PSI
CUMANN CÓGAISEOIRÍ NA hÉIREANN
The Pharmaceutical Society of Ireland

AN RIALTÓIR CÓGAISÍOCHTA
THE PHARMACY REGULATOR

Supporting Paper B

Consultation Programme

Summary of stakeholder responses from the consultation exercise for the Future Pharmacy Practice in Ireland - Meeting Patients' Needs Report, 2016

pwc

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1. Introduction

This Summary Consultation Paper has been produced as part of the Future Pharmacy Practice in Ireland-Meeting Patients' Needs Report, to provide an overview of contributions made through the extensive consultation process, conducted by PricewaterhouseCoopers (PwC) on behalf of the Pharmaceutical Society of Ireland (PSI). This consultation process was conducted to gain insight and opinion from a wide range of relevant stakeholders both national and pharmacy specific. This process of engagement was very positive, with a broad range of overarching and converging themes emerging, which highlighted the value pharmacy currently provides, and could contribute in the future, to improving and enhancing the care of patients and the public in Ireland.

In order to present information gathered through the thorough consultation process, this summary paper has been divided into a number of specific sections. Firstly, overarching themes assimilated from the consultation process as a whole are set out. In light of the patient focus of the Future Pharmacy Practice project, patient viewpoints collected in the consultation process are summarised next and then other relevant themes. The paper also provides specific consultation summaries attributed to individual key stakeholders/organisations (e.g. Department of Health). Finally, there are substantial sections relating to the broader consultation process with pharmacists and pharmacy stakeholders, i.e. relating to the Community Pharmacy and Hospital Pharmacy, Pharmacists in non-clinical and academic settings and Pharmacy student perspectives.

2. Methodology

A key part of the project was consultation and feedback with all key stakeholders, including policy makers, patients, pharmacists, and other healthcare professionals, conducted through focus groups and meetings. PwC conducted the consultation process over the period August 2015 to January 2016. A full list of these consultations and the method of engagement is available in section 3 of the report.

National consultations with policy makers and other key stakeholders were conducted via face-to-face interviews.

Focus groups were carried out with patients, pharmacists, and other healthcare professionals, to gain valuable insight on the opinions of these groups.

Patient feedback was a crucial part of this process and indeed the entire project. It should be noted that gaining patient feedback was a challenge and several approaches were adopted to capture this essential insight. Participation for patient focus groups was gained through wide consultation with national patient representative groups and by the identification of participants through the community and hospital pharmacy subgroups (Appendix A, Future Pharmacy Practice-Meeting Patients' Needs Report). Through these means patient focus groups were held with a group of community pharmacy patients in Cork, a group of patients in Dublin and with a cardiac rehabilitation patient group in a large hospital. Patient engagement was also gained through one-to-one interviews with patient advocates nominated through national patient representative groups. These consultations were conducted either in-person or by phone.

There was a positive participant response in the pharmacist focus groups from both community and hospital pharmacy, and focus group with pharmacists took place in November and December 2015. To provide further breadth to these perspectives, focus groups with pharmacy students and pharmacy interns were also held.

Feedback from other healthcare professionals was gained both through focus groups and national consultations with regulators and representative bodies.

Every effort was made to ensure that as broad a consultation process as possible was conducted and the PSI and PwC would like to thank all of the contributors for giving so generously of their own time to provide valuable input for this exercise.

3. List of Consultations

Meeting Type	Group	Date	Location	Attendees
NATIONAL CONSULTATION				
National Consultation	School of Pharmacy, Royal College of Surgeons in Ireland (RCSI)	29-Sep-15	RCSI, Dublin 2	Paul Gallagher
National Consultation	School of Pharmacy, Trinity College Dublin (TCD)	12-Oct-15	TCD, Dublin 2	Anne Marie Healy
National Consultation	Irish Pharmacy Union (IPU)	19-Oct-15	IPU, Dublin 14	Pamela Logan
				Kathy Maher
National Consultation	Irish Institute of Pharmacy (IIOP)	22-Oct-15	IIOP, Dublin 2	Catriona Bradley
National Consultation	Department of Health (DoH)	28-Oct-15	DoH, Dublin 2	Teresa Cody
				Maria Egan
				Eugene Lennon
				Kate O'Flaherty
				Fionnuala Duffy
				Grainne Duffy
				Eamonn Quinn
				Rosarie Lynch
National Consultation	School of Pharmacy, University College Cork (UCC)	04-Nov-15	UCC, Cork	Stephen Byrne
National Consultation	Hospital Pharmacists Associations of Ireland (HPAI)	05-Nov-15	Hilton Hotel Kilmainham, Dublin 8	Deirdre Lynch
				Elaine Conyard
				Nuala Doyle
				Ger Colohan
				Sarah Foley
National Consultation	Health Service Executive (HSE)	11-Nov-15	Dr. Steeven's Hospital, Dublin 8	Tony O'Brien
				Shaun Flanagan
				Ciara Kirke
				Patricia Heckmann
National Consultation	Pharmacists in Industry Education and Regulatory (PIER)	17-Nov-15	PSI, Dublin 2	Maura Kinahan
				Gwynne Morley
National Consultation	Irish Colleges of General Practitioners (ICGP)	24-Nov-15	Lincoln Place, Dublin 2	Mary Sheehan
				Fergus O'Kelly
				Margaret O'Riordan
National Consultation	Nursing and Midwifery Board of Ireland (NMBI)	27-Nov-15	Carysfort Avenue, Blackrock, Co. Dublin.	Ursula Byrne
				Kathleen Walsh
National Consultation	Health Products Regulatory Authority (HPRA)	12-Jan-16	Earlsfort Terrace, Dublin 2	Lorraine Nolan
				John Lynch
				Caitríona Fisher
				Rita Purcell
National Consultation	Health Information and Quality Authority (HIQA)	13-Jan-16	George's Lane, Dublin 7	Phelim Quinn
				Mary Dunnion
				Patricia Harrington
National Consultation	Health Research Board (HRB)	06-Apr-16	Mount Street, Dublin 2	Graham Love

Meeting Type	Group	Date	Location	Attendees
INDIVIDUAL CONSULTATION				
Individual Consultation	Migraine Patient Representative	12-Nov-15	PwC, Dublin1	Jane Whelan
Individual Consultation	Dementia Patient Representative	16-Nov-15	PwC, Dublin 1	Avril Easton
Individual Consultation	Diabetes patient Representative	18-Nov-15	PwC, Dublin 1	Kieran O'Leary
Individual Consultation	Cystic Fibrosis	30-Nov-15	PwC, Dublin 1	Katie Murphy
Individual Consultation	Peter McVerry Trust	02-Dec-15	Mount Joy Square, Dublin 1	Pat Doyle
				Brian Freel
Individual Consultation	Asthma Society of Ireland	08-Jan-16	PwC, Dublin 1	Sharon Cosgrave
				Pheena Kelly
Individual Consultation	Patient Focus	11-Jan-16	PwC, Dublin 1	Sheila O'Connor
Individual Consultation	Family Carers	20-Jan-16	PwC, Dublin 1	Catherine Cox
FOCUS GROUP				
Focus Group	Patient Representatives	04-Nov-15	PSI, Dublin 2	Volunteers
Focus Group	Pharmacy Students	04-Nov-15	School of Pharmacy, UCC, Cork	Volunteers
Focus Group	Community Pharmacists Group 1	09-Nov-15	PSI, Dublin 2	Volunteers
Focus Group	Hospital Pharmacists Group 1	10-Nov-15	PSI, Dublin 2	Volunteers
Focus Group	Hospital Pharmacists Group 2	10-Nov-15	PSI, Dublin 2	Volunteers
Focus Group	Community Pharmacists Group 2	10-Nov-15	PSI, Dublin 2	Volunteers
Focus Group	Joint Hospital & Community	23-Nov-15	PSI, Dublin 2	Volunteers
Focus Group	Cardiovascular Patients	23-Nov-15	Mater Hospital, Dublin 7	Volunteers
Focus Group	Patients	07-Dec-15	Blarney Hotel Golf Resort, Cork	Volunteers
Focus Group	Hospital Pharmacists Group 3	08-Dec-15	PwC, Limerick	Volunteers
Focus Group	Community Pharmacists Group 3	08-Dec-15	PwC, Limerick	Volunteers
Focus Group	Other Healthcare Professionals	15-Jan-15	PwC, Dublin 1	Volunteers
Focus Group	Patients	15-Jan-15	PwC, Dublin 1	Volunteers

4. Overarching Themes and Observations

In general, engagement conducted as part of the consultation process was very successful, with stakeholders providing valuable insight into how they envisage pharmacy and pharmacists can best contribute to the care of patients and the public in our evolving health system. A number of overarching and converging themes and frequently arising areas emerged in the course of the consultation process.

These themes and areas have been broadly subdivided as follows;

- Particular Practice/Care Roles
- Patient Views on Pharmacy Practice
- Other Relevant Themes

4.1 Particular Practice/Care Roles

4.1.1 Medicines efficacy and safety

All pharmacists, representatives, national policy level contributors, other healthcare professionals and patient representatives were unanimous in their view, that above all else, the future roles of pharmacy and pharmacists would continue to have medication efficacy and safety at their core. In this respect the continued core role of the pharmacist in optimising patient care, by ensuring the safe and rational use of medicines, was re-iterated throughout the consultation process. Further to this, the procurement and supply of safe and appropriate medication was also deemed by all contributors to be a critical component of appropriate use of pharmacist's skills and knowledge in the area of medicines.

4.1.2 Transitions of Care

All focus group attendees and participants in national consultations were asked to identify key points of constraint in the health system, where an enhanced pharmacy practice role could achieve the most improved patient outcomes. The most frequently cited area, where improvements could be made, was transitions of care. Feedback in this regard was provided through both national consultations and focus groups, highlighting the role of pharmacists' in improving patient care through enhanced collaborative involvement in the following areas:

- Admission medicines reconciliation;
- Managing patient medical history;
- Discharge information and patient medicines usage;
- Addressing prescribing errors;
- Interactions between hospital, community pharmacist and prescriber;
- Addressing inconsistency in prescribing formats.

