An Roinn Sláinte
Department of Health

Expert Taskforce to Support the Expansion of the Role of Pharmacy

Final Report

July 2024

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Executive Summary

Introduction

The evolving healthcare landscape in Ireland necessitates innovative approaches to improve access to care. Pharmacist prescribing represents a significant opportunity to leverage pharmacists' expertise, alleviate pressures on GPs, and provide timely care for common conditions. The policy aligns with numerous national policies such as Sláintecare and the HSE Climate Action Strategy.

In July 2023, the Minister for Health, Stephen Donnelly, T.D, established the Expert Taskforce to Support the Expansion of the Role of Pharmacy. The remit of the Taskforce was to identify and support the delivery of specific objectives, which will serve to align services and practices that can be delivered by pharmacists, and pharmacies, with the needs of the health service and patients.

This report, arising from the work of the Expert Taskforce, presents a pathway for implementing pharmacist prescribing in Ireland, focusing initially on a Common Conditions Service (CCS), and eventually progressing to full prescribing authority for pharmacists. The 99-page document details the strategic, operational, and regulatory frameworks required to achieve these objectives, aiming to enhance healthcare delivery and improve access to healthcare.

Approach

This report is a culmination of the work of the Taskforce, along with its three Sub-Committees. These were established with a view to developing the policy on expanding the role of pharmacy.

Over ten months, the Taskforce discussed the expansion of the role of pharmacy, examining the regulations, education, leadership, and governance that is required to ensure safe person-centred care across primary and secondary care. Meetings were held fortnightly and engagement from Taskforce members was required on a regular basis. This was supported by the Department of Health.

Targeted submissions were sought from identified stakeholders in the initial weeks of the Taskforce's work. A dedicated mailbox was established at the outset and was open for submissions throughout the process. Further stakeholders were contacted throughout the process to better understand the process of introducing non-medical prescribing. A public consultation was held in May of 2024 to better understand the public's views on expanding the role of pharmacy.

Recommendations

The overarching recommendations from the Taskforce are as follows:

1. That pharmacists be enabled to exercise independent, autonomous prescriptive authority within and related to the individual practitioner's scope of practice and competence.
2. This should be implemented in a stepwise manner, commencing with the introduction of a common conditions service, with pharmacists provided with prescriptive authority linked to the service and its parameters.
3. The development, over the coming years, of models of pharmacist prescribing within primary and secondary care settings, recognising the requirements for specific enablers.

The Taskforce has made several additional recommendations to assist in the implementation of these overarching recommendations. Full details of these recommendations can be found on pages 6- 8 of the report, and they address the following aspects:

- **Patient and Public Involvement**
  The inclusion of patients and the public in the implementation, research and review of the recommendations made by the Taskforce.
- **Regulatory Framework and Legislative Amendments**
  A regulatory framework, including legislation, standards, guidance, and education requirements be developed in tandem by the responsible and accountable entities.
- **Leadership and Governance**
  Leadership for the profession at a senior level within the Department of Health.
- **Education and Training**
  Educational courses of training underpinned by legislative and regulatory authority.
- **Operational and Infrastructure Resourcing Requirements**
  Operational and resourcing supports, including supporting technology, information communication, and infrastructure, should be facilitated to evolve to streamline administrative processes, optimise interprofessional communication, and facilitate recording, reporting and feedback between professions involved in the care of a particular patient, and to facilitate research. These resources are essential to the timely and safe implementation of these recommendations.
- **Communication and Engagement**
  Campaigns to inform the public about the CCS, highlighting the change in practice and the new services available, as well as the safety and efficacy of the new service. Engagement with stakeholders to inform the implementation of pharmacist prescribing is also envisaged.
- **Research and Review**
  Ongoing research to provide the implementation with a strong Irish evidence base. Review of the change in policy to ensure the services are achieving their goals are being achieved in accordance with good governance policies and procedures.

Conclusion and Next Steps

This report represents a forward-thinking approach to utilising the skills and professionalism of pharmacists as healthcare delivery continues to evolve and modernise in Ireland. From its initial recommendation around the provision of a Common Conditions Service and moving to full pharmacist prescribing authority, the delivery of increased pharmacist autonomy seeks to enhance patient care, optimise healthcare resources, and support the development of Ireland's healthcare system.

This detailed report provides a pathway for the successful implementation of pharmacist prescribing, along with recommendations for its phased rollout, regulatory support, and continuous research and evaluation to ensure its long-term success.

Foreword from Taskforce Chair

It is my privilege on behalf of the Expert Taskforce to Support the Expansion of the Role of Pharmacy to present our second and final report to the Minister for Health.

This report, provided within the mandated timeframe, contains a number of recommendations of the Expert Taskforce to the Minister on the topic of extending full prescribing authority to pharmacists, in line with current Government policy. It builds on our interim report, which recommended that pharmacists be empowered to extend six-month prescriptions by up to an additional six months, within the scope of their practice and where it is safe and appropriate to do so. We welcome the fact that the Minister accepted that recommendation and that it has been implemented. This was recommended with the aim of creating capacity in primary care with subsequent benefits for patients, pharmacists, and the wider health sector.

I would like to express my thanks to the Minister, all Taskforce members, and the additional colleagues who joined the three Committees established by the Expert Taskforce to advance our work. I also want to thank the Department of Health colleagues for their support of the work of the Taskforce. The amount of time expended by all involved is greatly appreciated.

The fundamental principle of patient safety has been foremost in all our Taskforce deliberations and duly reflected in our recommendations. The Taskforce agreed and implemented high standards of governance for all our activities and business rules that governed how we conducted our work. We also put in place arrangements to ensure we had access to expert patient advocates so that any output from the Taskforce would take full account of the views of people who use medicines.

The Terms of Reference for our work are set out in Appendix Three.

The Health and Social Care delivery system is complex, with very many interrelated parts. It is also highly regulated, and in the context of the work of the Taskforce, there are extensive legislative and regulatory frameworks in place. The Health Products Regulatory Authority regulates the safety, quality, and efficacy of medicines and the practice of Pharmacy is regulated by the Pharmaceutical Society of Ireland.

Health care delivery continues to evolve. In relation to pharmacy, we are fortunate to have a highly qualified and widely experienced cohort of healthcare professionals who are very knowledgeable in all matters pertaining to medicines, who have strong connections to people in communities, and who operate a wide network of outlets and extended opening hours.

The recommendations of the Taskforce are grounded in knowledge and experience, both national and international, from academic research and practice, and by the technical skills and knowledge of Taskforce members, along with input by way of submissions received from the wider healthcare delivery system and submissions received from the public consultation.

It has been my privilege to have been appointed by the Minister for Health to Chair the Expert Taskforce to Support the Expansion of the Role of Pharmacy and to serve with the Taskforce members in addressing this important area.

On behalf of the Taskforce, I now commend this set of recommendations to the Minister.

We look forward to support from the wider healthcare community in implementing whatever the Minister may mandate.

Dr Pat O'Mahony, Taskforce Chair

Introduction

On 24th July 2023, the Minister for Health, Stephen Donnelly TD, established an Expert Taskforce to support the expansion of the role of pharmacists in Ireland.

The remit of the Taskforce is to identify and support the delivery of specific objectives, which will serve to align services and practices that can be delivered by pharmacists and pharmacies with the needs of the health service and patients. Delivery will help to address increasing capacity and access challenges in primary and secondary care. The initial request of the Taskforce (Phase 1) was to make recommendations to empower pharmacists to extend prescriptions. The Taskforce considered the scope of the Phase 1 request and made recommendations, which the Minister for Health subsequently accepted, the substance of which was implemented on the 1st of March 2024.

The life of the Taskforce was extended for an additional six months, and the mechanism to empower pharmacists to prescribe within their scope of practice (Phase 2) was examined with a view to issuing recommendations to give effect to this policy position. Those recommendations are detailed in this report.

Role of Pharmacists

The pharmacy profession comprises a cohort of highly skilled individuals who are subject to a high level of clinical governance and regulatory standards, enabled by strong educational and professional development structures. Medicines are one of the most used and effective interventions which serve to treat, manage, and optimise patient health. Pharmacists are medicines experts. The evolution of the practice of the profession of pharmacy internationally and the scope for the application of pharmacist prescribing subject to appropriate governance, safety and clinical controls nationally realises and illustrates an opportunity to further explore how pharmacists' skillsets and training may be optimally used to enhance the health service. The fundamental aim is to deliver the best patient outcomes within and throughout the system and to align with the concept of keeping people well and cared for at the point of easiest access.

Patient need for healthcare in Ireland is growing at a rapid rate in terms of volume, cost, and complexity. The only rational and deliverable solution to meeting this demand is through a multidisciplinary approach to healthcare to deliver the highest quality of care as close to the patient's home as possible.

Consideration and policy discussions with respect to the advent of pharmacist prescribing have occurred over several preceding years. This policy decision, while based on recognition and appreciation of the experience of pharmacist prescribing nationally and internationally, will be robustly underpinned by recommendations and an elucidated framework thereunder which will ensure safe and appropriate patient care.

Alignment with National Policies

The provision of healthcare in the community and within easiest access aligns with the HSE Climate Action Strategy 2023-2050 by making care more accessible and sustainable, driven by the strong connection between caring for the environment and caring for patients' health. It aligns with the Healthy Ireland Framework 2019-2025 to reduce health inequalities by improving access to health services. It also aligns with the principles of Sláintecare in that it aims to provide the right care, in the right place, at the right time.

The eight principles of Sláintecare (patient is paramount; timely access; prevention and public health; free at the point of delivery; workforce; public money and interest; engagement; and accountability) are designed and elaborated to improve safe, timely access to care and promote health and wellbeing; addressing health inequalities as the system moves towards universal healthcare. One of the key recommendations of the Sláintecare report is the expansion of primary care and the shifting of treatment from the acute sector to the community.

Strategic Steps

The realisation of this policy decision will require the implementation of a series of recommendations and the concurrent cooperative alignment and delivery of specific tangible outputs identified therein. This will need to be underpinned by robust legislative (Chapter Three) and educational (Chapter Five) provisions and contextualised in the sector in which the pharmacist practises and prescribes (Chapters Six, Seven and Eight). Chapter Six focuses on the short-term, looking at the introduction of a Common Conditions Service in Community Pharmacy. Chapters Seven and Eight focus on Pharmacist Prescribing in the medium-long term, setting out the vision and ambition for the pathways to achieve independent autonomous prescriptive authority. This will require a centrally coordinated communication plan, and engagement and involvement with patients, the public and stakeholders (Chapters Two and Nine). This policy decision will need to be resourced and funded. It will also need to be evaluated by a rigorous programme of research (Chapter Ten).

Recommendations – Phase Two

In this context, the Expert Taskforce to Support the Expansion of the Role of Pharmacy proposes several recommendations to the Minister to give effect to this policy. Implementation of these recommendations will deliver opportunities and benefits for the health system and patients.

Supporting evidence, discussion and analysis, and further information can be found in the chapter number noted alongside each recommendation.

Having regard to the Terms of Reference, considering national and international practice in facilitating safe access to prescription-controlled medicines through an appropriate governance framework, and with due regard to the policy imperatives of the health system and service, the Taskforce recommends:

1. Overarching Recommendations

a. That pharmacists be enabled to exercise independent, autonomous prescriptive authority within and related to the individual practitioner's scope of practice and competence. (1-10)

b. This should be implemented in a stepwise manner, commencing with the introduction of a common conditions service, with pharmacists provided with prescriptive authority linked to the service and its parameters. (6)

c. The development, over the coming years, of models of pharmacist prescribing within primary and secondary care settings, recognising the requirements for specific enablers. (7, 8)

2. Patient and Public Involvement

a. The inclusion of patients and the public in the implementation, research and review of the recommendations made by the Taskforce. (2)

3. Regulatory Framework and Legislative Amendments

a. A regulatory framework, including legislation, standards, guidance, and education requirements be developed in tandem by the responsible and accountable entities. (3)

b. The governance and regulatory framework should recognise the distinct roles of prescribing, administering, and dispensing and provide safe and appropriate controls, structures, and standards, including a nationally agreed written decision framework to effectively operate where such services are carried out, either by one, or more practitioner(s). (4)

4. Leadership and Governance

a. The appointment of a Chief Pharmaceutical Officer at an appropriate senior level and as a full member of the management team of the Department of Health. (4)

5. Education and Training

a. Educational courses of training underpinned by legislative and regulatory authority must be undertaken in respect of recommendations 1A, 1B and 1C. (5-8)

b. Continuous Professional Development courses of training will be required for the Common Conditions Service, and independent prescribing will initially require a post-graduate qualification. (5-8)

c. In circumstances where a pharmacist has undertaken equivalent prescribing training in another jurisdiction or where equivalent prescribing is a component of their core competence and scope of practice at initial registration, a method of assessment and recognition of this training should be developed and applied, referenced against national standards. (3,5,7,8)

d. An increase in the numbers of university undergraduate pharmacy places to enable the expansion of the role of pharmacists. (5)

