1.4%	0.8%	68.5%
Direct communications to pharmacists (emails and letters)	18.4%	48.6%	19.3%	4.7%	1.4%	7.5%
Webinars	12.1%	18.6%	6.2%	4.8%	1.7%	56.5%
Accredited training programmes	17.2%	29.9%	9.0%	5.1%	1.1%	37.6%
IT support	7.3%	16.3%	7.6%	3.7%	2.0%	63.1%
Peer Support Pharmacist network	9.7%	11.4%	6.3%	5.1%	2.8%	64.8%
IIOP newsletter	18.7%	44.4%	20.9%	6.4%	1.7%	7.8%
My calendar	5.3%	13.7%	14.3%	7.3%	2.0%	57.4%