Many of the gaps in care identified were directly linked to a lack of communication between the healthcare professionals themselves, the manner in which medicines were prescribed or insufficient information being provided to the patient regarding prescribed medicines. More specifically, when a patient was discharged from an acute setting, the lack of information provided with prescriptions and prescribing errors, often led to difficulties for the patient, the patient's GP and the patient's community pharmacist.

Pharmacists' pointed out that the reconciliation of these types of errors was highly time consuming and that technology solutions adopted in the future might alleviate much of the burden, however, the presence of a pharmacist at either the point of admission to hospital; or during prescribing, would encourage good prescribing practice. This input was also identified by pharmacists and other healthcare professionals as assisting in reducing errors, where clinical pharmacy review would allow medicines optimisation and enhance the correct use of medication.

"If medicines are involved, the patient journey should always include a consultation with a pharmacist." – Hospital Pharmacy focus group

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4.1.3 Chronic illnesses and "at risk" categories

Patients suffering from chronic illnesses were frequently identified as a critical area of required focus for future pharmacy practice. Contributors, through focus groups and national consultations, saw a particular role for pharmacists in the care of these patients in the context of the following characteristics frequently seen in these groups:

- Complex medication regimes that may need adjustment based on one or more indicators;
- High chance of co-morbidity and polypharmacy;
- High cost medications;
- Vulnerable patient groups who are more likely to lapse into non-adherence.

While there was frequent reference to potential new services and further clinical work that could be carried out by pharmacists, this was thought to most usefully apply to selective 'at risk' patient groups such as those suffering from chronic illness.

"Further patient care we could be giving is not for the general public, it should be highly targeted to vulnerable, confused, anxious and chronically ill patients." – Community pharmacy focus group

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4.2 Patient view of Pharmacy Practice

Patient views of pharmacy practice tended to be substantially informed by the level and nature of engagement patients had with the pharmacist whether in community or hospital setting, resulting in variations in perspectives on the current and future roles of pharmacists.

Patients suffering from chronic illness or who were prescribed more complex medicine regimes relied more heavily on the expertise of the pharmacist and were more likely to seek out that expertise. Patients with chronic illnesses (e.g. Cystic Fibrosis) were also more readily able to identify the role of hospital pharmacy, where some had specialist knowledge on medicines used in their illness area.

"I would always visit my GP first if I have a medical issue, but I find that my pharmacist helps me understand how and why I'm taking my medication. When I'm part of the discussion in this way, it all makes more sense." – Patient focus group

The patient view of the scope of pharmacy practice in the community varied greatly based on personal experience, with some patients citing highly unique and innovative delivery of service (e.g. INR clinics) while at the other end of the spectrum, many patients equated their experience as more closely aligned with a standard supply function.

4.3 Other Relevant Themes

4.3.1 Pockets of innovative practice

As highlighted through the innovation portal, used as part of the information gathering process, there is substantial appetite amongst pharmacists across all healthcare settings, for innovation and a changing role of practice. For many of the contributors, their appetite for innovation is strong, however, unless initiatives were funded or were aligned with academic research and a wider network of pilot initiatives, they expressed the view that there did not appear to be any outcomes in terms of policy influence.

Many pharmacy contributors expressed a desire to be involved in more nationally co-ordinated programmes:

"We are willing to be a part of any new studies or initiatives, but there's no value in me introducing a pilot initiative if there isn't a structure to use the evidence." – Hospital pharmacy focus group

While contributors felt that the establishment of the Irish Institute of Pharmacy (IIOP) was a positive step in the co-ordination of research initiatives, there was a view that there could be more done to co-ordinate activities of individual pharmacists, in order to convert evidence of good practice into policy and regulation. This was thought to be particularly true in the community pharmacy sector.

The introduction and growth of the vaccination scheme was consistently referred to as a good example of the successful introduction of a new service that appeared to have benefits across the health system.

4.3.2 Underutilisation of skills

A consistent theme, which spread throughout many consultations, was that there are and have been substantial, missed opportunities for enhanced patient outcomes arising from the underutilised skills and expertise of pharmacists in the area of medicines. This was a theme which emerged at both a national and focus group level.

Participants felt that sub-optimal leveraging of pharmacists' skills had a knock on effect for medication safety, patient outcomes and the cost effectiveness of treatment within the health service.

4.3.3 Resourcing influences on practice

While the issue was articulated differently depending on the setting, adequate resourcing was repeatedly cited as a critical constraining factor in current pharmacy practice.

In particular, a variability in hospital pharmacy service was identified, whereby pharmacists in smaller hospitals and those in rural geographies expressed a view that they currently could not provide full clinical pharmacy services. In some hospitals, it was reported that resource constraints meant that merely dispensing was a strain for the existing facilities and staff capacity.

Contributors in these hospitals felt that standards nationally should be harmonised, before any new services were introduced. Further development of the pharmacy profession could then use the additional resources to create appropriate structures to aid quality patient care through clinical pharmacy.

"It is improper that there is a disparity in pharmaceutical care in different hospitals in Ireland…" – Hospital Pharmacy focus group

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In the community sector, a similar sentiment was expressed in that pharmacists stated that they had less and less time available to spend with patients, as dispensing was increasingly taking up the majority of their time, with administrative burden also contributing to reduced patient contact time.

4.3.4 Technology

Many of the consultations with pharmacists covered future services, centred on the role that technology would play in pharmacy. Pharmacists' views on the benefits of technology largely fell into two key categories:

1. Technology would remove much of the administration and/or time consuming activities involved with dispensing, thus allowing for more of the pharmacist's time to be spent addressing clinical pharmacy activities and engaging with patients.
2. Technology would enable more appropriate sharing of patient information between pharmacists and other healthcare professionals. The outcome of this was generally thought to be highly positive, and the current barrier to accessing the full medical history of patients was hindering a cohesive and truly integrated care service between primary and acute care.

"The less information I have about the patient and their medicines the more I am hindered in ensuring their safety and good care. The lack of an integrated communication system for patient information limits the detail of this information, often to the bare minimum." – Community pharmacy focus group

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Technology was also felt to enable a great number of opportunities, with the potential advent of health informatics cited as an opportunity for improved effectiveness of medications and potentially more

patient-tailored medication regimes. New facilities, such as the National Children's Hospital were suggested as possibilities for Ireland to pilot 'cutting edge' initiatives in relation to pharmacy.

Conversely, existing technology and data systems were felt to be hindering the progress of pharmacy practice. The introduction of smart cards, e.g. as available in France, and other initiatives are thought of as crucial to the full implementation of many services such as medicines reconciliation. With a unifying system linking admission and discharge information, with lab results and other patient records, future practice would likely have far fewer gaps in patient care and missed interventions with regard to medicines.

4.3.5 Pharmacists' Optimising their Contribution to Patient Care

A recurring issue noted by contributors, was the role pharmacists themselves played in optimising their contribution as part of the multidisciplinary team (MDT) in both acute and primary care settings. Many felt that pharmacists needed to foster understanding of their skills and expertise in order to most effectively add to patient care and allow for the best utilisation of their abilities.

"As a profession we can be quite inward looking, and it doesn't help our cause. We all need to bang the drum in terms of demonstrating the expertise we all have" – Hospital pharmacy focus group

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Many of those interviewed from the pharmacist focus groups felt that it was not only a case of resourcing or designation of new services, but a change in behaviour was required by pharmacists to take their place as part of patient care teams.

It should also be noted that previous interaction with pharmacists and an understanding of their potential contribution facilitated further engagement and the ongoing understanding of the value of pharmacist input by other healthcare professionals and MDTs.

5. Viewpoints

5.1 Patients

The patient consultations consisted of patients with varying usage levels and perceptions of pharmacy. During the focus groups, it was noted that patients experience with pharmacy varies. It was also noted that pharmacists were the first point of call for several patients. However, others reported that they simply saw pharmacists as a dispensary service and all their medical interaction was with a doctor. Special patient consultations took place for patients (through representative bodies) with Cystic Fibrosis, Diabetes, Migraine, Dementia and Cardiovascular conditions. The nature of patient's use of pharmacy differed greatly across these groups, with some patient groups requiring increased specialty pharmacist care in a hospital setting whereas others were mainly primary care based.

Identifying Potential Improvements in the health system

Transitions of Care

Patients reported that moving across care settings is a challenging process. It was noted that the fragmented patient information was the primary challenge in transitioning patients. It was indicated that the relationship between GP and pharmacists is vital to the success of moving patients across care settings, with some very good examples given of GPs and patients working together.

"I would like to think that my doctor and the pharmacist are in regular contact and between them can act on any issues with my health". – Patient focus group

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The patients explained that the inefficiencies in the system resulted in moving back and forth between care settings to receive prescriptions and medication, which in some cases were needed urgently. The lack of information flow was identified as a significant barrier, as patients' information does not necessarily follow them from care setting to care setting. Patients were of the opinion that an improved IT system might increase the likelihood of identifying issues through the increased accessibility of patient information, which could significantly improve patient care overall.

In relation to special patient groups with specific healthcare needs, it was indicated that every patient is different in relation to moving care setting:

"It is difficult to implement a single method of transitioning patients across settings as different methods are more suitable for different patients… It is easy for people to fall through the cracks." - Patient representative body

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Patients also discussed a lack of clarity when prescribed highly complex medicines, initiated by a hospital Consultant, as their full medicine's history might not be known to all healthcare professionals involved in their care. In a patient focus group involving eight cardiac rehab patients, only one patient indicated that they had received medicines reconciliation on admission into an acute Hospital.

Multidisciplinary Teams (MDT)

It was agreed by patients that pharmacists should be involved in the healthcare team, but in their experience they have rarely seen this occurring. It was indicated that diabetes patients are now advocating for an integrated care approach in primary and acute care through the use of the multidisciplinary team. There are also clinics for chronic migraine patients in five locations in Ireland, where Doctors, Nurses and Physiotherapists are involved. There is no pharmacist involvement but the patients would like to see their involvement due to the complex medicines they are currently receiving.

Role in Education and Information

It was agreed among patients that pharmacists should be a larger part of the primary care team with their GP and other healthcare professionals. Patients generally indicated that they would like to have their medication explained to them. They viewed the ownership of their health as a major benefit, and possible side effects or adverse reactions are critical information that they should be aware of. It was generally accepted that community pharmacists are very willing to help, but they sometimes do not get to see the pharmacist. When the pharmacist talks to the patient about their medicines, patients indicated that they found this very helpful.