6. Operational and Infrastructure Resourcing Requirements

a. Operational and resourcing supports, including supporting technology, information communication, and infrastructure, should be facilitated to evolve to streamline administrative processes, optimise interprofessional communication, and facilitate recording, reporting and feedback between professions involved in the care of a particular patient, and to facilitate research. These resources are essential to the timely and safe implementation of these recommendations. (1-10)

b. Any proposals for expanded or new pharmacist roles are introduced in a planned manner that takes into account strategic workforce planning for the sector and existing workforce needs. (5)

c. The HSE and DoH should align and, in tandem, design and deliver a system to realise the concept of pharmacist prescribing. This must include devising models of care, service delivery and supporting the training to utilise the enhanced capacity and capability. (3-8)

d. The models of care, service delivery and training must be resourced within the system from a financial, remunerative, contractual, and governance structure perspective, including arrangements for clinical indemnity. (1-10)

e. Appropriate monitoring and audit processes within all settings, operated and delivered by the responsible and accountable governance and public service entities, should underpin the implementation of these recommendations to ensure that professional accountability, clinical governance, and delivery of improved health outcomes for patients are achieved. (3,6,7,8,10)

f. An implementation oversight structure, with appropriate standing, be instituted and resourced to support the sectoral implementation of this policy under the stewardship of an appropriate senior leader such as a Chief Pharmaceutical Officer. (1-10)

7. Communication and Engagement

a. A centrally coordinated communication plan, cognisant of the distinct roles, accountabilities, and expertise of identified stakeholders should be developed, both to explain the changes linked to the introduction of pharmacist prescribing to pharmacists, other healthcare professionals and members of the public, and to facilitate support for and uptake of pharmacist prescribing. (9)

b. Regular engagement should occur between and with relevant stakeholders, including pharmacist representatives, representatives of other existing prescribers, and patient advocates, to provide updates and obtain input to inform the implementation of pharmacist prescribing. (1-10)

8. Research and Review

a. A programme of funded research should be implemented to monitor the implementation of these recommendations. There should be patient and public involvement in this research. (10)

b. Appropriate robust governance arrangements should be put in place to facilitate, direct, and support this ongoing research. (10)

   i. A key enabler to this research is access to appropriate data and the availability of indicator variables that (a) a pharmacist extended a 6- month prescription or (b) a pharmacist prescribed a medicinal product, among others. It is recommended that steps should be taken to implement such indicator variables into prescribing and dispensing software. (10)

c. The Department of Health should oversee a review of these recommendations at an appropriate interval of their practical implementation into practice to determine whether its goals are being achieved in accordance with good governance policies and procedures. (10)

Indicative Timeline for the Introduction of Pharmacist Prescribing

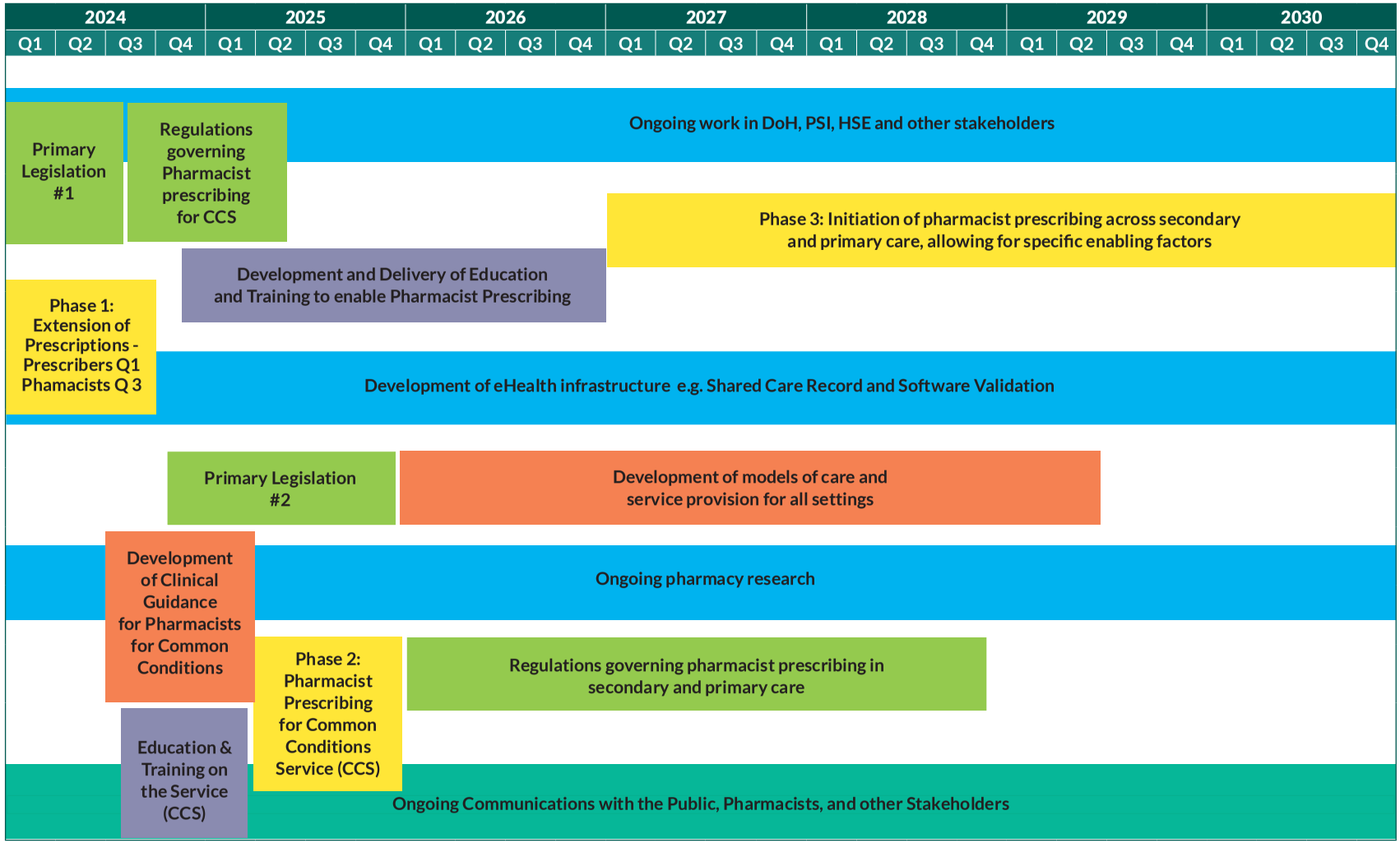
This indicative timeline is recommended by the Taskforce to the Minister for Health and his Department, following engagement with key stakeholders to discuss the essential enablers for each phase.

The Taskforce recommends that the introduction of Pharmacist Prescribing and the extension of the role of pharmacy in Ireland should be introduced on a phased basis, considering the main recommendations made at the start of this report. The summary chart highlights the phased approach for the introduction of pharmacist prescribing, as discussed throughout the report and as recommended by the Taskforce.

The specified timeframes in the following timeline relate to when the phase in question is expected to become operational or when documents referenced are developed. The intention is that each phase will continue to expand as required to meet the needs of the healthcare service.

For example, it is expected that Phase 2 – “Pharmacist Prescribing for Common Conditions” will be operational between Q2 and Q4 of 2025 but will continue to expand following its initial implementation during this time.

Indicative Timeline for the Introduction of Pharmacist Prescribing



Chapter One: Evolution of Pharmacy and Pharmacy Prescribing in Ireland

Introduction

This chapter presents and considers the evolution of pharmacy in Ireland, considering previously published reports and research that led to this policy decision. Grounded in this evidence, recommendations for introducing pharmacist prescribing in Ireland are presented.

Background and Evidence

The Council of the Pharmaceutical Society of Ireland (PSI) in April 2008 published an Interim Report entitled 'Advancing Clinical Pharmacy Practice to Deliver Better Patient Care and Added Value Services' (1) the purpose of which was to preliminarily review pharmacy services provided in Ireland at that time and compare them with best practice in other countries. This report noted that with the introduction of nurse prescribing and following the commencement of the Pharmacy Act 2007, pharmacists, due to their training and knowledge in pharmaceutical chemistry, pharmaceutics, pharmacology, clinical pharmacy and therapeutics, should be in a position to have prescriptive authority assigned to them through independent prescribing. It called for a national policy on pharmacist prescribing and called out certain enablers to this, including access to patient medication records (PMRs) and the establishment of an integrated patient record system.

The subsequent publication in 2016 of the 'Future Pharmacy Practice in Ireland Meeting Patients Needs Report' (2) was fundamentally about patients and how the pharmacy sector could continue to contribute to public and patient care. It aimed to build on the existing good practice and patient trust and to develop new practices to meet the evolving needs of the patient and the health system of the future. It was compiled following consultation involving patients, patient advocacy groups, pharmacists (both community and hospital), other healthcare professionals, national healthcare representatives (including the DoH and HSE), regulatory bodies, academics, pharmacy students and a wide range of other stakeholders. This report noted that various forms of pharmacist prescribing were in place internationally, and it extrapolated and explored opportunities in the context of the Irish system as to where its potential value could be realised. This report also made a series of recommendations which could be reviewed in the context of the current health system and its developments and changes since the time of publication.

In March 2020, the COVID-19 pandemic necessitated that the practice and delivery of the spectrum of healthcare provision adapted, pivoted and evolved to address the situation of the global pandemic. Pharmacists and pharmacies carried out a vital role in supporting patients' needs. The experience of patients has been reported as "limited access to face-to-face care, different perceptions of quality of care, but did not describe any differences to safe use of medicines, while pharmacists highlighted the impact of rapid response to the pandemic, adapting practice, and how patient care was impacted…For pharmacists, the COVID-19 pandemic triggered many changes that affected their practice, and necessitated workflow changes within pharmacies, many of which were perceived as beneficial to continue beyond the pandemic(3)". One of the key learnings is that change in practice can happen. That change and evolution are of value once supported by the appropriate skillset, knowledge and governance framework to optimise those changes.

Following a policy decision from the Department of Health, the Expert Taskforce to Support the Expansion of Scope of Pharmacy was established on July 24th, 2023. On 24th July 2023, the Minister for Health, Stephen Donnelly T.D., established an Expert Taskforce to support the expansion of the role of pharmacists in Ireland. The remit of the Taskforce was to identify and support the delivery of specific objectives, which will serve to align services and practices that can be delivered by pharmacists and pharmacies with the needs of the health service and patients.

Discussion and Analysis

While pharmacy can clearly deliver, and while there is a role for the system, there is also an opportunity for individual practitioners and practices to innovate within their current scope of practice.

In this context and regarding the policy decisions, further increasing the scope of practice for pharmacists (and indeed potentially other healthcare practitioners) and introducing appropriate regulated and governed prescribing practice is a natural, logical evolution.

Work of the Taskforce

The Taskforce met regularly, often fortnightly, holding 19 meetings between August 2023 and July 2024. In order to fully consider all aspects of their work, the Taskforce established three sub-committees. A patient and public sub-committee was established in September 2023 and is discussed in Chapter Two. An implementation sub-committee was established in January 2024 to aid implementation of the first recommendations from the Taskforce. A research sub-committee was established in January 2024 and is discussed in Chapter Ten. All sub-committees were chaired by Taskforce members and reported to the Taskforce at Taskforce meetings. Stakeholders were invited to comment on the Taskforce Terms of Reference in September 2023, specific stakeholders were invited to present at Taskforce meetings in December, and all submissions were considered in Taskforce deliberations. The Taskforce was supported by the Department of Health throughout its lifetime.

Prescribing models and settings

Prescribing and dispensing roles have traditionally been regarded as a critical safety net for patients and healthcare funders – by minimising the potential for medication errors to reach the patient, and by managing potential conflicts of interest. This is discussed further in Chapter Four. Best practice advocates the separation of responsibilities in the systems associated with medication management i.e. separation of prescribing and dispensing of medications. Recently, these traditional roles are changing. The word "prescribe" has long been used to mean the writing of a prescription for a prescription-only-medicine (POM) to be dispensed by a pharmacist. Pharmacists in Ireland have had the authority to exercise their right to not dispense a prescribed medicine, on the basis of their clinical and professional judgement that to not dispense was in the greater interest of the health and safety of the patient. On a daily basis, pharmacists use their knowledge and skills to recommend over the counter (OTC) medicines or refer to another appropriate healthcare professional following discussion with a patient or member of the public. The current policy direction to consider the pharmacist's role in prescribing POMs is a natural next step, and is strongly supported by evidence of safety benefit, cost-effectiveness, and patient preference, as will be detailed in the coming chapters.

Where does prescribing take place?

The prescribing of a medicinal product is the most common intervention in healthcare. The majority of prescribing takes place in a primary care setting with the HSE PCRS reporting that they paid for over 92 million prescription items in 2022. This figure does not include the volume of POMs processed privately and otherwise than the Community Drugs Schemes, and for which there is limited data available. Regarding secondary care, the HSE reported in 2023 that there were 3,679,802 outpatient episodes, 1,202,378 day-case episodes and 652,770 inpatient episodes in public hospitals(4). The data on private hospital activity is less available. A conservative estimate is that half or more of these episodes involved the prescribing or deprescribing of one or more medicines. It is estimated that approximately 0.6% (>32,000) of the population reside in nursing homes in Ireland, and prescribing activities for this population takes place within the nursing home itself, or between both GP and hospital settings, as per the individual resident's health status, and with frequent transitions between these settings.

Models of pharmacist prescribing

Across the literature, pharmacist prescribing has been described as a spectrum of activities that include provision of OTC medications, extension or refill of prescriptions, therapeutic substitution, dosage adjustment, provision of emergency supplies, and *de novo* prescribing of POMs(5). With regard to *de novo* prescribing of POMs, this can be further classified across a spectrum from independent or dependent prescribing (Figure 1).

Independent pharmacist prescribing means that the decision on what to prescribe and who to prescribe it to is solely the pharmacist's decision. This doesn't mean that other practitioners are not involved; on the contrary—they may be informed and consulted, but the essence is that the decision lies with the pharmacist. Independent prescribing does not require permission or a prior agreement with another practitioner. A prescribing decision might involve a decision to initiate, continue change or discontinue a medicine. The latter discontinuation is commonly called deprescribing.