Patients felt that the pharmacy setting was preferable to the GP, for minor or re-occurring conditions, due to accessibility and because they would prefer not to be exposed to other sick patients in the GP waiting rooms.

"For small ailments, I don't see why I should have to wait in a crowded GP waiting room with a room full of other sick people". – Patient focus group

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Pharmacists' role in hospitals

Pharmacist interaction with patients in hospital were recognised by many of the patients as a valuable service but it was noted that generally they would not see a pharmacist every time they are in an acute setting. It was highlighted in patients with Type 1 Diabetes, the medical devices and medicines are constantly changing, which can be very confusing for patients, they said that pharmacists in the hospital are ideally placed for this role and should be included in their clinics. Similarly, the role of the Cystic Fibrosis (CF) pharmacist in St. Vincent's Hospital was highlighted as a very good service; currently it is not always possible for all patients to see the pharmacist, and one patient stated that they had only seen the CF pharmacist once in their last eight yearly visits. Patients reported that this role, when carried out by an available pharmacist, included talking to the patient about their treatment and medicines, informing their community pharmacist of any relevant information and ensuring that patients are adhering to their medication.

Patients with complex conditions generally agreed that when a pharmacist involvement was provided in the hospital setting, that it was very positive. The lack of opportunity for patient engagement with the pharmacist was apparent from the comments received.

"I never see the pharmacist when I am in the hospital" – Patient focus group

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Population Health and Chronic Disease

Patients explained that they would like to see more promotion and preventative measures taken by pharmacies to prevent people from becoming sick. Patients were open to more pharmacists offering better services for health prevention and diagnosis, as the location of pharmacies is ideal in many rural areas. Patients discussed that additional structures may be required in order for pharmacists to perform extra services, but they would like to see the pharmacy as the first port of call, and then be referred when necessary.

A patient indicated:

"I was diagnosed with diabetes ten years ago. If a pharmacy-based clinic had been available for me to manage my health better back then, I think it would have made a huge difference. I was in and out to hospital for years." – Patient focus group

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Patients considered that pharmacists were well placed to provide additional services in their area of expertise in medicines. It was noted that patients believed a pharmacist could utilise their knowledge of medication in a further role by providing home visits to help patients understand and manage their medicines better.

"Pharmacists are essential in a nursing home setting to manage the large amount of medicines on site at all times" – Patient focus group

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Specific patient groups

Patient groups indicated that, in particular with dementia, there is a problem around misdiagnosis, and pharmacists need to be in a position to refer patients for testing, as the earlier you can detect dementia the higher the probability of a healthier patient. It was indicated that the pharmacist is ideally placed to identify the first signs of dementia and their intervention in this regard can be significant. Migraine patients also have problems of diagnosis due to their common misconception of a headache, it was indicated that this misconception can occur regularly by healthcare professionals including community pharmacists.

Diabetes is becoming an ever-growing problem according to patients; treatment of Type 2 Diabetes involves the management of diet and exercise. It was indicated that the service being offered by pharmacists surrounding the overall care of Type 2 Diabetes could be improved.

Patients generally were not fully aware of services that pharmacists could do, a patient in the cardiac rehabilitation service noted:

"I only found out the other day that you could get your blood pressure checked in the pharmacy" – *Patient focus group*

Persons experiencing drug addiction and homelessness

This segment of society was reported to be particularly vulnerable with regard to drug rehabilitation. In cases where methadone clinics were available they were typically centred in a small number of urban centres. This meant those recovering from addictions, who were living in rural communities, would have to travel long distances, often on a daily basis to receive their medication. Patient representatives felt that structures, which made these services more readily available in rural settings, would greatly benefit service users.

A representative group for the homeless and persons experiencing drug addiction stated that while the service was thought to be closely aligned with the availability of level 2 GPs Methadone Prescribers, a greater emphasis on decentralised delivery was thought to be likely to lead to greater adherence to rehabilitation programmes and reduce some of the negative impacts of convergence of service users to urban locations.

'New'/Innovative service

In the course of the various patient consultation processes, patients were asked to discuss their opinions and provide their views on a number of potential future roles and innovations;

Internet pharmacy

It was noted that there was a split in opinion with regard to internet pharmacy. Some patients stated their desire to speak face–to-face with the person providing them with their medication while others were open to the idea of other delivery mechanisms for convenience purposes.

Those who supported internet pharmacy often cited cases where the same medication had been dispensed for years at regular intervals, and how a regular delivery would make more sense to their lifestyle.

Pharmacist Prescribing

Pharmacist prescribing was presented to be both positive and negative by patients. In migraine patients, it was noted that pharmacists should be able to prescribe '*Triptan*' medicines for the treatment of migraine, as this can be better for the patient when having a migraine attack. Patients felt that access to this medication without a GP visit would greatly improve the patient experience, but recognised that this

would only be possible in the case that there was prior agreement between the pharmacist and GP. Some patients also highlighted the benefit of allowing a pharmacist to extend prescriptions for cases when they are on long-term medication and change is unlikely:

"If the dosage is not going to change I should be able to go directly to the pharmacist and not back to the doctor" – Patient focus group

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Some patients indicated that they would need to see pharmacists receiving more training if they were to prescribe, as currently, they understood that a community pharmacist's clinical knowledge was not on par with their doctor. It was recognised by patients that the influenza vaccination programme showed pharmacists can do more than originally perceived.

Specialism/additional services

In the course of the consultation process when asked about suitable initiatives to be explored, patients indicated a range of additional services that they would like to be offered in the pharmacy setting, the main services cited were; anticoagulation services, blood pressure monitoring, cholesterol screenings, asthma services and travel vaccinations.

5.2 Department of Health (DoH)

The Department of Health (DoH) were represented at the meeting by members of staff from the Disability Unit, Health and Wellbeing Programme, Mental Health, Primary Care Unit (now Community Pharmacy), Medicines, Controlled Drugs and Pharmacy Legislation Unit, Acute Hospital Policy Unit, and Clinical Effectiveness Unit. Future Pharmacy Practice-Meeting Patients' Needs project was discussed under a number of headings;

Pharmacy and policy implementation – translating policy into action

- What has been good?
- What could be improved?

The DoH reported that the recently introduced pharmacy vaccination programme was considered positive, as it reflects value to the health system, derived from the increased access and uptake of the vaccination and also the lower cost of vaccination to the system. There is an opportunity to extend the uptake of this service. The DoH acknowledged the positive contribution made by community pharmacists in implementing the reference pricing and generic substitution legislation and in supporting patients through this change process to ensure their safety and understanding of their medication. The recent introduction of the emergency medicines legislation is seen as increasing pharmacists' contribution to patient care.

The DoH acknowledged the challenges brought about by the economic crisis and fee reductions made under the Financial Emergency Measures in the Public Interest (FEMPI) legislation. The removal of the retail mark-up has largely broken the link between drug price and reimbursement.

Major challenges for the health system where pharmacy could potentially offer valuable input

The DoH representatives were of the view that many of the areas where pharmacy expertise may be best utilised could be aligned to the new health structures (Hospital Groups and Community Healthcare Organisations) with the purpose of garnering efficiencies and standardisations. Effective healthcare delivery across the hospital groups would require much specialist knowledge to be centralised to tertiary and quaternary units within these groups. It was felt that the other hospitals should be able to draw on the expertise in these centres, therefore achieving efficient clinical networks – this could apply to many aspects of pharmacy expertise including specialist procurement and inventory management. Available services across the groups must be shared to support more marginal services, whilst certain functions could be centralised thereby freeing up pharmacists for clinical roles e.g. drug procurement, as a hospital group would be more efficient and the pharmacists' role here would be important. This should fit together with HSE Primary Care Reimbursement Service/Medicines Management Programme initiatives since secondary care procurement has a knock-on effect in primary care.

Transitions of care was identified as an area of challenge where pharmacists could support patients e.g. by discharge prescription review and improved inter- and intra-professional communication around the transition from secondary to primary care and vice versa.

Chronic disease management was identified as an area of future challenge. It is a potential area for pharmacists to add value to patient care, especially medication management and supporting self-care by patients, aligned with the overarching healthcare system needs by "making every contact count".

In clinical effectiveness, variation was identified as a problem. Pharmacists could improve this by supporting the National Clinical Guidelines, and actively participating in collaborative care of patients. There may be a need for clarification of the pharmacists' role within the multidisciplinary care model.

The current economic pressures continue to be a challenge to which pharmacists can contribute positively, through optimisation of the drugs budget and optimisation of resources already there. Pharmacists can specifically be involved by influencing effective and appropriate prescribing, decreasing inappropriate polypharmacy and reducing waste.

Under the implementation of *Healthy Ireland* in the health sector, frameworks to support Brief Intervention and 'making every contact count', as well as self-management support for patients with chronic disease, are in development. These will be relevant to all healthcare professionals including pharmacists.

Evidence based policy. Where are the pharmaceutical (information) gaps? Expectation of pharmacy in bringing evidence to the table?

In making the case for the introduction of new reimbursable services to be provided by pharmacists, a clear demonstration of value must be provided. Value in this regards reflects: value for money; demonstrate clear clinical effectiveness; improvement in patient experience and outcome; and delivery in a cost effective manner.

It was noted that many of the new services, which pharmacy had previously sought the DoH's reimbursement for, exist in the current community pharmacy scope of practice and thus should not be considered as "new services" – these included Medicines Use Review (MUR), New Medicines Services (NMS) and Disposal of Unused Medicines Safety (DUMP) schemes.

It is important that evidence be provided for requested changes to reimbursable services. Such evidence should align with the performance indicators set for the DoH and HSE in achieving their strategic plans. In providing the evidence, which should be data-rich, consideration should be given to collaboration with the Health Research Board (HRB) and/or The Economic and Social Research Institute (ESRI).

Integration of services and multidisciplinary working

Cohesive treatment between the acute sector and primary care was thought to remain a challenge; discharge in particular was noted as an area of difficulty, and provides an opportunity for pharmacists to work with other health care professionals to ensure proper integrated care in a patient's transition from and into the community.

There is a role for pharmacists in transitions of care; currently pharmacist involvement in the discharge process is seen as valuable.

In relation to mental health, the aim is to treat more patients in the community and pharmacists would have a key role in supporting both the patient and the mental health care teams.

The future place of pharmacy in a changing healthcare environment – implications for change

Pharmacy's potential role in Chronic Disease management was expressed in terms of a need to involve and empower patients to care for their own condition. Pharmacy's future role, in that regard, is to work closely with other primary care professionals to ensure fully integrated care is achieved.

In particular, with respect to elderly care structures and non-acute care settings, including the residential disability sector, pharmacy has a greater role to play in ensuring effective medicines management. As people move from institutional settings to the community, monitoring the potential increased use of medicines in community based settings will be important and pharmacists could have a key role in this regard. Pharmacists, patients, hospitals and social care facilities all have a role in medicines management. Of particular note were 'at-risk' sections of society such as Mental Health or Intellectual Disability service users, whose level of readmission to acute settings is often a function of non-adherence issues.

There is also an extended role for pharmacists in advising on the use of preferred medicines, prescribing initiatives and containment of drugs budgets, in line with the national Medicines Management Programme

5.3 Health Service Executive (HSE)

The Health Service Executive (HSE) were represented at the meeting by members of staff from the Leadership Team, the Corporate Pharmaceutical Unit, Quality Improvement Division and the National Cancer Control Programme. The report and role of pharmacists was discussed under a number of headings;

Pharmacy and policy implementation – translating policy into action

- What has been good?
- What could be improved?

There was an acknowledgement from the HSE that the recession has brought challenges to all health services including those provided by both community pharmacists and hospital pharmacists. The Financial Emergency Measures in the Public Interest (FEMPI) initiatives led to restructuring of reimbursement as well as a moratorium on staffing and additional budget cuts in the hospital sector.

Despite this, there were a substantial number of positive experiences of pharmacy adding value to the Health Service; "Undertheweather.ie" was a good example of this. Other examples include community pharmacists involved in vaccination services, pharmacy as part of clinical rounds, supporting medical and nursing roles, medicines reconciliation, specialist roles (e.g. palliative care, aseptics), improved medicines information, IT initiatives and building business intelligence, cost avoidance in hospitals and quality and safety of medications in the hospital setting.

It was further recognised that hospital pharmacists are engaged in an on-going dialogue with the HSE in relation to implementing a new career structure.

Major challenges for the health system where pharmacy could potentially offer valuable input.

Representatives of the HSE acknowledged the substantial risk in the transitions between care settings, in particular in cases where polypharmacy is involved. It was noted that pharmacy could play a critical role in admission and discharge back into the community through effective clinical medicines management delivered by pharmacists. In particular, the value of medicines reconciliation was thought to need further exploration to prove the concept in transitioning from Irish hospitals.

> *"Care is often handed over the fence between hospitals and the community. Pharmacists can be the gatekeeper in this transition ensuring good patient outcomes in relation to medicines, cost effectiveness and patient safety." – National Healthcare Organisation*

Evidenced based policy. Where are the pharmaceutical (information) gaps? Expectation of pharmacy in bringing evidence to the table?

When providing evidence of the benefits or effectiveness of new services, HSE representatives indicated the patient voice and support was critical in the assessment – is it a service that the patient wants and needs? A service that responds to a strong patient need is important when considering limited resources, together with safe, rational and effective use of medicines.

It was felt that pharmacy has unique strengths. Aside from the expertise in medications, a key feature was the great network of community pharmacists who had a remarkable footprint that could be utilised in many instances, even as a back-up resource at times of medical emergency. The existence of this footprint is set in stark contrast to some of the emerging struggles in the primary healthcare system in rural communities where there are currently sub-replacement levels of recruitment.

In terms of evidence structures, HSE representatives felt there were three main considerations in assessing a case for a future pharmacy service:

1. Introduction of proven, evidence based models from other jurisdictions
2. A business case for a demonstrator project/pilot to prove the worth of a service
3. Identification of services that are already being delivered in the health system but could be more effectively delivered by the pharmacist, perhaps creating extra capacity for other health care professionals as well as giving value for money.

Economic evaluations of many services are currently thought to be poor, and any research that links in with the work of the Health Research Board (HRB) is to be welcomed. Even with strong evidence bases and cost benefit analyses, not every proposal can be implemented. It needs to provide benefits to a wide group of stakeholders and be a compelling service that can help decrease demand for services and preferably (but not always) demonstrate its value within a 12 month funding cycle.

Integration of services and multidisciplinary working

It was felt that the current lack of a more structured collaborative relationship between GPs and pharmacists was leading to missed opportunities to benefit patient care. A pharmacy role working directly with GPs may be very beneficial – there are models where this happens more frequently (e.g. palliative care) and the learnings from successful integration of professionals should be used. In specialist areas in particular there needs to be further integration to leverage in those areas of niche expertise - links with the acute sector may be critical to accessing this knowledge. The Intellectual Disability sector and Mental Health are two areas where patients would benefit from more pharmacist input. The management of complex medicines is a growing challenge and the pharmacist is well placed to provide support to patients, particularly when they are frequently transitioning between care settings.

The unique network of community pharmacies throughout the country was again noted as an important resource for the health system, particularly in the context of a view that “every contact counts” with patients, especially those who are at risk of, or already suffering from chronic illnesses.

The future place of pharmacy in a changing healthcare environment – implications for change

Pharmacists should be involved in leading, developing and delivering healthcare services to include involvement in eHealth and technology-enabled solutions and integrated care.

Enabling patients to care for themselves in the community was seen as a key component of a sustainable health system. It was noted that initiatives such as the Minor Ailments Scheme may not work in Ireland given that our medicines classifications are different from other jurisdictions to which this has applied. However, the idea of the [community] pharmacist being able to treat minor ailments rather than attending hospitals and GPs unnecessarily is certainly a positive one.

Initiatives that focused on prevention and maintenance were viewed very positively, and a number of initiatives that were already underway were discussed. This was an area where a longer term macro view on benefits was required to assess the impact of a greater level of health in the overall population and a reduced incidence of chronic illnesses developing. Specific clinics that tackled major growing health issues such as obesity were thought to be a valuable possible future service, if delivered in the right way.

The benefits gained from increased pharmacy roles by freeing up other primary care resources, including GPs, was mentioned. In particular potential future roles for pharmacists in improving the care of the elderly, chronic disease management, preventative health, transitions of care and filling care gaps particularly in rural areas was raised.

It was highlighted that pharmacy will need to link in with the multidisciplinary approach outlined in the National Clinical Programmes.

Hospital services may benefit from an increase in the technology available in future years in the area of ePrescribing and dispensing. Robotics and information sharing technologies may reduce the time required for some dispensing activities and may naturally lead to a greater opportunity for clinical skills to be utilised.

Acute medical assessment models were thought to be a good practice where the resources of a hospital allowed for them. Increased clinical pharmacy input into patient care on wards and at discharge, in acute hospitals as well as residential settings (e.g. intellectual disability, nursing homes) was acknowledged as important. Initiatives such as emergency department pharmacists were thought to be a good service but again, an evidence base for the required resourcing and the acquired benefit to the patient and health service would be critical.

The pharmacist's role in developing and delivering statistical process analysis capability and building business intelligence was highlighted.

5.4 Health Information and Quality Authority (HIQA)

HIQA was represented by members of the executive management, regulation and health technology assessment teams. The report and the role of pharmacists was discussed under a number of headings,

HIQA's experience of the Pharmacy sector to date

- What works well?
- What needs improving?

HIQA reported that one of the positive experiences they have had thus far with pharmacists was their role in antimicrobial stewardship in improving infection control. It was noted that antimicrobial stewardship expanded across all band 3 hospitals in March 2016 (Note: "band 3" is a hospital with an intensive care unit, at least 300 beds, and emergency department though possibly not an acute trauma ward) and that there was further potential to share such resources within hospital groups to promote effective infection control. HIQA outlined that they are currently undertaking a report into antimicrobial stewardship in hospitals, and hoped that this report would be available in the near future. As part of this work some wider issues were noted including lack of clinical pharmacy in some Irish hospitals.

In relation to the services they currently inspect including **care for disability and the older person,** as the regulator HIQA noted that medication issues were of concern. There is significant disparity in pharmaceutical care provided in these settings and some medication practices seen are still quite outdated. Where poor medication practice was seen, the absence of a pharmacist was noted. It was considered that pharmacist input and pharmacist review is required in relation to medicines management.

Pharmacists' role and medicines expertise requirements for different levels of acuity in the health system:

- Acute Care
- Primary Care
- Nursing Homes/Non acute Care
- Social Services/Mental Health/Disabilities
- Quality and Safety Issues

HIQA stated they considered that pharmacist have a role in staff training by providing education on the medicine itself, on medicines handling including correct storage etc. Patients with **behavioural issues** are an "at-risk" group of the population who could benefit from proactive pharmacists' interventions, which may particularly relate to addressing issues with regards to the complexity of their medicines regime. Specifically, the use of chemical restraint in this patient group was discussed. HIQA stated that as well as the specific issues of infringement of rights and the conditions from a regulatory point of view under which chemical restraints may be used, multidisciplinary assessment was essential and pharmacists' expertise would be beneficial in this area.

It was noted that when pharmacists are involved in residential care, staff recognised their contribution as providing significant positive patient benefit.

When residential care patients are being transferred to acute hospitals the main causes for admission were respiratory, confusion and infection and often medication issues arise. HIQA considered correct reconciliation of medicines and actively managing the patients' medication, at both admission and discharge, was an essential part of an integrated healthcare, in which pharmacists have an important role.

HIQA considered that many patients with **chronic conditions** could benefit from education, training and support to self-manage their condition. Pharmacists can help in this regard, e.g. monitoring the inhaler techniques of patients with asthma.

Given their regular interaction with patients, pharmacists also have a large role in chronic disease management and prevention, through brief interventions and efficient communication with other healthcare professionals and the patient. Education and support for patients can lead to substantial benefits to the patient and also the State. However, given the pharmacists' knowledge of certain common conditions and their access to healthcare information, it was considered that pharmacists have a role to play in broader primary care provision, including disease prevention and self-care.