Dependent prescribing is when a pharmacist reaches an agreement with an authorising body or another practitioner with the authority to prescribe. This agreement typically outlines which patients the pharmacist can prescribe for and what the pharmacist can prescribe(5). Several levels of dependent prescribing have been described (Figure 1), with varying degrees of pharmacist authority and dependence on another practitioner with prescribing authority. A variety of terms are used to describe "protocol" prescribing, whereby the pharmacist may dependently prescribe medicines de novo, based on an agreed protocol, collaborative practice agreement, or other such authorised guideline(6). Dependent forms of pharmacist prescribing which require agreement with a patient's designated independent prescribing practitioner have been described as potentially widening healthcare inequities because they are only available to those people already registered with or attending that practitioner, whilst independent pharmacist prescribing is in theory available to all who access the pharmacist.

Collaborative prescribing fits between the extremes of independent and dependent prescribing, whereby there is collaboration between the practitioner who oversees the patient's care including diagnosis, e.g. a hospital consultant or a general practitioner, while the pharmacist selects, monitors, modifies, continues, or discontinues the medicinal treatment as appropriate.

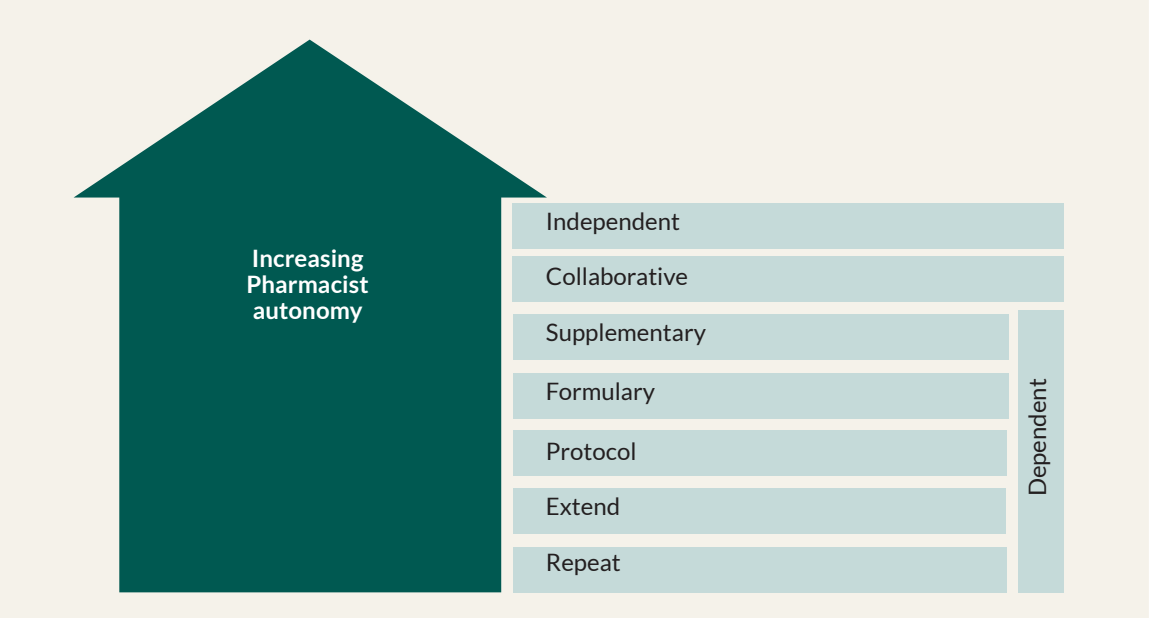


Figure 1. Relative authority of models of pharmacist prescribing
Adapted from Poh, EW, et al. JBI Evidence Synthesis. 2018;16(9):1823-73 (6)

Drivers for pharmacist prescribing

The scientific evidence identifies multiple drivers for pharmacist prescribing, and these may be summarised across the categories of (1) Access, (2) Safety and (3) Sustainability.

1. **Access**
   Pharmacist prescribing may widen access to both healthcare and to medicinal products by expanding the range of practitioner and clinical sites that citizens can access.
2. **Safety**
   Pharmacist prescribing in several settings is associated with patient safety as evidenced by a reduction in prescribing errors in the hospital setting, enhanced achievement of goals (i.e. BP, cholesterol, CVD risk reduction) and no difference in the volume of revisits as compared to medical prescribing or prescribing in traditional settings (i.e. primary care, urgent care or hospital care).
3. **Sustainability**
   Pharmacist prescribing will support the sustainability of the Irish health system as it faces the challenges posed by an ageing population, and the increasing pressures on hospital and GP healthcare settings. Pharmacists have already demonstrated the positive outcomes they can provide in primary care in supporting existing aspects of healthcare delivery, such as flu vaccination and COVID-19 vaccination. The delivery of pharmacist prescribing will be an effective use of the pharmacist component of the healthcare workforce and strengthen the sustainability of the health system as it adapts to evolving challenges.

Recommendations

Based on the available evidence and analysis in the context of the Irish healthcare service, the Taskforce recommends:

1. That pharmacists be enabled to exercise independent, autonomous prescriptive authority within and related to the individual practitioner's scope of practice and competence.
2. This should be implemented in a stepwise manner, commencing with the introduction of a common conditions service, with pharmacists provided with prescriptive authority linked to the service and its parameters.
3. The development, over the coming years, of models of pharmacist prescribing within primary and secondary care settings, recognising the requirements for specific enablers.

Chapter Two: Patient and Public Involvement

Introduction

Patient and public involvement (PPI) was identified as a priority to the work of the Taskforce from the outset. A panel of patient advocates contributed to this work by attending four meetings in parallel to the Taskforce, and one meeting with the Taskforce.

The patient advocates' collective view on the implementation of recommendations from Phase 1, and their view on pharmacist prescribing (Phase 2) are presented below, followed by recommendations for future PPI.

Background and Evidence

Communication around the recommendation from Phase 1

The patient advocates were asked how best to communicate with the public about the Phase 1 Recommendation and its implementation. This included their review and suggestions around early drafts of illustrative case vignettes and communication messages. The patient advocates felt there was a strong opportunity to enhance and optimise the accessibility of the messages, and they provided suggestions about the content, the format, and the preparation of these communications.

Content

The patient advocates strongly described that the communications should accessibly guide patients and members of the public about what would happen and why. They considered a need for further explanation around:

- The process to be followed by patients and by the relevant healthcare practitioners
- What the decision to extend or not is, and why?
- What would happen if the prescriber objected to the extension of the prescription?
- The particular process that would apply in relation to specific types of recommendations, e.g. medicines with associated risk minimisation measures.

Format

It was suggested that a media campaign incorporating a model interaction between the prescriber and the patient and, subsequently, the pharmacist and the patient may be helpful. It was highlighted that there is a need to ensure the information is accessible for all and to use language, including sign language, that is appropriate and use graphics where possible. It was strongly felt that no group should be disadvantaged in accessing such messages, and therefore, the need for multiple modes of communication, such as sign language on videos, is critical. A set of questions and answers (Q&As) should be developed to complement these messages and to help answer practical questions.

Reflecting on the draft communications presented, the patient advocates felt they needed to be made more creative and accessible (simpler and shorter) for patients and the public to better access them. Short decision trees, frequently asked questions (FAQs), and infographic style (with reasons why prescriptions could not be extended and reasons why they could) could help.

The demographic diversity apparent in the gender and names of the characters in the proposed case vignettes were welcomed, although it was felt it would be useful to have more clinical diversity, e.g., someone experiencing polypharmacy, inclusion of patients at extremes of age, inclusion of a case with an informal carer, and to illustrate more diversity in (dis)ability and level of (in)dependence.

Preparation

Outputs from this series of patient advocacy meetings were shared with those involved with leading the Phase 1 implementation.

Pharmacist prescriptive authority (Phase 2)

It was agreed that the extended pharmacist prescriptive authority, as proposed in recommendations 1A – 1C of this document, would be useful to meet the needs of patients and the health service in several practice settings.

- The first was the management of common and self-limiting conditions. The patient advocates felt that the convenience of access to the pharmacist should be used to support faster patient access to certain prescription-only treatments.
- The second was patients having stable chronic conditions and not needing to attend a doctor but instead being able to attend and receive prescriptions at the pharmacy, e.g. management of uncomplicated high blood pressure.
- Thirdly, patients felt that pharmacists should be able to facilitate prescribing pending a subsequent visit to a physician. This was felt to be important where timely access to a prescription only medicine is critical, but access to a physician or nurse prescriber is not feasible.
- Finally, for more complex prescribing for chronic conditions, it was noted that pharmacists will often identify interactions and contra-indications. The relationship with the pharmacist and the pharmacy staff was considered to be crucial. It was felt that hospital pharmacists should be able to do much more than currently and that their input, in particular around transitions of care, would be important.
- The patient advocates did not have experience of pharmacists operating within the GP practice but could see the potential benefits of the involvement of pharmacists in medication reviews.

Enabling patient safety around pharmacist prescribing

The patient advocates identified that it would be important for pharmacists to have access to the necessary patient information in the healthcare record to support safe and appropriate prescribing. The level of access was felt to directly relate to the safety of the prescribing activity, for example, access to medical history, allergy history. The patient advocates felt that a scenario where a pharmacist might need to prescribe in the absence of sufficient clinical information should be provided for in guidance and protocols, in which situations the range and nature of prescribing activities might be necessarily limited. Continuity of care was identified as an important consideration, and it was questioned whether there would be a transfer of records from one pharmacist to another.

To support the discussion, the patient advocates were presented with information about the conditions for which pharmacists can prescribe prescription-only medicines across the United Kingdom. No concerns were raised by patient advocates about pharmacist prescribing for these conditions, and the inclusion of conditions like shingles was welcomed.

The patient advocates queried whether pharmacists would have additional equipment/skills that they perceived as necessary to perform assessments for prescribing medicines. They felt additional training would be needed and that pharmacists may wish to be able to perform additional patient assessments.

The patient advocates felt that training should be compulsory if pharmacists want to prescribe, but it could be undertaken through continuing professional development until all skills are taught at the undergraduate level. There were no concerns about the ability of pharmacists to learn assessment skills. It was felt that there should also be an opt-out for pharmacists who do not want to prescribe.

It was felt that community pharmacies are already busy places, and there would therefore need to be consideration as to how pharmacist prescribing could be implemented and how this might impact all the routine work in pharmacy.

The need for clear guidelines for pharmacists on when referral would be more appropriate than pharmacist prescribing was highlighted to avoid potential patient safety incidents.

Further considerations

Potential data protection issues relating to the sharing of medical records between the GP and pharmacies were highlighted. A patient summary could provide sufficient information without necessarily sharing full medical records. It was noted that it was important that the pharmacists would be aware of allergies, etc. It was suggested that additional training for pharmacists could help increase confidence in sharing more details of patients' records. Other steps (e.g. limitations on pharmacy staff who can have access to information within the pharmacy) could also help.

Attendance at Taskforce meetings

Patient advocates attended a Taskforce meeting on May 28th, 2024, where they were given the opportunity to comment on this report. The patient advocates initially made general comments on the pathway document, noting it appears coherent, strong, and thoroughly professional. The recommendations were then discussed in detail, with the patient advocates given the opportunity to comment on each.

The patient advocates highlighted opportunities in the document to clarify timelines, phasing, and operationalisation of the proposed changes. The need for clear and accessible communications was highlighted to the entirety of the Taskforce, along with communications colleagues from the DoH, HSE and PSI who were also in attendance.

Discussion and Analysis

The importance of the patient voice in the Taskforce was highlighted at the first Taskforce meeting on August 29th, 2023. The optimum mechanism for patient input was discussed during the initial Taskforce meetings. Taking into account the need to obtain such input in a timely manner, it was agreed to approach patient advocates who were members of the Health Products Regulatory Authority (HPRA) Patient Forum to invite them to provide input to the Pharmacy Taskforce, separate to their role on the HPRA forum. Expressions of interest were sought, and eight patient advocates agreed to engage with the Pharmacy Taskforce. Two members of the Expert Taskforce with significant experience in this area volunteered to be direct liaisons to the Patient Forum.

Person-centred care is a cornerstone of modern healthcare, emphasising the importance of understanding patient values and desires. By involving the public in policy discussions, the Taskforce have aimed to ensure the recommendations are in line with the expectations and requirements of the public.

The patient advocates who worked with the Taskforce provided practical feedback on how the proposed new policies might work in real-world settings. They highlighted potential challenges and provided suggestions for overcoming them, ensuring that the policies are theoretically sound and practically feasible. This input was crucial for finalising the recommendations.

There was strong advice from the patient advocates that the Taskforce should start small with an initiative like the common conditions which can be communicated simply and concisely to the public emphasising what would be different and more beneficial to them now. Concurrently, a medium- and long-term strategy should be developed to enable more comprehensive pharmacist prescribing, supported by ICT, university-accredited training programs, and a trained workforce to ensure successful implementation.

The ICT considerations will be addressed through the introduction of the Shared Care Record and ePrescribing ICT solutions which are key dependencies for the introduction of Pharmacy prescribing in a safe and appropriate way.

Public Consultation

In order to understand the views of the wider public, a public consultation was run by the Department of Health for six weeks from 16 May until 28 June 2024. The results of this consultation were considered by the Taskforce when finalising the recommendations in this report. A detailed analysis of this consultation can be found in the report "Expanding the Role of Pharmacists in Ireland: Report on the Responses to the Public Consultation, July 2024".

Recommendations

Considering the available evidence and analysis in the context of the Irish healthcare service, the Taskforce recommends:

1. The inclusion of patients and the public in the implementation, research and review of the recommendations made by the Taskforce.

Chapter Three: Regulatory Framework and Legislative Amendments

Introduction

This chapter discusses the legislation and regulatory framework that governs pharmacist prescribing in Ireland. Recommendations for legislative amendments and the regulatory framework to support pharmacist prescribing in Ireland are presented.

Background and Evidence

Professional regulation of healthcare professions in Ireland is characterised by a prioritisation of patient safety, quality of service provision, ethical practices, accountability, and transparency.

Pharmacists in Ireland function within a robust legal and regulatory framework, which serves to support safe, patient centred service provision, uphold appropriate qualification standards, and oversee access to the profession.

Within primary and secondary care, pharmacists function within the regulation of the professional practice of pharmacy by the PSI, the relevant primary and secondary legislation, and the established standards, guidance and regulations governing the healthcare setting in which they work, e.g., the National Standards for Safer Better Healthcare overseen by HIQA(1). Community pharmacists are likewise subject both to the PSI standards for the profession, and to the legislation and guidance in place for the operation of retail pharmacy businesses.

All pharmacist activity is governed by the primary and secondary legislation concerning safe supply of medications, the provision of prescriptions, dispensing activity, and the misuse of drugs. This includes the Pharmacy Act, the Health Act, the Irish Medicines Board Act, Medicinal Products (Prescription & Control of Supply) Regulations, the Misuse of Drugs Act, the Regulation of Pharmacy Businesses Regulations and the Falsified Medicines Directive, amongst others(2).

Discussion and Analysis

The current legislative framework enables medical, nursing, and dental prescribing within the appropriate context and governance controls – it does not include pharmacist prescriptive authority. It provides that pharmacists may supply and administer defined medicinal products in the absence of a prescription and under autonomous authority, but these constitute a number of limited products of a particular class and circumstance. Pharmacists may also issue emergency supplies of prescription controlled medicinal products in the absence of an authorising prescription.

In circumstances where supported by an evidence-based proposal, the Minister has decided that the policy is to enable and facilitate pharmacists to prescribe, legislative change will be necessary. Given the overall context of regulation of healthcare professions in general, and pharmacists specifically, the question that arises is how best to apply pharmacist prescribing within the existing legislative and regulatory environment. Regulation generally in Ireland is guided by the "Better Regulation" principles(3) of being effective, proportionate, consistent, agile, accountable and transparent.

To abide by these principles, it is important any legislative and regulatory changes resulting from the Taskforce recommendations are:

- Effective in enabling the recommendations of the Taskforce
- Proportionate to the existing practice of the pharmacy profession and avoid the creation of barriers to accessing the profession
- Consistent, both with the existing regulatory framework governing the profession and with comparable innovations introduced to other professions
- Agile, ensuring that there are mechanisms for review and expansion if appropriate (particularly in relation to the introduction of prescribing for common conditions)
- Accountable, with clarity as to the responsibilities of the professions, stakeholders, the PSI as regulator, the HSE and the Department of Health
- Transparent, with clear communication to the public and stakeholders as to the impact of the changes, and consultation as part of the preparation of legislation.

Pharmacists should not be subject to a restricted expansion of their profession and should be empowered to maximise their contribution to healthcare in the State, with enabling provisions in primary legislation giving a robust basis for the introduction of pharmacist prescribing, and the development of relevant secondary legislation phased in with appropriate sequencing.

Legislation changes will be required, at a minimum to:

- Pharmacy Act 2007 (as amended) to ensure the PSI continues to have appropriate oversight of the profession.
- Irish Medicines Board Act 1995 (as amended) to enable prescribing powers for pharmacists.

The Department may also wish to consider amendment to:

- Health Act, 1970 (as amended) to include pharmacists as a prescriber under that Act
- Health (Pricing and Supply of Medical Goods) Act 2013 to include pharmacists as prescribers under that Act, and to ensure that a 'prescription' includes pharmacists as prescribers.

Essential secondary legislation includes:

- Regulation of Retail Pharmacy Businesses Regulations 2008, as amended
- Medicinal products (Control of Wholesale Distribution) regulations 2007, as amended
- Medicinal Products (Prescription and Control of Supply) Regulations 2003, as amended

Together, these regulations have direct effect on the daily activities of pharmacists and the operation of pharmacies. It is crucial that amendments are carefully considered, allowing time for stakeholder consultation.

The amendment enabling community pharmacist prescribing for common conditions should set out the medicinal products that the pharmacist can prescribe in a clear schedule within the legislation. These amendments must also encompass communication and dialogue with the patient and appropriate record keeping, including of the decision to prescribe.

Regulation of independent pharmacist prescribing will require detailed consideration as to the best approach to support those activities, and position them within the existing standards, guidance and regulations that govern primary and secondary care settings.

The Taskforce notes that the prescription regulations, in particular (Medicinal Products (Prescription and Control of Supply) Regulations 2003, as amended) are now quite voluminous. The Department may wish to consider whether it is appropriate to review, consolidate, and where possible simplify, these regulations - this could be done in conjunction with the implementation of the revised EU pharmaceutical legislation currently under discussion. This would provide an opportunity to facilitate new and emerging working methods, technological advances and address future requirements concerning records (for example the HSE ePrescribing project, the implications of the European Health Data Space, the Department of Health's own eHealth Strategy).

Amendment of the Misuse of Drugs Act 1977 (as amended), and the related regulations, may be appropriate in the future, as medicinal products within the scope of that legislation may be relevant to some pharmacist prescribers as the competencies develop and the scope of practice expands.

The Department of Health and the PSI will be aware of the implications for expansion of the pharmacy profession in terms of their respective responsibilities under the Proportionality Directive (Directive (EU) 2018/958). This requires Member States to assess the proportionality of any new laws, or changes to existing laws, prior to enactment, which restrict access to regulated professions, such as pharmacists, within the meaning of Directive 2005/36/EC.

The Department of Health must conduct a proportionality test, in line with the directive, when introducing legislation to make any changes to a profession, including expansion of that profession. It is understood that this may not be limited to the introduction of new primary legislation only, but to secondary legislation where the impact on the profession is delivered via that effect. In other words, the test concerns the impact of the changes, not the medium through which that change is delivered.

In addition, and subsequent to the legislative change, the development of the detail of a policy direction and framework for the appropriate use within the health service of this enhanced scope, capacity and capability, facilitated by a robust contractual and service delivery model, will be necessary, to optimise and appropriately utilise this enhanced capacity and capability within the system.

Recommendations

Considering the available evidence and analysis in the context of the Irish healthcare service, the key recommendations for regulation of pharmacist prescribing in Ireland are:

1. Amendments to primary legislation to enable pharmacist prescribing, to give pharmacists the authority to prescribe, following the completion of the necessary education and training.
2. Amendments to primary legislation to ensure the continued regulation of the profession by the Pharmaceutical Society of Ireland, and ensure they have oversight of the qualification standards required to access pharmacist prescribing in the State.
3. Amendments to secondary legislation to enable pharmacists to prescribe within an expanded regulatory framework.
4. Due consideration to the need to conduct proportionality tests, in line with Directive 2005/36/EC, throughout the process of establishing pharmacist prescribing in the State.
5. Amendments to or introduction of secondary legislation where necessary, to establish appropriate regulation of independent prescribing, including consideration of how best to maximise the potential of pharmacists in primary and secondary care. It is essential that regulations are developed in consultation with the appropriate stakeholders.
6. A separate section of the Pharmacist register to identify pharmacists who can exercise independent prescriptive authority

Chapter Four: Leadership and Governance

Introduction

This chapter explores the opportunities that having a Chief Pharmaceutical Officer brings to a profession and provides recommendations for introduction of this role in Ireland. It also examines the potential dual role of pharmacist prescribers, before offering evidence-based recommendations.

Background and Evidence - Leadership

Chief Pharmaceutical Officer

In Ireland, there is currently a Chief Medical Officer, Chief Nursing Officer, Chief Dental Officer, Chief Veterinary Officer and as of May 2023, a Chief Health and Social Care Professional Officer. These Officers provide leadership for each of the statutory health professional regulators, with the exception of Pharmacy. These roles provide professional leadership and guidance within their respective fields. However, it is notable that there isn't a specific Chief Officer post for the pharmacy profession. Research evidence suggests that a key enabler to successful implementation and integration of pharmacist prescribing within a health service is strong and strategic pharmacist leadership(1).

A similar role to the Chief Pharmaceutical Officer (CPO), the Chief Pharmacist, was in place in the DoH until 2013(2). Until that time, Chief Pharmacist post-holders were responsible for policy and legislation relating to the regulation of medicines, medical devices, cosmetics, narcotics and psychotropic substances, as well as policy and legislation regulating pharmacists and pharmacies.

The position of a CPO exists in many countries. Northern Ireland, England, Scotland, and Wales employ a Chief Pharmaceutical Officer in a senior position. Further afield, this position is in place in Australia, New Zealand, Canada, and Singapore. The role of a CPO in other jurisdictions is far-reaching and often works across several areas to ensure the safe and appropriate supply of medicines to the public.

In Scotland(3), the CPO role has been in place for 25 years. The CPO, a registered pharmacist, is the professional lead for NHS pharmaceutical care and medicines policy in Scotland, providing advice to the First Minister, the Health Secretary, the wider Ministerial team, and strategic leadership to the pharmacy profession in Scotland. The CPO works within the Chief Medical Officer Directorate of the Scottish Government(4).

In Wales(5), the CPO, a registered pharmacist, provides independent advice on all aspects of medicines including the regulation of medicines, ensures that pharmaceutical services are developed to meet specific healthcare needs, leads the modernisation of pharmaceutical services and continuing professional development of pharmacists, and works with other UK government departments to co-ordinate pharmaceutical advice and information. The CPO is one of the chief health professionals working in the Welsh government(6).

In Northern Ireland(7), the CPO, a registered pharmacist and their team are responsible for providing specialist advice on medicines and pharmaceutical issues to the Minister, Department and wider health service and for the development of policy relating to medicines optimisation prescribing and pharmacy practice. The Chief Pharmaceutical Officer works in the Chief Medical Officer Group in the Department of Health, and reports to the Chief Medical Officer(7).

In England(8), the CPO, a registered pharmacist, is a member of NHS England. The role has been in place for the last 18 years. The CPO is a member of the NHS Improvement Medical Directorate's senior management team, the UK Government Chief Medical Officer's senior clinical group, Head of the Pharmacy Professions in England, and the principal advisor on pharmacy and medicines use in the NHS, which includes supporting the Department of Health and Social Care. The CPO also leads a team of pharmacy professionals, working at both national and regional level, to ensure pharmacy professional advice is deployed effectively to improve patient care as well as being the professional leader to over 70,000 pharmacists and pharmacy technicians registered in England. The CPO reports to the National Medical Director within the NHS(9).

In Singapore(10), the Chief Pharmacist and their office develop the pharmacy profession, advance professional practice and set policies to ensure a high standard of professional practice and service, and drug supply resiliency to empower and meet the needs of the population. The Chief Pharmacist reports directly to the Director- General of Health in Singapore(11).

In all jurisdictions where pharmacist prescribing has been implemented, a Chief Pharmaceutical Officer has been in place either within the Department of Health or Health Service to lead the change.

In Ireland, there is strong support for the appointment of a Chief Pharmaceutical Officer(12). Numerous stakeholders who responded to the Taskforce's initial targeted consultation highlighted the need for a Chief Pharmaceutical Officer to be appointed in the Department of Health at a senior level.

Table 1: International Examples of a Chief Pharmaceutical Officer

Scotland			
Establishment of CPO role	**Reporting Structure**	**Responsibilities**	**Impact**
The role of the Chief Pharmaceutical Officer (CPO) in Scotland has been in place for over 25 years.	Senior Civil Service Level 1(13)	Professional lead for NHS pharmaceutical care and medicines policy in Scotland, providing advice to the First Minister, the Health Secretary, the wider Ministerial team and strategic leadership to the pharmacy profession in Scotland.	Scotland has implemented several key pharmaceutical care strategies over the years, aiming to enhance the role of pharmacists in healthcare delivery and improve patient outcomes: The Right Medicine (2002) (14) Prescription for Excellence (2013)(15) Achieving Excellence in Pharmaceutical Care (2017)(16) Pharmacist Prescribing: The CPO in Scotland promotes polices supporting independent prescribing.
Northern Ireland			
Establishment of CPO role	**Reporting Structure**	**Responsibilities**	**Impact**
Has been in existence for several years.	The CPO provides specialist advice on medicines and pharmaceutical issues to the Minister, Department, and wider health service.	Providing specialist advice on medicines and pharmaceutical issues to the Minister, Department, and wider health service Development of policy relating to medicines optimisation prescribing and pharmacy practice Inspection of premises and the enforcement of human and veterinary medicines under the Medicines Act, Misuse of Drugs Act, Pharmacy (Northern Ireland) Order and Poisons (Northern Ireland) Order(16).	**Roadmap for the pharmacy sector(17)** The CPO is determined to deliver a clear roadmap for the future of the pharmacy sector, through to 2030. **Pharmacist prescribing** The CPO in NI provides oversight and strategic direction for pharmacist prescribing(18).

Table 1: International Examples of a Chief Pharmaceutical Officer continued

England			
Establishment of CPO role	**Reporting Structure**	**Responsibilities**	**Impact**
Has been in existence for at least 18 years	The CPO is the principal advisor on pharmacy and medicines use in the NHS, which includes supporting the Department of Health and Social Care(19).	Professional leadership - establishing and supporting the UK Pharmacy Professional Leadership Advisory Board to lead sustained benefits for patients, the public and pharmacy professionals across the UK from future pharmacy professional practice. Medicines Optimisation Transformation Prevention of ill- health and addressing health inequalities Workforce education, training and development Primary care integration NHS Long Term Plan emphasises the role of pharmacists in delivering primary care and public health services (20).	The responsibilities of the CPO highlight their significant role in shaping the health system in England. **Pharmacist prescribing** Preparing for every newly qualified pharmacist being an independent prescriber on registration from September 2026.