The role of pharmacy in medicines optimisation and assuring appropriate polypharmacy for nursing home residents was discussed. HIQA recognises the benefit of pharmacist input into medicines management for patients.

The Future Healthcare Environment – Pharmacy role and expertise requirements - Implications for Change

There is evidence for community based multidisciplinary teams, especially with regards to cardiac rehabilitation and pulmonary rehabilitation for patients, with pharmacist as part of these teams. This multidisciplinary role could incorporate potential future roles for pharmacists in prescribing, including supplementary prescribing and dose adjustment.

The pharmacist's role in chronic disease management could be enabled through the use of technology such as telemonitoring, although the limited international evidence was noted.

With the further movement of patients to domiciliary care settings, there will be an important role for pharmacists in providing care for these patients.

HIQA concluded by noting the importance of the roles which pharmacists hold, outside of core pharmacy service provision, in areas such as regulation and industry (including pharmacoeconomic and health technology assessment roles), and the flexible skill set of pharmacists that facilitates them filling such roles.

HIQA also highlighted the positive contribution pharmacists' skills has made to the work of their own organisation and are considering expanding pharmacist input in carrying out their role.

5.5 Health Products Regulatory Authority (HPRA)

HPRA was represented by members of the Management Committee. The report and role of pharmacists was discussed under a number of headings.

HPRA's experience of collaboration with the Pharmacy sector to date

HPRA noted that their interaction with pharmacists has been positive for many years. There is regular interaction for: clarification of medications; quality defects; changes to packaging; reclassification of medicines; and adverse reaction reporting to name a few. HPRA also made the point that pharmacists have a large part to play in drug safety and this can always be improved by them and other healthcare professionals.

It was noted that issues such as drug shortages can cause significant problems for patients. There have been informal talks with pharmacist representative bodies to improve the communication efforts in times of shortages and/or more serious events such as medicines recall. This collaboration is improving the working relationship with the HPRA and healthcare professionals on the ground.

It was noted that the upcoming Falsified Medicines Directive (due to be implemented in 2019) will require additional tasks and IT investment but should lead to greater patient safety.

Pharmacist role in Medicines Safety

HPRA were strongly in agreement with the important role that pharmacists have to play in medicines safety. They consider that pharmacists have a key role in reinforcing advice and information to support safe and appropriate use of medicines, counselling patients as necessary and appropriate. HPRA have commenced publishing education material for various products which are aimed to optimise the safe and effective use of the product. Some of this material is specifically directed at pharmacists. Initiatives such as the circulation of information newsletters and drug safety newsletters to pharmacists work well. It was also noted that pharmacists were the largest users of the HPRA website. It was mentioned that in the UK, these notifications have a "read and understood" feature which ensure all healthcare professionals have read the appropriate information and this system was cited as something that the HPRA could review further.

The role all healthcare professionals have to play in adverse reaction reporting was highlighted. In 2014, pharmacists directly reported approximately 230 adverse reactions to the HPRA (pharmacist reporting accounted for 8% of those submitted during 2014 and 2015). While this number indicates engagement by pharmacists, HPRA were of the view that this engagement could be further developed. It was highlighted that the majority of reporting currently comes from doctors and patients.

HPRA were strongly optimistic about the future role of pharmacy in Pharmacovigilance requirements. It was noted that generally "pharmacovigilance needs as much data as it can get". Pharmacists currently have a large amount of patient data, and with the future introduction of unique patient identifiers, electronic health records and e-prescribing, the role should be increased. This "big data" can influence reporting of adverse reactions, and the efficacy of medicines. Notwithstanding this role, it was noted that all reports should be appropriately anonymised and provision of any data should be within the context of reporting needs to respect data protection requirements.

Access to Medicines

HPRA noted that they have an interest in the further reclassification of medicines for sale under the supervision of the pharmacist. The positive reaction to the pharmacy supply of Emergency Hormonal Contraception (EHC) among the public and other healthcare professionals, was highlighted.

Reclassification of medicines is progressing, although engagement with this initiative has been slower than anticipated on the pharmaceutical industry side. It was noted that patient safety remains the top priority, ensuring that in the supply of these medicines there is an interaction with a healthcare professional (pharmacist) to optimise the safe and rational use of medicines.

Healthcare and Medicines

HPRA noted the complexities of compounding of medicines, both external to and within hospital settings, with highly specialised compounding expected to remain in the control of the hospital pharmacy.

It was also noted in relation to new complex medicines, these will mostly be prepared and dispensed within the acute setting, where complex regimes and novel administration techniques are more prevalent. These will require specialist compounding facilities, pharmacist supervision and input. The evolving prevalence of biosimilar medicines will also require monitoring and tracking by pharmacists.

Future medical devices will also see an enhanced role for pharmacists, such as in the area of connected devices and monitoring, relating back to pharmacovigilance activities.

Future Place for Pharmacy in the Healthcare System

The view was that the future of pharmacy practice would include the following developments:

- Facilitating increased access for patients through appropriate reclassification of medicines
- Increased role in a primary care setting, incorporating collaboration with other healthcare professionals;
- Point of care testing for patients
- Testing/screening for chronic conditions and monitoring and dose adjustment for long term patients
- Increased role of pharmacists in transitions of care;
- Prescribing – HPRA was asked for its views on pharmacist prescribing and was supportive of this in principle, mentioning a possibly low uptake in the community setting beyond dose adjustment, however, it could be initiated in the hospital setting.

Pharmacy role and expertise in pharmaceutical, regulatory and healthcare industries

The extensive skill set of pharmacists was considered advantageous, particularly in terms of their potential contribution to the pharmaceutical industry. There was a shortage of pharmacists available historically and roles were evolved without pharmacy input. Numbers of pharmacists entering the industry are rising - which is viewed as a positive development.

5.6 Health Research Board (HRB)

The HRB were represented at the meeting by a member of the Senior Management Team. The report and the role of pharmacists in research was discussed under a number of headings;

Current research in Pharmacy

It was highlighted that;

- There are some pharmacists involved in research but these tend to be nestled within larger research programmes e.g. HRB SPHERE, a structured PhD programme in population and health services research
- The HRB Health Professional Fellowship programme is a route that has been targeted by some pharmacists to train to PhD level. However, this programme is currently under re-design at the HRB, as it is seeking a more structured approach in keeping with modern PhD training
- The key point is that there does not appear to be a strategic approach to research in pharmacy, other healthcare professionals have a much more structured approach (e.g. ICGP), this may be because of their scale

Funding for research

It was also discussed that;

- Funding typically follows academic projects
- Hospitals are likely to lead a lot of the research and hence community pharmacy may not be as involved.

Developing research in pharmacy

The following elements were considered important in developing research in pharmacy;

- Establishment of a well-planned approach to building credible research in pharmacy, preferably aligned to national policy initiatives
- Consideration to incentivise pharmacists who are running their own retail operation, aligning incentives to the core mission of the research
- Potential allocation of “protected time” for some pharmacists in community and hospital settings (it was noted that this can be difficult to achieve in practice)

Overall, it was noted that it is important to develop a culture of research as part of practice.

Potential new structures to encourage research

A number of structures which may encourage future research were discussed;

- There may be an opportunity and value to forming collectives for research purposes, such as syndicated research between a number of community pharmacists may work
- In industry this works for commercial interests whereby they contribute to a fund to produce objective research findings. It is important that the results remain independent of the funding interests
- This may be possible via some state agency partnering with an interest group at arm’s length

5.7 Community pharmacists and representatives

There was a wide range of community pharmacists consulted, from independent pharmacists to members of chain or symbol groups, from experienced business owners to newly graduated pharmacists, incorporating an urban to rural mix.

Generally, it was noted by all community pharmacists that they have very good relationships with their patients and would like to spend more time in roles away from the dispensary and in front of patients. They also felt they had many skills that are currently not being used for the benefit of patients.

New services

Community pharmacists expressed that they would like to use their clinical pharmacy skills to help their patients more.

The point was made that nurses and other professions had been quicker to adapt and take on new services; however community pharmacists didn't have this mind-set as they had to consider the business implications of a new service carefully and were reluctant to "dive in". Concerns were raised regarding the practical difficulties in implementing innovative practices in the pharmacy without compromising the quality of their basic dispensing and pharmaceutical care functions.

There was also thought to be a low level of standardisation of new initiatives that were trialled by pharmacy business owners and that there needed to be some sort of central system that co-ordinated the outcomes from a smaller number of pilots. It was thought that the IIOP might fill this role well as its remit over research activities gained momentum.

Multidisciplinary Teams (MDT)

The communication with the local GP was thought to be critical to achieve a greater influence of pharmacy practice in producing greater patient outcomes. Many new services could be best implemented where there was an element of collaborative management of patient health between multiple healthcare professionals. Technology was seen as the critical enabler to improving this relationship in the community.

> *"Pharmacists should work as part of multidisciplinary team in order to utilise their knowledge, accessibility and relationships with patients to improve patient care." – Community Pharmacy focus group*

The majority of informal successes tend to be in rural communities and focus on specific problem patients who are well known to all healthcare professionals in the area. In these instances it was reported that GPs might meet with community pharmacists on a semi-regular basis to informally discuss certain at risk patients with specific reference to their medicines. These meet-ups were thought to be good for knowledge sharing and gave a chance for some dialogue between GP and pharmacist in a context that was not "fixing an error" of the GP or time bound by a waiting patient. The possibility of implementing this kind of multidisciplinary approach nationally was discussed but it was recognised that the value might be

quickly lost if it was forced on healthcare professionals as an administrative exercise, where its strength in its ad-hoc application was the personal relationship between GP, pharmacist and patient.

The role of a practice pharmacist that worked directly with GPs and communicated with community pharmacists was strongly endorsed. This role was thought to be most effective when targeting at risk patient groups, those who had a history of non-adherence and incidences of polypharmacy.

Elderly care and the link with home care was thought to be an area that had inconsistent service in terms of pharmacy care, with those patients who "shout the loudest" thought to receive the best service.

Prescribing

Independent prescribing did not have strong support from a community pharmacist perspective and it was thought that there was still a critical distinction between the role of prescriber and dispenser which must be maintained. Independent prescribing may be suitable in an area of particular pharmacy specialism, but this was mostly thought to be confined to a hospital setting. There was however, support for supplementary prescribing where dose adjustment was based on simple measurements A consistent view was the scope of this change, should be limited to a sensible range of situations where a visit to a GP was not really required.