Table 1: International Examples of a Chief Pharmaceutical Officer continued

Wales			
Establishment of CPO role	**Reporting Structure**	**Responsibilities**	**Impact**
During the early-mid 2000s, it seems that the role transitioned from an advisory to a more official 'officer' level role.	Senior Civil Service 1 Level The post is supported by the Deputy Chief Pharmaceutical Officer and leads the Pharmacy and Prescribing Branch. The Branch is part of the Primary Care Division within the Welsh Government's Directorate for Health Policy. The post holder will also be able to draw upon the expertise of colleagues within Public Health Wales. The post is responsible to the Minister for Health and Social Services for the provision of pharmaceutical advice and is professionally accountable to the Chief Medical Officer for Wales for day-to-day management. As a senior member within the Directorate for Health Policy, the Chief Pharmaceutical Officer will also be responsible for delivery of individual projects and initiatives and to represent the Welsh Government on a wide range of healthcare issues(21).	Providing independent advice on all aspects of medicines, including the regulation of medicines Ensuring pharmaceutical services are developed to meet specific healthcare needs Leading the modernisation of pharmaceutical services and continuing professional development of pharmacists Working with other UK government departments to coordinate pharmaceutical advice and information(5).	Establishment of Pharmacy: Delivering a Healthier Wales Board. The Board was established by the CPO in response to the report which outlined the pharmacy profession's commitment to working in partnership with the Welsh Government, the NHS, the social care sector and public to maximise the profession's contribution to a sustainable health care system and improved health and wellbeing of the nation(22) **Pharmacist prescribing** The strategy document 'A Healthier Wales' outlines the role of pharmacists, includingprescribing, in transforming primary care services.

Table 1: International Examples of a Chief Pharmaceutical Officer continued

Singapore			
Establishment of CPO role	**Reporting Structure**	**Responsibilities**	**Impact**
2015	The Chief Pharmacist Reports to Ministry of Health's Director General. The Director General of Health's Office comprises of the Chief Allied Health Officer's Office, Chief Dental Officer's Office, Chief Medical Informatics Officer's Office, Chief Nursing Officer's Office, Chief Pharmacist's Office, and Traditional and Complementary Medicine Branch(11). There is also a Deputy Chief Pharmacist role.	Develops the pharmacy profession, advance professional practice and set policies to ensure a high standard of professional practice and service, and drug supply resiliency to empower and meet the needs of the population. This is done through harnessing the power of data and technology, promoting patient centric care, excelling in clinical expertise through developing a future-ready workforce, and re-designing the drug supply chain, to transform care models and improve health outcomes in a sustainable health ecosystem(11).	Their 'National Pharmacy Strategy' (23) is a 10-year plan that is aligned with the Ministry of Health Singapore strategic healthcare shifts of Beyond Hospital to Community, Beyond Quality to Value, and Beyond Healthcare to Health. It sets out the plans to enhance the role of pharmacists, including their prescribing capabilities to improve patient care.

Discussion and Analysis

Chief Pharmaceutical Officer

As the healthcare landscape continually evolves, it becomes more complex with higher expectations for quality, safety and efficiency in the delivery of care. In this context, the role of pharmacists in Ireland has taken on greater significance, as highlighted by the COVID-19 pandemic and acknowledged by the establishment of the Expert Taskforce. This Taskforce has identified specific objectives that can be delivered by pharmacists, including the pharmacist prescribing recommendation outlined in this paper.

To maximise the contributions of pharmacists and ensure their integration into the wider healthcare system, it is crucial to have strong and strategic governance and leadership for pharmacists at management level within the DoH. This is particularly important when implementing the recommendations of the Expert Taskforce.

The need for a CPO was a key finding from the PSI's 2023 Workforce Intelligence Report(24). It made a recommendation calling for leadership of and for the profession. One of the actions from this recommendation is to bring the appointment of a CPO forward for consideration within the DoH to provide strategic leadership, evidence - based analysis and expert advice to the DoH, Government, broader health system, and regulatory and professional bodies, helping to shape policy and optimise the contribution of the pharmacy sector around the needs of the health service.

Jurisdictions where a CPO is in place are seeing considerable developments in pharmaceutical care. Take Scotland as an example, where pharmacists operate in line with a well-defined national pharmacy strategy that is part of the broader health service. This is just one of many critical pharmaceutical care strategies that have been put into action over the years.

It has also been highlighted that CPOs in jurisdictions that have brought in non- medical prescribing have influenced the expansion of pharmacist prescribing roles through strategic leadership, policy development, and support for training and education. This is important not just to secure the successful initial introduction of pharmacist prescribing but also to ensure ongoing support and to leverage the maximum benefits for all stakeholders. The introduction of pharmacist prescribing is multi-faceted and is a significant change to the healthcare service in Ireland. This highlights the importance of establishing a CPO role to provide strategic direction and policymaking for the expansion of pharmacy service and pharmacist scope of practice.

The appointment of a CPO at an appropriate senior level and as a full member of the management team of the DoH

The appointment of a CPO at appropriate senior level in Ireland would likely yield comparable benefits. There are numerous areas where a CPO, along with adequate resources, could make a significant difference to the functioning of the healthcare service in Ireland, particularly around pharmaceutical care. These include, but are not limited to:

1. Implementation of recommendations from the Expert Taskforce

The CPO could play a key role in the effective implementation of the Expert Taskforce recommendations to support the expansion of the role of pharmacists, including the recommendation from this report surrounding pharmacist prescribing.

By overseeing the expansion of pharmacy services and the integration of pharmacist prescribing, the CPO would help ensure pharmacists are empowered to provide a broader range of services that meet the documented needs. This will enhance the overall capacity of and responsiveness of the healthcare system, making it more adaptable and person-centred.

2. Policy development and implementation - providing strategic vision

The CPO could lead on developing a strategy for pharmaceutical care in Ireland which aligns with broader healthcare objectives and policies, including the expanding role of the pharmacist. An integral part of a CPO role could be collaborating with stakeholders across the health sector to develop a strategy in pharmaceutical care which aligns with broader healthcare objectives and policies.

The CPO could help shape and influence national healthcare polices, ensuring that pharmaceutical considerations are integrated into all aspects of healthcare planning and delivery, in areas such as:

- Effective in enabling the recommendations of the Taskforce
- ePharmacy through the identification and maximisation of opportunities presented by the eHealth and ePharmacy initiatives.
- Revision of EU pharmaceutical legislation by representing Ireland's interest, shaping policy during negotiations on the revision of EU pharmaceutical legislation and implementing the resulting legislation at a national level.
- Addressing medicine shortages by responding to their impacts and working to reduce disparities in approaches among Member States, which could potentially disadvantage Irish patients, particularly in the case of critical medicines.

Furthermore, the strategic positioning of a CPO would allow for the development of cohesive policies that align with Ireland's healthcare objectives, such as those outlined in the Sláintecare report. This would help maximise the professional value of pharmacists' contribution to the delivery of health services in a manner that aligns with the policy objectives, thereby ensuring the best possible health outcomes for patients.

3. Leadership on national public health initiatives

A CPO could play a key role in leading on national public health initiatives such as:

- Antimicrobial resistance strategies: a CPO's leadership, in collaboration with others within DoH, could strengthen these initiatives by promoting the rational use of medicines to help control antimicrobial resistance.
- Vaccination campaigns: a CPO, in collaboration with others within DoH, could lead public health campaigns to increase vaccination uptake(25), leveraging the expertise of pharmacists to address vaccine hesitancy and improve immunisation rates.

Conclusion

By adopting this recommendation of the appointment of a CPO at a senior level within the DoH, it would ensure that the pharmaceutical care of the population and medicine supply in the global context is consistently addressed. It would also pave the way for the development of a strategic vision for a more integrated, effective and patient-centred approach to advance pharmacy and pharmaceutical care within the health service, including the implementation of pharmacist prescribing.

Background and Evidence – Governance

A key consideration with the introduction of pharmacist prescribing in any setting is the management of the potential dual role of prescribing and dispensing or prescribing and administration by the same healthcare professional. This section presents the national and international evidence and experience of this and makes recommendations for its management in Ireland.

Rationale for the separation of prescribing, dispensing, and administering medicines

Historically the roles of prescribing and dispensing medicines have been performed by separate healthcare professionals. Typically, this would involve a doctor, nurse or dentist prescribing a medicine for a patient and a pharmacist performing a second independent check on the pharmaceutical and therapeutic appropriateness of the prescribed medicines for the patient, during the dispensing process.

Among the reasons for this are the patient safety benefits of having at least two independent healthcare professionals involved in the prescribing and dispensing of medication for the patient and to overcome any potential for conflicts of interest that may arise.

1. Patient safety

The traditional separation of prescribing, dispensing, and administering roles aims to enhance patient safety by ensuring multiple healthcare professionals independently check the medication at each stage. In theory, this provides a safety net for error identification and mitigation across the cascade of prescribing, dispensing, and administering which enhances patient safety across the medicines management cycle.

2. Potential commercial conflict of interest

The dispensing of prescriptions prescribed by a pharmacist within the same practice is a relatively new phenomenon with the introduction of pharmacist prescriptive authority over the past thirty years. Therefore, there is little evidence available regarding potentially conflicted practices. However, the more traditional practice of dispensing doctors provides an alternative lens to explore this issue. Goldacre et al studied whether dispensing medical practices in the UK were more likely to prescribe high-cost options for four commonly prescribed classes of drug where there is no evidence of superiority of high cost options(26) (statins, proton pump inhibitors, angiotensin converting enzyme inhibitors and angiotensin receptor blockers). They found that for all four drug classes, doctors in dispensing practices were more likely to prescribe higher cost drugs than doctors in non-dispensing practices.

Similar concerns have been reported in studies undertaken in Korea and Mexico(27–29). One study in Korea reported the association of the separation of prescribing and dispensing functions in patients with viral illness and reported that it resulted in a significant reduction in the volume of antimicrobial prescribing(27). Another Korean study identified that the separation was associated with an increase in both prescription drug claims and expenditures for peptic-ulcer medication. A study in Mexico compared out-of-pocket expenditure and the number of medicines prescribed by patients attending doctors' offices independent of private pharmacies and those adjacent to them. They reported that users of adjacent practices were more likely to have higher expenditure and a higher number of medicines prescribed, than those in independent practices.

Prescribing and dispensing by the same healthcare professional

Nationally and internationally, examples of healthcare practitioners including doctors, nurses and pharmacists, discharging the responsibilities associated with both prescribing and dispensing and/or administering medicines to patients in certain circumstances are available. This is in response to changes in how care is now being delivered by various healthcare professionals in different settings.

In general, it is recognised that the roles of prescribing and dispensing/administering medicines should be separated, however in certain circumstances it may be appropriate for these roles to be undertaken by the same healthcare professional.

This section examines how patient safety risks are mitigated and potential conflicts of interest managed in these circumstances through one or more of the following mechanisms:

- Mandatory Practice Standards
- Scopes of Practice
- Health Service Provider policies, procedures, protocols and guidelines (PPPGs)
- Risk Assessments
- Auditing of prescribing practices
- Obtaining informed consent from patients to prescribe and dispense their medicines or providing patient choice to have their prescription dispensed by another pharmacy
- Professional or proprietary misconduct – in cases where prescribing decisions provide financial advantage to the pharmacist and/or pharmacy, that do not provide clinical benefit to the patient.

1. Northern Ireland

In Northern Ireland the Standards and Guidance for Pharmacist Prescribers(18) elaborate on the principles of the Code of Ethics for pharmacists and explain a pharmacist's responsibilities as a supplementary or independent prescriber.

The Standards and Guidance provide that pharmacists:

- must not both prescribe and dispense medicines except in exceptional circumstances, for example, where the need for the medicine is urgent and not to dispense would compromise patient care,
- must have robust procedures in place to demonstrate the separation of prescribing and dispensing,
- should choose a medicinal product based on clinical suitability and cost effectiveness and acting solely in the patients' interest,
- must not base any decision to prescribe on potentially biased information, fraud or commercial gain,
- are involved in both prescribing and dispensing a patient's medication, a second suitably competent person should be involved in checking the accuracy of the medicines provided, and wherever possible, carrying out a clinical check, and
- where there may be a perceived conflict of interest, the pharmacist must record a declaration of interest and produce it on request if required for audit purposes.

2. Great Britain

a. General Pharmaceutical Council standards and guidance

In Great Britain, pharmacists must follow regulatory standards for pharmacy professionals(30), standards for registered pharmacies(31) and regulatory guidance for pharmacist prescribers(32) that highlight several considerations for pharmacist prescribers in relation to prescribing and supplying by the same pharmacist, including that they should:

- keep the initial prescribing separate from the supply of medicines prescribed, to protect the person's safety and minimise risk.
- use their professional judgement when considering whether or not to prescribe and supply,
- have robust procedures and arrangements in place and weigh up the risks of supplying against not supplying,
- where possible, involve a second suitably competent person in carrying out the final accuracy check and the check for clinical appropriateness
- give the patient the choice to take their prescription to another pharmacy for supply.