Community pharmacists and their representatives generally advocated dose adjustment and other forms of supplementary prescribing.

Preventative

Community pharmacists were highly supportive of wellness and preventative initiatives but said that resourcing hindered any real development in the area. A number of contributors noted that while the pharmacist had great expertise, they may require further training on the soft skills to initiate the right conversations with patients – for example to address or prevent a problem with obesity. It was felt that the focus on having a positive patient experience was sometimes hindering this. A more structured education on how to approach patients, who may benefit from preventative regimes, was thought to be useful.

Further areas where preventative initiatives were seen to be well implemented and valuable were:

- Asthma awareness events
- Cholesterol checking and awareness events
- Sexual health awareness
- Blood glucose level screening.

Communication and transitions of care

Poor prescribing practice from hospitals was cited as a critical problem in the transition of care from hospital into the community setting. A large proportion of patients were thought to have little awareness of their medication change when discharged. It was noted that if a pharmacist was present at the discharge point, this problem may be addressed. The transitions of care methods of other jurisdictions were endorsed - most notably Sweden where prescriptions include indications and medical history.

"All the information we are given about the patient is on the prescription. If we had more details about the patient it would be hugely beneficial for everyone" – Community Pharmacy focus group

'*High-tech medicine*'[1] prescription errors also occur, with patients often not feeling comfortable in questioning the prescription at the hospital. As a result, many community pharmacists reported spending a substantial amount of time contacting hospitals in relation to prescription errors regarding high tech medicines in particular.

Clinical pharmacy

Support for the initiatives in the "Interim Report of the Pharmacy Ireland 2020 Working Group, 2008" plan was strong, however it was thought that the implementation effort backing these up had not materialised, though mostly due to the economic recession and the accompanying cuts to resources, including pharmacy.

Medicines Use Review (MUR) and New Medicines Service (NMS) (England) were thought to be well aligned with pharmacists' core skills. New patients were often in need of this counselling following recent diagnosis with a condition where they may be quite emotional or confused. Often pharmacists are the health professional that manage the practicalities of living with this new illness for the patient.

MUR was thought to provide great benefits for relatively little investment. Pharmacists indicated that huge savings could be made to the health system and to the patients themselves from brief consultations regarding their medicines.

"A consultation I delivered for 15 minutes with a diabetic patient saved the HSE significant cost on medications" – Community Pharmacy focus group

It was noted that many pharmacists thought some of the most expensive medicines had the highest degree of wastage and that this could be avoided through services such as MUR. However, these services need to be proactive. Many patients (e.g. elderly patients, patients treated for Mental Health issues) are not comfortable with discussing their non-adherence with the medication regime and thus need appropriate consultation. A conflict of interests for pharmacists to engage in MURs was raised as a concern as in the current payment structure reducing a patient's medication is detrimental to the pharmacy's income.

[1] www.thepsi.ie/Libraries/.../PRACTICE_NOTICE_6_**High_Tech**_Scheme.sflb.ashx

Monitoring patients with chronic illnesses

Anticoagulation and diabetes were identified as key opportunity areas for pharmacy. It was stated that pharmacists were well equipped to provide screening and management services in these cases and that these are the areas that should be prioritised. However, the demand for 'warfarin clinics' were thought to be higher in rural areas compared to urban areas which are well served by outpatient clinics. One pharmacist led 'warfarin clinic' was said to have delivered huge patient benefit to the region in Cork as well as changing the perception of pharmacists' clinical abilities from a patient and other healthcare professionals' perspective.

Similarly cancer and cystic fibrosis patients were thought to be quite well served by other healthcare structures and may not necessarily benefit greatly from additional specific community pharmacy services.

Needle exchanges and Sexually Transmitted Disease (STD) clinics (diagnostics) were something that many pharmacists were interested in becoming involved in but it was felt that there simply wasn't enough resourcing from the HSE available for this. Pharmacists may need further structured training in this area to be comfortable in delivering this service on a regular basis.

5.8 Hospital pharmacists and representatives

There was a wide range of hospital pharmacists consulted, from chief pharmacists to newly graduated basic grade pharmacists, and pharmacists at all levels of hospital from specialist tertiary centres to community hospitals, mental health and intellectual disability services.

Specialisation

- Specialisation of pharmacy was the most frequently mentioned topic amongst contributors from hospital pharmacy.
- In a practical sense, specialisation already exists in many hospitals, particularly within clinical areas such as Oncology, Cystic Fibrosis, and Emergency Medicine etc. Patients were said to have a much more positive reaction to treatment which was bespoke to their condition and felt more at ease when a specialist was involved in the conversation regarding their medicines.
- Anti-microbial specialisation was considered the best existing model providing evidence of the benefits of specialisation.
- Specialisation was also mentioned in terms of aligning skills with patient needs. Hospital pharmacists expressed the view that there should be a clear grade structure that would allow for mentoring in the hospital and for work to be assigned on the basis of experience, expertise and specialism.
- A number of key barriers were articulated to achieving these benefits through pharmacy specialisation:
  - Resource constraints contributing to a lack of capacity, prohibit specialisation.
  - Career structures were not in place to recognise specialist positions and therefore they were in place in an ad-hoc manner where more resourcing allowed it or where there was a critical mass of patients to be treated with a particular illness.
  - Training structures were not seen to be in place to support specialisation – it was felt that Continuing Professional Development (CPD) was not enough in this sense and that a postgraduate qualification (e.g. a Masters) in the area of specialism should be required. It was felt that hospitals associated with teaching institutions were better equipped to accommodate and foster specialisation. Academic credentialing was thought to give legitimacy to the specialisation in the hospital setting.
  - The grade of specialist clinical pharmacist is included in the new agreed career structure for hospital pharmacists which is outlined in the 'Review of Hospital Pharmacy Nov. 2011'[2]. The significant delay in the implementation of the agreed new structures was cited as impacting considerably on the clinical and cost benefits that could be delivered for patients and the health service.
- A number of hospital pharmacists raised the issue that specialisation was not for everyone but that everyone could benefit from the development of these roles. In particular, pharmacists referenced the benefit of being able to access specialist knowledge informally from individuals who had particular knowledge in a clinical area. It was noted that while this currently happens in an informal and ad-hoc fashion, it would align with the proposed 'hub and spoke' model of future acute care structures (hospital groups) if specialism were to sit in the centre but be accessible to the smaller hospitals.

[2] Report on the review of hospital pharmacy, Chair: Dr Ambrose McLoughlin, November 2011. [online] Available at: http://www.hpai.ie/uploads/Review2012.pdf

- While specialisation may have many benefits in terms of clinical care of the patient and improved medicines regimes, the core role of dispensing should not be lost, and the distinction between other healthcare professional roles and that of the pharmacist should remain intact.

Integration of Care

Pharmacists' membership in a wider clinical team in hospitals was consistently raised as an opportunity for pharmacy practice to deliver improved patient outcomes.

- The impact of a greater utilisation of the clinical skills of pharmacy was noted. A particular instance of this was referenced in cases where there was collaborative prescribing (e.g. Cystic Fibrosis, Transplant treatments). Evidence suggested that the advice of the pharmacist was followed in 100% of cases where it was detailed directly on the Drug Kardex and in 55% of cases where this was written on advisory notes (a supplementary note attached to the original prescription).
- The introduction of the MPharm degree was cited as having a positive influence on the operation of Multidisciplinary Teams (MDT) as pharmacists mixed with other healthcare professionals as part of their training, fostering an improved mutual understanding of the potential contribution of the different disciplines, to improve patient outcomes.
- Many focus group participants felt that the greatest barrier to MDT membership was resourcing constraints, in that pharmacists had little opportunity for clinical pharmacy activities, as dispensing took up much of their time.
- While resourcing was one constraint, many contributors felt that pharmacists did not appropriately advocate for themselves and their profession, and that those who did, had demonstrated the value of pharmacy practice to the other healthcare professionals and had, in some cases, become an indispensable part of the MDT.
- In this respect many felt that the pathway to better utilisation of pharmacy skills was through a concerted education process both at a national and individual level to make other healthcare professionals aware of the value of pharmacist knowledge and expertise, so that they might be more frequently involved in enhancing good prescribing practice.
- The important role of hospital pharmacists within multi-disciplinary teams and within an integrated model of care was raised. Hospital pharmacy having the added potential to play a key role in designing, developing and implementing medicines management solutions within the new integrated systems of care proposed by the HSE
- Many examples where MDT membership was the norm in hospitals were provided. However, few of these were through formal structures but more so following the demonstration of a particular pharmacist's value.
- It was noted that this particular aspect of clinical pharmacy was particularly difficult to deliver in rural hospitals where resourcing constraints were most pronounced.
- The potential value of consistent input from pharmacists in ward rounds was not thought to be well understood by other healthcare professionals.
- Pharmacists' noted the difficulty in demonstrating the exact benefit or cost saving that pharmacists' presence on the ward had, and that there was no straightforward method of calculating this.

Prescribing

Feedback from hospital focus groups was mixed in the area of prescribing.

- Many contributors were strongly in favour of full prescribing and believed that legal changes were required to allow this, largely in the form of a new role within pharmacy – that of the "Pharmacy Consultant".
- Most however, felt there was an important distinction in the role of prescriber and dispenser and thus felt that there should be some degree of separation between these roles particularly in community settings where a patient was not being overseen by a wider clinical team.
- Many contributors advocated for cases where supplementary prescribing or contingent prescribing would greatly benefit the patient.
- There was a broad consensus that if prescribing by pharmacists were to be introduced in any format, it must be predicated on the pharmacist being suitably qualified and operating within specific clinical areas, where their skills are matched with the range of prescriptions for which they are responsible.

Admission/discharge

The introduction of pharmacists in Emergency departments was thought to substantially reduce the likelihood of medication errors later in the patient journey.

The writing of prescriptions was thought to be particularly poor and it was believed that pharmacists could aid in the education process and improve prescribing practice throughout the hospital.