The guidance recognises that there may be circumstances when the medicine may be supplied at the same time, for example, in certain hospital situations, remote or rural areas where there is no other pharmacist available to dispense the medicine independently, or when a person needs medicine urgently.

b. Royal Pharmaceutical Society of Great Britain

The Royal Pharmaceutical Society in Great Britain together with the Royal College of Nursing published a position statement in 2024(33) that states that whenever possible, the actions of prescribing/dispensing/supply/administration are performed by separate healthcare professionals. In addition, the statement advises that where there is a risk assessment in place, and it is in the best interests of the patient, the same healthcare professional can be responsible for the prescribing and dispensing/supply/administration of medicines.

The position statement provides that a robust risk assessment must be conducted, documented and available to colleagues providing the service. This is to ensure the service is appropriate and risks are identified and mitigated. It is the responsibility of the organisation to undertake the risk assessment and it should be developed in collaboration with team members involved in prescribing, supplying and administration.

3. Canada

a. Alberta College of Pharmacy, Canada

In Alberta pharmacists must follow the Standards of Practice for Pharmacists and Pharmacy Technicians (34) that set out minimum acceptable standards of practice for pharmacists. Standard 15 deals with the issue of separate prescribing and dispensing and provides that:

- a pharmacist who prescribes a drug or blood product based on the pharmacist's own assessment of the patient must not dispense the drug him or herself unless:
  - they are satisfied that not dispensing the medicine would compromise the health of the patient, or,
  - the patient chooses to have the pharmacist dispense the drug.

The Standards also provide that where a pharmacist dispenses a drug that they prescribed based on their own assessment of the patient, they must:

- have advised the patient that they may choose to have the prescription dispensed by another pharmacist,
- take reasonable steps to be satisfied that the patient has enough information to participate in the decision-making process,
- obtain the patient's informed consent to dispense the drug,
- document compliance with each step of the dispensing process.

b. Saskatchewan College of Pharmacy Professionals, Canada
In Saskatchewan pharmacists must comply with the regulatory bylaws(35), policy on the general provisions for prescribing authority(36), as well as guidance and standards.

The Code of Ethics provides that pharmacists and proprietors shall hold the health and safety of the public to be of first consideration and shall not engage in any practice which may compromise acceptable standards of the profession.

When presented with a new prescription or refill request, a pharmacist must, among other things:

- use their dispensing scope of practice first, and
- follow through their dispensing scope of practice until all the dispensing options have been reasonably exhausted,
- only exercise their prescribing authority after the dispensing options have been reasonably exhausted, and
- decisions to prescribe should be based on clinical suitability, cost effectiveness and the patient's best interest.

Prescribing decisions that provide financial advantage to the pharmacist and/or pharmacy, that do not provide clinical benefit to the patient, may be regarded as professional or proprietary misconduct.

4. Ireland

a. Nurses and midwives in Ireland
Nurse and midwife prescribers in Ireland are required to comply with the Nursing and Midwifery Boards Practice Standards and Guidelines for Nurses and Midwives with Prescriptive Authority(37).

The Practice Standards and Guidelines recognise the fundamental principle and need for separation of responsibilities in the medication management cycle in relation to prescribing, supplying and administering medicines. However, the Standards and Guidelines recognise that situations can arise where these activities are merged as part of the provision of a person/service user's care.

In situations where there is a merging of these activities, the Standards and Guidelines specify that this practice should be outlined in the local health service provider's policies, procedures, protocols and guidelines and there should be auditing of such practices as part of the overall audit of prescriptive practices.

b. Dispensing General Practitioner's in Ireland
A very small proportion of dispensing general practitioners exist in Ireland, in rural locations where there is no pharmacy within 3 miles (4.3km) of the GP practice. The GP dispensing services provided are subject to oversight by the Health Service Executive Primary Care Reimbursement Service and must comply with HSE Dispensing Guidelines.

A number of controls have been implemented by the HSE to promote safe dispensing and medicines management practices in these locations. All medicines to be dispensed by dispensing GPs are supplied by a nominated community pharmacy on foot of signed requisitions/stock orders. Stock orders for dispensing doctors must be sent by the dispensing GP for approval by HSE Pharmacists in their area. HSE Pharmacists visit the practice on an annual basis to perform stock takes and audits.

GP practices are required to use a drug dispensing module, integrated into the accredited GP practice management system software, to record all dispensing activity for patients at the practice which is visible to the HSE.

c. Community Pharmacy Contractor Agreement

The HSE Community Pharmacy Contractor Agreement in Ireland requires the pharmacist to review the prescription prior to making a decision to dispense. It also establishes a fee for non-dispensing recognising the separate professional judgement of the pharmacist in the best interest of the patient. In determining suitability prior to granting a HSE Community Pharmacy Contractor Agreement, the process includes confirmation through a Statutory Declaration to ensure that there are no business relationships or arrangements between prescribers and Dispensing Pharmacists such that a conflict of interest arises.

The separation of prescribing and dispensing is also secured in the existing Community Pharmacy Contractor Agreement under Clause 21 which provides;

"An agreement in respect of any community pharmacy, the owner or beneficial owner of which is a practitioner who practices or who commences to practice as such in the area in which the pharmacy is located, shall be void"

These existing contractual provisions serve to render a community pharmacy contractor agreement void where a practitioner is a beneficial owner within a pharmacy. Through these arrangements, the Irish Health system has to date insisted on separation of prescribing and dispensing in the interest of patient safety and fiduciary assurance

Discussion and Analysis

This is a critical policy issue. It is imperative that safeguards are in place where the same healthcare professional is enabled to prescribe, dispense and administer medicines to patients in certain circumstances.

As can be seen from national and international evidence discussed above, patient safety risks can be mitigated, and potential conflicts of interest managed through a range of mechanisms. In terms of existing available regulatory structures and processes that could be utilised or adapted, in the Irish pharmacy context, the following could be considered:

- Statutory Code of Conduct for Pharmacists: One of the principal duties of the PSI under Section 7 of the Pharmacy Act 2007, is to draw up codes of conduct for pharmacists. The Code of Conduct – Professional Principles, Standards and Ethics for Pharmacists(38) is a public declaration of the principles and ethical standards which govern pharmacists in the practice of their profession, and which the public, patients, other healthcare professionals and society require and expect from pharmacists. The Pharmacy Act 2007 defines professional misconduct as any act, omission or pattern of conduct which, amongst other things, is a breach of the Code.
- Clinical Governance structure in pharmacies.
  - All registered retail pharmacies must appoint a superintendent pharmacist and a supervising pharmacist. Under the legislation, there are clear legislative responsibilities associated with both of these roles and the roles of pharmacy owners. This structure provides clarity and assurance to patients and the public with regard to the responsibilities of pharmacists and the quality of services delivered in retail pharmacies.
- Pharmacy Practice Guidance(39): In the interest of the safety of patients and the public the PSI issues guidance to facilitate compliance with pharmacy and medicines legislation, as well as best practice in relation to the supply of medicines and the operation of a pharmacy. All pharmacists and pharmacies are required to comply with the guidance issued by the PSI.
- Investigation Processes: Part 7 of the Pharmacy Act 2007 provides PSI with powers of investigation for the purposes of ascertaining whether any offence under the Act, any breach of a code of conduct or any professional misconduct has been committed. In accordance with the PSI's Inspection and Enforcement Policy(40), the PSI conducts inspections, quality assessments and investigations in pharmacies to assess compliance with pharmacy and medicines legislation, PSI Guidance and the Code of Conduct.

Recommendations

Considering the available evidence and analysis in the context of the Irish healthcare service, the Taskforce recommends:

1. The appointment of a Chief Pharmaceutical Officer at an appropriate senior level and as a full member of the management team of the Department of Health.
2. A regulatory framework, including legislation, standards, guidance and education requirements be developed in tandem by the responsible and accountable entities
3. The governance and regulatory framework should recognise the distinct roles of prescribing, administering, and dispensing and provide safe and appropriate controls, structures, and standards, including a nationally agreed written decision framework to effectively operate where such services are carried out, either by one, or more practitioner(s).

Chapter Five: Education and Training

Introduction

This chapter discusses the education and training that pharmacists undertake to become pharmacist prescribers in other jurisdictions. It discusses the current training in Ireland. The chapter concludes by offering recommendations to support the education and training of pharmacist prescribers in Ireland.

Background and Evidence

Multiple systematic reviews have reported the importance of rigorous models of education and training to support non-medical prescriber's readiness for practice, and the successful implementation of non-medical prescribing models into the health service(1–5).

Key considerations for the provision of high-quality education and training to support pharmacist prescribing are:

- Resources and funding
- Supports for integration within the health system
- Mentorship
- Experiential learning, clinical placement, and supervision of prescribing training
- Accommodation and support of practising pharmacists returning to education and training

Curriculum content reported, in systematic reviews, as important to support pharmacist independent prescribing competence were:

- pharmaceutical care
- effective interprofessional working
- patient assessment, diagnosis, and monitoring
- communication and consultation skills

Several studies have also identified the importance of training for the professional colleagues who will experience practice change with the integration of pharmacist prescribers into their setting(4). Further information on the international education and training requirements can be found in Table 2.

1. Northern Ireland

The Post-Graduate Certificate can be undertaken as a stand-alone course or can be combined into a larger programme of an Advanced Pharmacy Practice course (6). Pharmacists who practise in Northern Ireland can also apply to NI Centre for Pharmacy Learning and Development for funding to undertake these courses.

Applicants must be registered as a pharmacist with the General Pharmaceutical Council (GPhC) or the Pharmaceutical Society of Northern Ireland (PSNI) and:

- be in good standing with the regulator with which they are registered.
- must have relevant experience in a pharmacy setting and be able to recognise, understand and articulate the skills and attributes required by a prescriber
- must identify an area of clinical or therapeutic practice on which to base their learning
- have a designated prescribing practitioner (DPP) who has agreed to supervise their learning in practice

Independent pharmacist prescribing was introduced in Northern Ireland in 2006 (7). Pharmacists who have completed accredited pharmacist independent prescribing training and are registered on the Pharmaceutical Society of Northern Ireland's annotated register may practice as independent pharmacist prescribers (7). This training could be a postgraduate course or integrated into the pharmacist's undergraduate training - from 2026, all newly qualified pharmacists will be eligible to register as Independent Prescribers (8).

Prescribing authority is based on a pharmacist's competence rather than drug class. Since 2012, independent pharmacist prescribers may prescribe any licensed medicines for any medical condition, including Schedule 2, 3, 4 and 5 Controlled Drugs, with some exceptions for the treatment of addiction; however, they must only prescribe within their own level of experience and sphere of competence (7).

2. Great Britain(9)

In Great Britain, a qualified, registered pharmacist independent prescriber (PIP) may prescribe all medicines independently for any condition within their scope of practice and clinical competence, including controlled drugs, with very few exceptions (10).

They can prescribe in many different clinical and therapeutic areas, either as a specialist or a generalist, within their knowledge, skills and clinical competence and are responsible and accountable for their clinical assessment, management of patients and the prescribing decisions they make(10).

Regulations to enable pharmacist-independent prescribing in Great Britain came into effect in 2006(11). Until recently, pharmacists could only qualify as independent prescribers by completing an accredited postgraduate qualification; however, pharmacist independent prescriber competencies now form part of pharmacist undergraduate training in Great Britain, and from 2026, newly qualified pharmacists can be annotated as independent prescribers upon first registration(10).

An accredited independent prescribing course typically takes six months to complete. The course is part-time and often delivered through a combination of face-to-face teaching sessions (often one day a week) and self-study. Some universities offer distance learning courses, but with a minimum of 26 days of teaching time, which can be a mixture of study days, directed and self-directed learning. Each pharmacist must successfully complete at least 12 days (90 hours) of learning in a practice environment under the supervision of a designated prescribing practitioner. The courses are typically worth 40 UK learning credits, meaning that learners will need to dedicate approximately 400 hours to the programme(12).

There are more than 17,000 pharmacists registered with an independent pharmacist prescribing annotation in Great Britain, or approximately 28% of all registered pharmacists, although not all of these may be currently working as pharmacist prescribers(13). In comparison, there are more than 13,000 registered community pharmacies in Great Britain.

3. England(14)

Pharmacists prescribing training is being incorporated into the 5 years of pharmacy education in both the undergraduate and foundation programmes. This process began in 2021 in collaboration with Health Education England when the revised standards for the Initial Education and Training of Pharmacists came into effect.

From September 2026 all newly qualified pharmacists in England will be independent prescribers on the day of registration, and this presents an opportunity for NHS England to commission clinical services from community pharmacies incorporating independent prescribing as the new workforce enters the profession. Health Education England offered up to 3,000 independent prescribing courses from Autumn 2022 to end of March 2024 for community pharmacists with further cohorts of training for pharmacists working across other settings, including locums.

The Pharmacy Integration Programme is also introducing funded clinical examination skills training for community pharmacists to support registered pharmacists prepare for prescribing training or extending existing prescribing scope of practice.

4. Scotland(15)

NHS Education for Scotland (NES) Pharmacy supports Pharmacist Independent Prescribers (PIPs) within their training period, in implementation of their training into practice once they have qualified and those returning to prescribing practice. They commission Schools of Pharmacy in Scotland to organise and run Independent Prescriber courses each year. Pharmacists who practise in Scotland can also apply to NES Pharmacy for funding to undertake these courses. NES Pharmacy also provide support through clinical skills courses, teach and treat centres (in collaboration with health boards).

The Pharmacy Integration Programme is also introducing funded clinical examination skills training for community pharmacists to support registered pharmacists prepare for prescribing training or extending existing prescribing scope of practice.

5. Wales(16)

Independent prescribers are responsible and accountable for the assessment of patients with undiagnosed and diagnosed conditions and for decisions about the clinical management required, including prescribing. Whilst the newly registered pharmacist workforce in Wales will be independent prescribers from August 2026, the current workforce will be required to undertake a prescribing course, offered from a range of universities, to be able to prescribe. Each year Health Education and Improvement Wales (HEIW) Pharmacy allocates a set number of funded places to each health board and trust for pharmacists to undertake a prescribing course. HEIW are committed to supporting the development of the pharmacist workforce to become prescribers, so funding has been allocated to support the pharmacists working in patient facing roles to undertake this training, to enable the continued development of pharmacy services to support the population of Wales.

Schools of Pharmacy in Wales deliver programmes to prepare pharmacists to practice as Independent Prescribers and meet the standards set by the General Pharmaceutical Council (GPhC). The programmes can currently be undertaken as a stand-alone module, as part of a post-graduate programme e.g. Diploma or Post-registration Foundation Training programme(12). The course requires a mixture of directed and self-directed learning and time in practice under the supervision of a Designated Prescribing Practitioner.

6. New Zealand

In New Zealand, qualified pharmacists who have an accredited postgraduate qualification in specialised clinical, pharmacological and pharmaceutical knowledge may register as pharmacist prescribers(17). Pharmacists must submit a Practice Plan as part of their application that details their role within the team, how supervision/mentoring will be provided and the clinical areas in which they will prescribe (18).

There is a strong emphasis in the scope of practice for pharmacist prescribers in New Zealand on pharmacist prescribing as part of a collaborative and multidisciplinary healthcare team where they are not the primary diagnostician(19).

A qualified and authorised independent prescriber pharmacist may prescribe autonomously within the limits of their professional expertise and clinical competence and can play a key role in medicines management across the health system including in primary care and hospitals. Pharmacist prescribers are responsible and accountable for the care they provide.

Training for pharmacist prescribers began in 2012(20); however, the number of registered pharmacist prescribers is still relatively low in New Zealand. On 30 June 2023, for example, of the 4,143 pharmacists registered and entitled to practise, 51 were pharmacist prescribers(21). An additional two pharmacist prescribers held inactive registration on the same date.

7. California(22,23)

In California, pharmacists who have an Advanced Practice Pharmacist licence are authorised to practice 'advanced practice pharmacy' within or outside of a licensed pharmacy.

To be eligible to apply for the Advanced Practice Pharmacist licence, pharmacists must undergo the required training consisting of any two of the following:

- Certification in a relevant area of practice from a recognised organisation. This could include ambulatory care, critical care, pharmacotherapy, nutrition support, oncology, psychiatric, geriatric or paediatric pharmacy.
- Evidence of completing an accredited postgraduate residency where at least 50% involved providing direct patient care services with interdisciplinary teams.
- 1,500 hours of experience providing clinical services to patients under a Collaborative Practice Agreement or protocol with a physician, advanced practice pharmacist, pharmacist practicing collaborative drug therapy management, or health system. The clinical services must include initiating, adjusting, modifying or discontinuing drug therapy of patients.

8. Alberta, Canada

Alberta does not base authorisation for pharmacist prescribing on completing a specific course. Instead, pharmacists must demonstrate their ability to practise and document according to mandatory standards of practice by submitting a comprehensive application that includes patient case studies from recent practice (24). They must also meet other criteria, including being in good standing with the regulator, having strong, collaborative relationships with other regulated health professionals and having the required supports in their practice (e.g., access to information, communication, documentation processes) to enable safe and effective management of drug therapy(25).

The number of pharmacists with additional prescribing authorisation in Alberta increased substantially from 15 in 2007, when it was first introduced, to 3,664 in 2022 (almost 60% of all registered pharmacists in 2022 (n=6,128)). There were 1,663 licenced pharmacies in Alberta in 2022(26,27).

Context in Ireland

Community pharmacist prescribing

Community pharmacists reported that their existing knowledge and training would support their expanded role to pharmacist prescribing(28) and to identify potentially inappropriate prescribing(29) but that they would require additional training to prescribe (28).

GP pharmacist prescribing

Both GPs and pharmacists reported that the pharmacist's interpersonal skills, i.e. communication, assertiveness, teamwork, confidence and resilience, were critical to their successful integration into GP(30,31), that additional training would be required to support pharmacist prescribing roles(31), and that clinical skills could be addressed with future training(30). GPs reported they themselves would require additional training to work effectively with GP Pharmacists(GPP)(30). There was evidence that GPs were not aware of the content of the pharmacy curriculum(30).

In the iSimpathy project, pharmacists undertook training, participated in peer learning and were subject to independent and peer quality assurance of their medication review performance. James' evaluation of another GPP model(32) identified that the GPPs needed to learn about how to operate the practice systems and software, including how to access patients' electronic medical record.

Hospital pharmacist prescribing

The hospital-based model of collaborative prescribing study (PACT) reported that the two intervention pharmacists held a postgraduate Masters in Hospital Pharmacy, NFQ Level 9, and the General Level Framework of clinical pharmacy competence(33). In the recent public consultation, it was noted that 88 of the 841 pharmacists that participated had prescribing qualifications from other jurisdictions. 25 of these noted they work in hospital settings.

Discussion and Analysis

Currently, the national MPharm training programme is not required to teach Pharmacist Prescribing (*notwithstanding that Prescribing Science is taught in most courses*), and the accreditation of pharmacist training is not contingent on this. The mechanism by which the delivery of appropriate education and training to facilitate independent prescribing should be analogous to the robust framework currently in place under the Pharmaceutical Society of Ireland (Education and Training) (Integrated Course) Rules 2014, as amended. This regulation accredits the current MPharm programme. These rules provide for Accreditation Standards for the Five-Year Fully Integrated Master's Degree Programme in Pharmacy, approval processes and visits to recognised institutions by persons with relevant knowledge and experience. An analogous framework should be instituted whereby any prescribing course delivered should be accredited against robust standards developed by the regulatory body. The processes, procedures and governance of the accreditation mechanism should be analogous to the systems used for the MPharm, with appropriate expert assessment and approval mechanisms in place.

Table 2: International Education and Training Requirements

Common Conditions									
Jurisdiction	**Scotland**	**Wales**	**England**	**Northern Ireland**	**New Zealand**	**British Colombia**	**Ontario**	**Saskatchewan**	**Alberta**
Service	Pharmacy First	Independent Prescribing for Common Ailments and Contraception	Pharmacy First	Pharmacy First	N/R	Minor Ailments and Contraception Service	Minor Ailments	Minor Ailments	Minor Ailments, Assessments and Prescriptions
Model of prescribing	Patient Group Direction (PGD)	Formulary, national PGD	Pharmacy First - following specific clinical pathways, protocols and PGD	PGD	N/R	Follows guidelines	Follows guidelines and algorithms	Follows guidelines	Follows guidelines
Education	e-Learning module	Generic skills & competencies training	No mandatory training	No mandatory training	N/R	Mandatory module and self-declare completion	Mandatory orientation training	Mandatory accredited Level 1 prescribing authority training, approved basic course for prescribing for Minor Ailments	The minimum educational requirement for a pharmacist is a PharmD

Table 2: International Education and Training Requirements continued

Independent Prescribing									
Jurisdiction	**Scotland**	**Wales**	**England**	**Northern Ireland**	**New Zealand**	**British Columbia**	**Ontario**	**Saskatchewan**	**Alberta**
Service	Independent prescribing in primary care (GP practices, community pharmacy), hospitals and nursing homes					N/A			
Model of prescribing	Independent				Collaborative	N/A	Collaborative	Collaborative	Independent and collaborative
Education	Prescribing qualification Post- graduate Integrated into pre-registration training for those graduating 2026 onwards	Prescribing qualification Post-graduate Integrated into pre-registration training for those graduating 2026 onwards	Prescribing qualification Integrated into pre-registration training for those graduating 2026 onwards	Post- graduate certificate, or undertaking an Advanced Pharmacy Practice Course which includes the PG Cert materials Integrated into pre-registration training for those graduating 2026 onwards	Accredited postgraduate qualification and submission of a Practice Plan Training is being incorporated into entry-to- practice courses	N/A	Training incorporated into entry-to- practice courses	Adhere to certain criteria, as outlined in the text. Training incorporated into entry-to- practice courses	Submission of a portfolio for assessment

Recommendations

Considering the available evidence and analysis in the context of the Irish healthcare service, the Taskforce recommends:

For Common Conditions

- That in the first phase of a stepwise implementation of pharmacist prescribing, encompassing common conditions, a quality assured educational course of training, such as continuous professional development (CPD), should be developed and delivered.

For Independent Prescribing

The consideration of a model of training provision incorporating the following elements be developed in Ireland:

- Standards to be set by the PSI, the pharmacy regulator, setting out the knowledge, skills, and competencies that a pharmacist must demonstrate when prescribing, in addition to the requirements for course providers and expectations of those Higher Education Institutions (HEIs) who provide the designated training;
- Postgraduate training is to be aligned to the requirements of the National Qualifications Framework;
- Accreditation of all training is required, with pharmacists only empowered to prescribe subject to holding an accredited postgraduate qualification recognised by the regulatory body, until such time as it may be embedded into the undergraduate programme.
- Accredit programmes of training, for independent pharmacist prescribing, in accordance with the requirements of the National Qualifications Framework and the requirements of the PSI, the regulatory body.
- Postgraduate training should be cognisant of the education, skills and competence of the individual practitioner and build on this to deliver robust training in a flexible, agile manner;
- In circumstances where a pharmacist has undertaken equivalent prescribing training in another jurisdiction or where equivalent prescribing is a component of their core competence and scope of practice at initial registration, a method of assessment and recognition of this training should be developed and applied, referenced against national standards.
- That the flexibility of the existing pharmacy degree, which enables graduates to choose a variety of different career paths including non-patient facing roles(34), be maintained.

Chapter Six: Common Conditions

Introduction

This chapter outlines the scientific and policy evidence and provides some examples of Common Condition Services internationally. Evidence of patient services provided by independent pharmacist prescribers in community and primary care settings internationally are described in Chapter Eight.

This chapter also outlines the Taskforce's recommendations for a Common Conditions Service in Ireland.

Background and Evidence

Common conditions services (often called minor ailment/common ailment schemes) enable community pharmacists to provide advice and treat common and often self- limiting conditions in community pharmacies. Service aims include increased patient access, releasing capacity in other areas of the health service, and/or improving equity of access for patients, for example, those who have difficulty paying for non- prescription medicines.

There is typically an approved list of medicines or categories of medicines for the scheme, which may or may not include prescription-only medicines. In the schemes examined below, patients do not have to pay to have a consultation with the pharmacist. In some schemes, the patient may have to pay a charge for any medicine supplied. The pharmacy typically receives a service fee from the health service for providing the service, although fee structures vary from one jurisdiction to another.

Scientific evidence

Several studies have explored community pharmacist prescribing models to manage minor ailments, mostly undertaken in Canada, the United Kingdom (UK) and the United States of America (USA). A systematic review of pharmacy-based minor ailment schemes provided by community pharmacists, published in 2013, identified 31 evaluations all undertaken in the UK(1). The review reported positive benefit of the service, as evidenced by high symptom resolution and low re-consultation rates compared to standard healthcare. The conditions that have been investigated include minor ailments generally(2–4), impetigo(5), uncomplicated urinary tract infection (UTI) (5–7), chronic obstructive pulmonary disease exacerbation (5) and sore throat(8).

A systematic review (1), that aimed to explore the effect of pharmacy-based minor ailments schemes (PMASs) on patient health and cost-related outcomes, and to report their impact on general practices, examined 31 studies and concluded the following: Low re-consultation and high symptom resolution rates suggest that minor ailments are being dealt with appropriately by PMASs, that PMAS consultations are less expensive than consultations with GPs and provide a suitable alternative to general practice consultations(1). Further evidence suggests the economic benefits of pharmacist-led minor ailments schemes that include pharmacist prescribing(2,4).

In May 2024, a study from Washington State, USA, reported on community pharmacist management of minor illnesses, which included hormonal contraception, asthma, urinary tract infection, allergic rhinitis, headache, shingles, vaginal yeast infection, human/canine/feline bite, burn, swimmer's ear or anaphylaxis(9). The study compared the cost and the quality of care provided between the community pharmacy and traditional sites, which included primary care, urgent care and hospital care, over a three-year period. The authors reported that the community pharmacist care improved cost-effective access to care, and that there was no difference in the revisit rate between community pharmacy and traditional sites.

In Canada, there is evidence that community pharmacist prescribing for minor ailments is associated with a high rate of clinical improvement, patient satisfaction(3) and has a positive economic impact(2,4). For patients with uncomplicated UTI, there is evidence from both the UK and Canada that pharmacist prescribing is as effective as doctor prescribing to resolve symptoms and achieve clinical cure, and with no difference in the experience of adverse events(6,10). In Canada, the therapy prescribed by pharmacists for the UTI adhered to the guidelines for 95% of patients compared to 35% of patients with the doctor prescribing(10). For patients experiencing a severe sore throat, Canadian evidence suggests that community pharmacist prescribing contributes to cost savings for the health service(8). There is evidence that such interventions enhance patients' access to care and their perception of convenience.

In summary, scientific evidence suggests that, compared to standard care, community pharmacist-led management of common conditions can deliver the following benefits:

- Equivalent symptom resolution rates
- Equivalent experience of adverse events
- Equivalent or lower re-consultation or re-visit rates
- Enhanced patient access
- Equivalent patient satisfaction
- Cost savings and positive economic impact

Policy evidence

The examples provided below are from seven jurisdictions within Great Britain, Canada and New Zealand. Table 3 provides a comparative summary across the seven jurisdictions, while a list of conditions treated across the jurisdictions can be found in Table 4.