It was discussed that discharge can frequently be conducted in a hurry, to free up beds and for the patient to return to their home as quickly as possible. Often in these circumstances patients may not consult with a pharmacist at discharge, this often means that:

1. A patient leaves the hospital without knowledge of how to use the medicines which they have been prescribed.
2. There is a higher incidence of prescribing error, causing difficulty in the community pharmacy or adverse reactions/interactions.

Workforce planning

Some pharmacists expressed the view that there could be serious issues around workforce planning in the near future. A fall-off in the numbers of males in the profession is of concern. As demand becomes greater in terms of potential 7 day services/out of hours service and given the perceived moderate pay incentives and the attractiveness of the role, issues in meeting the health system needs were discussed.

While resources were felt to constrain clinical activities, a potential lack of experienced pharmacists was also thought to be an impending problem for the sector.

It was also mentioned that workforce planning for future compounding services will need to be considered as well as the capacity of current premises.

5.9 Academic institutions

The three schools of pharmacy were consulted (Trinity College Dublin (TCD), The Royal College of Surgeons in Ireland (RCSI) and University College Cork (UCC)) along with the Irish Institute of Pharmacy (IIOP).

Undergraduate Curriculum

The new integrated programme for pharmacy, introduced in September 2015 was thought to have substantially changed the way students are taught and is aligned to both national and international standards. The implementation of the new MPharm has presented significant challenges for the academic institutions. While the degree is more clinical and patient focused, there is still thought to be a strong science component to the curriculum. Contributors to consultations felt that the MPharm programme compared very favourably to the PharmD (US and Canadian programme), with the MPharm thought to deliver a higher level of scientific knowledge but thought to be lacking a key research element. The Canadian model was, however, thought to offer strength in terms of its hospital rotations which allows pharmacists to become much more advanced over time, after completing a shadowing role.

Placements are a key element of this clinical focus in the new courses; however there have been issues in securing enough placements in hospitals. These placements are often introduced from an early stage to "throw students in at the deep end" and ensure that they are not simply a passenger on ward rounds.

Increased interprofessional learning with Medicine and Dentistry have given the pharmacy students an understanding of how much they know in the area of medicines and a clear view of what they can offer in terms of clinical guidance in supporting the roles of other healthcare professionals.

The curriculum is revised as required (e.g. when vaccinations were introduced), however new elements are generally not added to the curriculum unless they are fully rolled out nationally, as this was thought to only serve to further disillusion students.

Developing Pharmacists' Postgraduate Skills

It was thought as well as developing the clinical skills of pharmacists it is also necessary to develop the personal and professional skills of pharmacists. A key element of this would be a network of appropriate mentors throughout the pharmacy profession who could act as role models for new pharmacists.

Pharmacists should develop their relationship at a personal and national level with other healthcare professionals to utilise their substantial expertise in the area of medicines.

The education and CPD structures were considered to already be in place to support specialisation in the profession. It was thought that the attitude towards CPD needed to change somewhat however, changing from one which deemed the process to be focused on "minimum standards" to move the perception to a wider professional development role including non-pharmacy based skills which could help to unlock their expertise.

Career pathways for students

Observations were made that students often became frustrated with their pharmacy careers after a number of years due to varying factors:

- In community pharmacy, new graduates felt that they were equipped for a much wider scope of practice, than they actually practiced – leaving clinical judgement and decision making skills underutilised. A declining salary level is thought to be making this a less attractive option for students.
- In hospital pharmacy careers were generally thought to be more fulfilling to a point (usually about 10 - 12 years in), but then a lack of career structure in the system stymied further advancement causing disillusionment.
- Graduates were thought to increasingly be looking at alternative career routes, with PhD work, medicine degrees, pharmaceutical science and roles in industry becoming increasingly popular choices for graduates. Pharmacists who do go into industry were thought to do very well, but often need a high degree of specialisation in terms of a PhD level of distinct knowledge.

Pharmacy policy

Academic contributors generally felt Ireland was slow to progress the pharmacy sector with little sense of a collective voice.

Pharmacy's influence on national policy was thought to be challenged by the fact that there was not a key policy role involved, at the very early stages of policy making. Progress made in other jurisdictions, most notably Scotland, was thought to be as a result of a Chief Pharmaceutical Officer sitting at the management level, with a substantial team. There has been an enhanced public health role delivered from pharmacy in Scotland, much of this technology enabled, that could act as a model for pharmacy in other jurisdictions to follow.

In this sense it was thought that the evidence of good pharmacy practice was only shared amongst pharmacists and not with decision makers – there was a need to shout louder and properly co-ordinate initiatives. Academics generally felt that given the high level of pharmacology knowledge students gained and the wealth of knowledge, which they had acquired, a lot of progress is not hindered by a lack of skills but by pharmacists needing to advocate more strongly for their role. It was felt that there was a greater need for pharmacists to stand up and be counted and demonstrate their value to other healthcare professionals.

Innovation

It was considered important to view innovations both in terms of patient care and whether the skills of the pharmacists were being demonstrated in the best way possible. It was thought that for any enhancement in patient care to take place, pharmacists would need to empower their teams to dispense and allow them to spend more time with the patient.

Vaccinations, for instance, while seen as a new innovation and a success, were not necessarily playing to the unique selling point of the pharmacist. Future innovations were thought to be in the area of therapeutic medicines and personalised medicines.

Examples of specific services such as coagulation clinics were thought to be valuable where there was a gap in service level in a region e.g. the INR clinic in Ballinasloe had been the only one available in the Galway/Mayo region – this service was thought to be something pharmacists could provide if there was no other provision. Dose adjusting was also taking place in Tallaght under the Collaborative Pharmaceutical Care in Tallaght Hospital (PACT) scheme[3]; it was acknowledged that there could be resistance from other healthcare professionals however.

A valuable role for pharmacists was also identified in Primary Care Centres (PCCs) or shared between a number of GP services. This role of a practitioner in a clinic would provide an auditing role, academic detailing, adverse drug reactions (ADRs), and an educational role for other healthcare professionals. With many of these services focusing directly on "at-risk" patient categories, pharmacy could then specifically assist in the care of patients with chronic disease.

Comprehensive MURs were also noted as a beneficial service, however the focus here was thought to be best placed on cohorts where the outcomes (and thus also cost savings) could be most clearly identified – mental health was seen as a strong case study for this, where a large level (up to 40%) of readmissions could be directly attributable to non-adherence.

In terms of prescribing, it was generally felt that this was more suited to a hospital setting, however the idea of collaborative prescribing whereby, the GP and pharmacist could both contribute to the prescription process through a technology enabled structure was thought to have strong merit. In hospitals specialisation was thought of as a key enabler to advancement of future pharmacy practice.

A number of areas where pharmacy could contribute more to future developments were identified:

- Advanced drug development technologies (e.g. stem cell);
- Pharmacist data analytics;
- Bio-informatics;
- Bespoke medicines (personalised).

Public Health screening

A role similar to that of the healthy living pharmacies in the UK was seen as one that would be strongly beneficial. As part of this system there are 10 standard intervention areas (e.g. asthma, diabetes, obesity etc.) and 2 to 3 are chosen based on the clinical need in the area. This form of preventative medicine is effective because it is directly addressing the disease demographics of a region.

It was stated that health clinics and related preventative care in the UK model were chosen based on their vetted ability to provide the service (in terms of staffing and facilities).

[3] Grimes TC, Deasy E, Allen A, O'Byrne J, Delaney T, Barragry J, Breslin N, Moloney E, Wall C. Collaborative pharmaceutical care in an Irish hospital: uncontrolled before-after study. BMJ quality & safety. 2014 Jul 1;23(7):574-83

5.10 Pharmacists in non-clinical settings

Pharmacists are also involved in the areas of pharmaceutical industry, education, research and regulation. Many pharmacists have been involved in commercial aspects of industry and working with community and hospital pharmacists through their representative roles.

It was indicated that the commercialisation of pharmacy services may improve implementation. Currently there are no initiatives being rolled out as there is no appropriate award for the work that is being done, and pharmacists do not have the correct mentality at the moment in order to implement these large scale services. Currently, the pharmaceutical industry is interested in bringing both the medicine and the service to the patient, this can be greatly enhanced by the use of community pharmacies, and providing a service through pharmacies that ultimately enhances patient safety, is a priority for companies.

It was indicated that the future of pharmacy is moving towards using their extensive knowledge in more patient facing roles. Community pharmacy is too dependent on pharmacist involvement at all points of dispensing, it was indicated that if pharmacists want to engage in more patient facing roles then there will have to be correct delegation to other skilled staff, a technique that pharmacists in Ireland seem to be currently implementing less than in other jurisdictions. In relation to the opinion of the profession, the influenza vaccine was an example of a centrally coordinated service that has impacted positively on the profession.

Hospital pharmacy was outlined as being a better setting for implementation of clinical pharmacy services, with the care of the patient at the centre of all clinical work. It was noted that pharmacist prescribing is a positive move for pharmacists but it should start in the hospital as part of involvement in multidisciplinary teams, and possibly through dose adjustment in the community setting. It was also noted that pharmacists in the hospital setting need to move away from the dispensary role and into more specialised clinical roles, and accreditation of this specialisation is a key component of progressing the profession.

It was indicated that there needs to be a concerted effort in organising research and pilot studies, and that if pharmacy services are to be proven then a coordinated, well-structured research plan should be used. A project regarding simplifying medicines (Pfizer – Simplify my Meds) was an important project targeting high risk patients with polypharmacy, the data which was received back from pharmacists was not as useful as expected and the motivation by community pharmacists didn't seem to be there. It was reiterated that a centrally coordinated research function would show how pharmacist intervention can make a measurable change.

It was concluded that pharmacists have a great knowledge base and large variety of skills through their experience in every aspect of the industry, and that this experience and knowledge needs to be brought together for the future of the profession in order to show categorically how pharmacy can provide benefits to the patient. For example, pharmacists in Industry and education can bring their skills of undertaking large scale research projects into the community setting.

5.11 Irish College of General Practitioners (ICGP)

The ICGP was represented at the meeting by members of the Board and a member of the Senior Management Team.

Pharmacy and Policy Implementation – Translating Policy into Action

– What has been good?

Pharmacist and GP working relationships: Strong working relationships were highlighted between pharmacists and GPs, particularly in local and rural settings where the GP and pharmacist share patients. The more transient nature of attendance in urban settings is considered to make the relationship less cohesive.

It was felt that there was a lot to be gained from both professions having an increased level of contact with each other educationally. Examples of this included GPs spending some time in pharmacies while training and for pharmacists and GPs in a community to have scheduled meetings (even if only annually).

The flu vaccine programme through pharmacies was generally perceived to have worked well, but some concern was expressed in relation to information on which GP's patients had been immunised. The lack of this information flow back to the GPs is a concern when extended to vaccinations such as pneumococcal as there are potentially dangerous implications of double dosing.

– What could be improved?

Concerns were raised about services or products provided by pharmacists whereby the scientific evidence was unproven e.g. food intolerance testing.

It was also noted that health checks by pharmacists should be meaningful with correct referral procedures followed. For example, it was noted that isolated cholesterol checks provide little information about a patient's condition.

Major Challenges for ICGP and GPs, in the Current Setting and In the Future

Online pharmacies with employed GPs were highlighted as a risk for patient safety.

It was thought that many children's minor ailments, which were brought to the GP could be addressed in the pharmacy (where all that may be required is ibuprofen and/or paracetamol).

Discharge prescriptions from secondary care were highlighted as a particular safety and continuity of care issue for GPs and their patients.

Polypharmacy, particularly in relation to Hi Tech medicine prescribing from secondary care, patients with co-morbidities and attending different hospital consultants, create information and drug interaction challenges for both GPs and their patients

Integration of Professional practice, across professions and across sectors.

- Transitions of care
- Enabling self-care in the community

Transitions of care; The view was shared that prescriptions issued in hospitals should always be reviewed by pharmacists and that each time this was not done, patient safety, time and money were being sacrificed. GP's experience of pharmacist reviews of prescriptions in Tullamore Hospital was seen as very beneficial. The flow of information was thought to be the most important aspect of discharge from hospital care. For instance when a patient's medication was changed in an outpatient setting, the GP may not receive the information that the patient is on a new prescription.

Ultimately technology would solve a lot of the problems that exist, however care should be exercised where a patient is aligned to a particular GP but attends a range of pharmacies. Access to patient data was thought to be a major issue that should receive the highest level of careful consideration before any new systems of services are implemented. The current system of a handwritten Kardex (inpatient prescription) however was deemed to be causing problems and should be automated.

Medicines Management

Polypharmacy was identified as a phenomenon that resulted in a huge number of problems for patients with 'deprescribing' it was noted, in Australia, as being a positive development to reduce medication levels.

In particular, problems were noted where patients had short lengths of stay in hospitals as medications changed quickly.

Any medications management initiatives such as Medicines Use Reviews (MURs) or New Medicines Services (NMS) were thought to be most effective if targeted to "at risk" patients to reduce the incidence of "revolving door patients"- these patients could require frequent (weekly/monthly) reviews if particularly high risk. This was seen as being best delivered using an integrated approach between GP and pharmacist with both being reimbursed and the cost of the service being covered by a reduction in medicines. It was felt of utmost importance that information flows between the GP and pharmacists were critical to this approach in order for it to be a success.

Preventative Medicine

It was acknowledged that there is a major role for all healthcare professionals in preventative medicine, particularly in the areas of smoking cessation, alcohol abuse and physical activity/obesity.

The Future Place of Pharmacy in a Changing Healthcare Environment – Implications for Change

Pharmacist prescribing

Concern was expressed about any development of pharmacist prescribing in the community. The 'fail-safe' system of separation of prescriber and dispenser was thought to be integral for patient safety and should remain clearly separated. The role of the pharmacist as a business person is also considered a conflict of interest in this area.

Pharmacists in GP practices

A role for pharmacists in GP practices, particularly larger ones such as Primary Care Centres (PCCs) was considered a good idea. The success of this role in the UK, where safer prescribing and cost containment had been achieved, demonstrated collaborative working in practice. It was suggested that this role could only work when provided by the HSE, and the role would involve a pharmacist moving around each GP service in an area or GP network.

5.12 Nursing and Midwifery Board of Ireland (NMBI)

The NMBI regulates the nursing and midwifery professions, including all registered nurse prescribers. The NMBI was represented by members of the Senior Management Team.

Experience of Collaboration with Pharmacists to Date

The focus of this discussion related more to hospital pharmacists due to their working proximity with the nursing community. Nurses would like to have access to more pharmacist expertise in the hospital setting and recognised them as a very valuable resource. The lack of "out of hours" supply and dispensing was a constant bottleneck in service. Nurses were supportive of the need for more MPharm qualified pharmacists. While there was no experience with students from the new MPharm structure, the change in curriculum was welcomed.

Nurse Prescribing and Multidisciplinary Team (MDT)

The experience of the regulator in implementing Nurse Prescribing was discussed. It was seen as a very positive step for the profession. In supporting this service Nurses pointed to the value of medicines use reviews and medicines reconciliation (particularly on admission where resources allowed it) where pharmacists may have a better level of competency to contribute to care.

Since nurses have been permitted to prescribe (with appropriate qualifications) there has been strong positive feedback in relation to the role of pharmacy in further educating prescribing Nurses, particularly in the area of guidance and standards – this was thought to be something that all healthcare professionals could benefit from.

It was noted that while the relationship had become closer, there was not a full understanding by the nursing profession of exactly what pharmacists could add to patient care. Consultations between Nurses and Doctors and other healthcare professionals are well established, however, Nurses would consult more with pharmacists if they had a better understanding of their areas of expertise.

Medicines Management

Medicines management is considered an area of potentially significant improvement, which would benefit from closer working between pharmacists, who have the greatest expertise in medicines. Pharmacists need to link in with the medicines management programmes in hospitals to provide education to other healthcare professionals and also work alongside Nurses and other healthcare professionals in order to provide the highest level of safety for the patient.

It was noted that in the HIQA quarterly review, that pharmacists are providing more medicines management. Where supply to a nursing home is provided by a community pharmacist, there needs to be a greater interaction by the pharmacist with Doctors and Nurses to ensure the correct prescribing and administration is being provided to the patient. Documentation needs to be improved and working with the pharmacist can achieve this (correct prescribing, returning medicines to pharmacy, ensuring adherence). The pharmacist is ideally placed to work with the nursing home staff to ensure possible life threatening adverse reactions are avoided and ultimately greater patient safety is achieved.

5.13 Other Healthcare Professionals

Members of other healthcare professionals were represented at a focus group. This included a non-consultant hospital Doctor, an intern Doctor, Nurses, a Physiotherapist and a Dentist.

General opinion of the work of pharmacists varied due to the differences in care settings in which they interacted. They were also aware of current working relationships that they have with pharmacists in one aspect or another.

Primary Care

All of the members of the focus group agreed that pharmacists provide a valuable front line service to patients. One of the group members was aware of colleagues using pharmacy infrastructure to provide a clinic to patients, in which they have received positive results.

Communication in relation to prescriptions was seen as a cumbersome procedure for all involved, including the pharmacist. Health professionals in the acute sector were aware of many occasions where they would receive calls from community pharmacists regarding prescriptions, in the majority of cases this was regarding legislative prescribing requirements but there were incidences where incorrect dosage was present on the prescription and picked up by the pharmacist. It was discussed this was especially prevalent around the rotation time when new junior doctors enter the acute setting. It was noted that a technology solution such as e-prescribing and electronic health records would facilitate efficiencies in this current cumbersome process.

Acute Care

The issue of transitioning patients between care settings was seen as a major concern for all involved, and issues were noted to primarily revolve around information gaps. Hospital doctors noted that when pharmacist involvement was seen in medicines reconciliation it was done very well.

Hospital clinical pharmacy services were also well received by hospital doctors and nurses. They indicated that pharmacist interventions were beneficial in specialist and new medicines, where they have great knowledge. There was a general consensus among professionals working in the acute sector that while clinical services such as medicines reconciliation and patient medication review is beneficial, they do not happen regularly due to lack of pharmacist resources in the hospital.

It was noted that prescribing rights for pharmacists could be provided but only in a specialised function in the hospital area. They indicated that the community setting requires a distinct ‘fail-safe’ system of prescriber and dispenser.

All professionals agreed that a more integrative approach to patient care was essential and welcomed pharmacist involvement, though some had not experienced a significant level of participation in their role to date.

5.14 Pharmacy Students

Groups of students were consulted as part of this process. The groups included students from the final year of their undergraduate pharmacy degree and also students from the MPharm year.

Perception of pharmacy and the role of pharmacy

Student contributors generally had very positive views on their own skills and discussed these skills in respect to other healthcare professionals, with whom they interacted through their undergraduate training.

The generally held view in student focus groups was mixed with respect to community pharmacy, with most contributors feeling that this was not an attractive career option as it lacked meaningful patient contact, was more monotonous and was increasingly less financially attractive. For those who considered a career in community pharmacy, most felt this was something they might do “after they had spent some years in hospital pharmacy or in industry”.

Level of expertise/knowledge

Pharmacy students felt they had a highly standardised education and that other healthcare professionals could experience a much more variable education in terms of having longer periods in a specific specialisation but much less in other areas. As a result many pharmacy students felt that they were better equipped to look at the patients’ health as a whole with respect to medicines. The students welcomed the new 5 year integrated course structure and noted that while the learning curve is steep, it should produce pharmacists who are better prepared for a working environment.

Student view of future pharmacy

Students felt that the current scope of practice in Ireland is very limited and pointed out the UK system whereby pharmacists were reimbursed to be the gatekeeper of medications for the health system. Conflict with other healthcare professionals was not thought to help things, nor was negative media commentary on pharmacy.

In the future the students thought that health screening may be conducted by a pharmacist which would then be directly sent to the GP allowing the pharmacist to be a triage point for primary care. The structure would allow constant communication between healthcare professionals to adjust medication or confer on outcomes as and when needed. In particular in the area of chronic illnesses, frequent patient monitoring through medicines review could be conducted by the pharmacist, thus not overloading the other areas of primary care.

The students mentioned the smart phone and increasing use of apps. They suggested having computer terminals available in community pharmacies for patients for medication information, with the pharmacist available to assist with any queries. Access to patients’ records was suggested as a must for the future so that the pharmacist had a full picture of what medication the patients had been prescribed.

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