1. Great Britain

a. Scotland – NHS Pharmacy First Service Scotland

The NHS Scotland Pharmacy First Service enables patients to access advice and treatment for a wide range of common conditions from their local community pharmacy (see Table 1)(11). The pharmacist carries out a consultation with the patient, leading to advice, treatment, or referral to another health service where appropriate.

Pharmacists may supply products from an approved list of medicines, including over the counter and pharmacy-only medicines, as well as prescription-only medicines.

Prescription-only medicines are supplied via national patient group directions (PGDs). Between April 2021 and March 2022, 23% of the Scottish population accessed Pharmacy First Scotland services at least once (12).

Pharmacists must complete a condition-specific e-learning module before they can supply a prescription-only medicine via the relevant PGD (13). They must also maintain their competence, be familiar with the medicine and keep up to date with product information and guidance (14). Pharmacist-independent prescribers may provide an extended version of this service called Pharmacy First Plus, using their prescribing qualification rather than a patient group direction (15).

b. Wales - Common Ailments Service (incorporating Sore Throat Test and Treat)
Community pharmacists in Wales can treat common conditions as part of the Common Ailments Service (see Table 3) (16). Following a consultation with the patient, the pharmacist can provide advice and reassurance, supply a medicine from a formulary if appropriate, or refer the patient to another healthcare professional (17).

The Common Ailments Service Formulary includes prescription-only medicines, pharmacy medicines (medicines available under pharmacist supervision), and general sales lists medicines. Similarly to Scotland, the supply of prescription-only medicines is enabled via national patient group directions (16,17)..

Prior to providing pharmacy services in Wales, pharmacists must have completed generic skills & competencies training (18). Pharmacists must meet any training requirements set out in the relevant patient group direction, maintain their level of competence and knowledge in the relevant clinical area and stay up to date with medicines information and national/local guidelines. There are specific mandatory training requirements for the Sore Throat Test and Treat service (17). Pharmacist independent prescribers may provide an extended version of this service called the Pharmacy Independent Prescribing Service (19).

c. England - Pharmacy First Advanced Service
The Pharmacy First Advanced Service, introduced in January 2024, enables community pharmacists to provide urgent medicines supply, manage referrals for people presenting with minor illness, and complete episodes of care for seven common conditions following specific clinical pathways.

The service enables the management of common infections for patients through offering self-care, safety-netting advice, and, if appropriate, supplying certain over- the-counter and prescription-only medicines via clinical protocol and patient group directions (20). Pharmacists must make a clinical decision on whether a supply of a medicine should be made (21). The pharmacist may also refer the patient to another healthcare service if appropriate.

For the seven common conditions, the pharmacist can initiate the service with patients who present to the pharmacy. For all other minor illnesses as part of the service, however, the patient must be referred electronically to a pharmacy from another healthcare service (for example, by an urgent/emergency care provider, NHS 111 service, or general practice) (21).

There are no mandatory training requirements for the Pharmacy First service. Pharmacists are expected to self-assess their competence using a self-assessment framework(20). Suggested learning resources are provided in the framework for pharmacists who self-identify gaps in their competence. Each patient group direction also requires pharmacists to be competent to undertake clinical assessment in accordance with the specification (20).

2. Canada

a. British Columbia - Minor Ailments and Contraception Service (MACS)
Since June 2023, community pharmacists can assess and treat 21 minor ailments. The service is free for patients who are resident in British Columbia (22). Following a consultation, pharmacists can prescribe and supply a prescription-only medicine within the drug category specified for each ailment in Schedule A of the Pharmacists Regulation (23).

The patient's condition must present a low risk of masking underlying diseases, be diagnosable without laboratory tests, and be expected to resolve with short-term or episodic treatment (24). Pharmacists must follow certain standards, limits, and conditions when making a diagnosis or prescribing a medicine as part of the service (25). They must also have completed a mandatory regulatory education module and self-declare completion of this training (26). There are also additional non-mandatory education and training resources available free of charge to pharmacists.

Pharmacists in British Columbia have access to CareConnect(27), a secure, view-only electronic patient health record and are expected to ensure they have obtained the relevant drug therapy information and have conducted a patient assessment to support their diagnosis and/or prescribing decisions (26).

b. Saskatchewan – Minor ailments prescribing (Level 1 Prescribing Authority)
Community pharmacists in Saskatchewan may prescribe from an approved list of products for minor ailments. Pharmacists must complete mandatory accredited Level 1 prescribing authority training as well as an approved basic course for prescribing for minor ailments and self-care (28). Pharmacists must follow approved guidelines when prescribing minor ailments (29).

Pharmacists must follow the same standard when prescribing as other prescribers by taking responsibility for monitoring the patient's response and following up with the patient as needed to ensure continuity of care (30). Patients may fill their prescriptions at any pharmacy, as pharmacist prescribing and dispensing functions are independent of each other in Saskatchewan. The original pharmacist who prescribed the medicine remains responsible for following up with the patient (31).

c. Ontario - Minor Ailments
Community pharmacists in Ontario may prescribe a range of medicines for patients for 19 minor ailments identified in Schedule 4 of Ontario Regulation 202/94(32).

All practising pharmacists who provide patient care in Ontario (Part A pharmacists) must complete mandatory orientation training for minor ailments prescribing(33). Pharmacists must also follow the Guideline from Ontario College of Pharmacists(34) and Ontario Regulation 202/94(32). There are also assessment and treatment algorithms for Uncomplicated Urinary Tract Infection and Antibiotic Prophylaxis to Prevent Lyme Disease Following a Tick Bite(35).

A care plan for the patient could include issuing a prescription if applicable, providing patient education or referring the patient to their GP. The pharmacist is required to follow up with the patient. The patient is entitled to take the prescription to any pharmacy of their choice for dispensing(36). Pharmacies are strongly encouraged to enrol in a clinical viewer via Ontario Health(37) (an electronic health record system that shares patients' health information with healthcare providers)(36).

3. New Zealand - Community Pharmacy Minor Ailments Service

Te Whatu Ora (Health New Zealand) ran a proof-of-concept pilot Community Pharmacy Minor Ailments Service as part of the New Zealand Winter Preparedness Plan 2023(38). The pilot is currently under evaluation to establish if it should be extended. The initiative aimed to improve access for patients who are unable to access or afford care for minor ailments and to give access to certain non-prescription medicines to those who cannot self-fund treatment and, therefore, must access care through general practice or urgent care settings(39).

The approved list of medicines for the pilot did not include prescription-only medicines; however, it did include pharmacist-only and pharmacy-only medicines in addition to general sales medicines(38).

Table 3: Examples of common conditions in other jurisdictions

	Scheme name	Is the service currently in place?	Are prescription-only medicines (POMs) included?	Mechanism for POMs	Is there specific mandatory training?	What medicines are included?	Free for eligible patients to access?
Scotland	NHS Pharmacy First Service Scotland	Yes	Yes	Patient group directions (PGDs).	Yes e-learning modules.	Approved list of treatment items.	Yes
Wales	Common Ailments Service (CAS) (incorporating Sore Throat Test & Treat)	Yes	Yes	Patient group directions (PGDs).	Yes Specific training for sore throat. Must also complete generic skills & competencies training.	Common Ailments Service Formulary.	Yes
England	NHS England Pharmacy First Advanced Service	Yes	Yes	Patient group directions (clinical pathways).	No But pharmacists expected to self-assess training needs	Specific medicines under each clinical pathway.	No Free consultation but NHS prescription charge unless exempt. Patient typically pays for over the counter medicines.
British Columbia	Minor Ailments and Contraception Service (MACS)	Yes	Yes	Pharmacist prescribing (within a schedule).	Yes	Specified drug category for each ailment.	Yes
Saskatchewan	Minor ailments (Level 1 Prescribing Authority)	Yes	Yes	Pharmacist prescribing (from an approved list).	Yes	Approved list.	Yes
Ontario	Minor Ailments	Yes	Yes	Pharmacist prescribing (within a schedule).	Yes	Schedule of medicines.	Yes
New Zealand	Community Pharmacy Minor Ailments Service	No Under evaluation following a 2023 pilot.	No	No POMs included.	No	Approved list.	Yes

Table 4: List of conditions treated across the examined jurisdictions

Condition	Scotland	Wales	England	British Columbia	Saskatchewan	Ontario	New Zealand
Acne Vulgaris (mild)	✓	×	✓ Via referral	✓	✓	✓	×
Allergic rhinitis	✓	✓	×	✓	✓	✓	×
Allergies	✓	×	✓ Via referral	×	×	×	×
Athlete's foot	×	✓	✓ Via referral	✓	✓	×	×
Chickenpox	×	✓ Under 14 yrs	×	×	×	×	×
Cold and flu	×	×	✓ Via referral	×	×	×	×
Cold sores	✓	✓	×	✓	✓	✓	×
Colic (infantile)	×	✓	×	×	×	×	×
Conjunctivitis (allergic, viral/ bacterial)	×	✓	×	✓	✓	✓	✓
Constipation	✓	✓	✓ Via referral	×	×	×	×
Cough	✓	×	✓ Via referral	×	×	×	×
Dermatitis (allergic/contact/atopic)	×	✓	×	✓ & Seborrheic	✓	✓	✓
Diarrhoea (acute/dehydration)	✓	✓	✓ Via referral	×	×	×	✓
Dry eyes disease	✓	✓	×	×	×	×	×
Dry skin	×	✓	×	×	×	×	×
Dysmenorrhea (painful periods)	×	×	×	✓	✓	✓	×
Dyspepsia (indigestion)	✓	✓	×	✓	×	×	×
Earache; ear infection	✓ Otitis externa	×	✓ Acute otitis media	×	×	×	×
Ear wax	✓	×	✓ Via referral	×	×	×	×

Table 4: List of conditions treated across the examined jurisdictions continued

Condition	Scotland	Wales	England	British Columbia	Saskatchewan	Ontario	New Zealand
Eczema	✓	✓	✗	✗	✓	✓	✓
Eye: infection/allergy	✓	✗	✓ Via referral	✗	✗	✗	✗
Folliculitis	✗	✗	✗	✓	✗	✗	✗
Fungal nail infection	✗	✗	✗	✓	✓	✗	✗
Fungal skin infection (Ringworm/ tinea cruris)	✓	✓ & Intertrigo	✗	✓	✓	✗	✗
Gastroesophageal reflux (acid reflux)	✓	✓	✗	✓	✓	✓	✗
Genital herpes	✗	✗	✗	✗	✓	✗	✗
Haemorrhoids	✓	✓	✗	✓	✓	✓	✗
Headache	✓ Migraine	✗	✓ Via referral	✓	✓	✗	✗
Head lice	✓	✓	✗	✗	✗	✗	✓
Urticaria (hives)	✗	✗	✗	✓	✗	✓	✗
Impetigo	✓	✗	✓	✓	✓	✓	✗
Ingrowing toenail	✗	✓	✗	✗	✗	✗	✗
Insect bites and stings	✗	✗	✓ Infected	✓	✓	✓	✗
Mouth ulcers	✓	✓	✓ Via referral	✓	✓	✓	✗
Musculoskeletal sprains/strains/pain	✓	✓ Acute lower back, no radiculopathy	✓ Via referral	✓	✓	✓	✗
Nappy rash	✓	✓	✗	✓	✓	✓	✗

Table 4: List of conditions treated across the examined jurisdictions continued

Condition	Scotland	Wales	England	British Columbia	Saskatchewan	Ontario	New Zealand
Nasal congestion	✓	✗	✓ Via referral	✗	✗	✗	✗
Nicotine dependence	✗	✗	✗	✓	✓	✗	✗
Nausea/vomiting dehydration	✓ Travel	✗	✓ Via referral	✗	✓ Of pregnancy	✓ Of pregnancy	✓
Oral thrush	✓	✓	✗	✓	✓	✓	✗
Pain and fever	✓	✗	✗	✗	✗	✗	✓
Scabies	✓ & Pubic lice	✓	✓ Via referral	✗	✗	✗	✓
Scalp disorder	✓	✗	✗	✗	✗	✗	✗
Shingles	✓	✗	✓	✓	✓	✗	✗
Sinusitis	✗	✗	✓	✗	✗	✗	✗
Skin infection (minor)	✓	✗	✗	✗	✗	✗	✓
Skin, blisters; rash or boil	✓ Boil	✗	✓ Via referral	✗	✗	✗	✗
Sore throat	✗	✓ & Tonsillitis	✓	✗	✗	✗	✗
Teething	✗	✓	✓ Via referral	✗	✗	✗	✗
Threadworms	✓	✓	✗	✓	✗	✓	✗
Tick bites, PeP to prevent Lyme disease	✗	✗	✗	✗	✗	✓	✗
Urinary Tract Infection/ cystitis (uncomplicated)	✓	✗	✓	✓	✓	✓	✗
Vulvovaginal thrush	✓	✓	✗	✓	✗	✓	✗
Vaginal discharge /itch/soreness	✗	✗	✓ Via referral	✗	✗	✗	✗
Warts and verrucae	✓	✓	✗	✗	✗	✗	✗

Development process: Common Condition Services

Four examples of how common condition services have been developed internationally using multi-professional consultation are provided below.

1. NHS England Pharmacy First Service (40)

The 7 clinical pathways of the NHS England Pharmacy First Service were developed by NHS England with input from a group of multi professional experts, including practising doctors, pharmacists and specialists in areas such as prescribing, children's health, allergies and antimicrobial resistance.

NHS England also sought input from representatives of organisations such as National Institute for Health and Care Excellence (NICE), UK Health Security Agency (UKHSA), Royal College of General Practitioners (RCGP), and Community Pharmacy England (CPE). All decisions made by this group were consensus-driven and grounded in the latest evidence and national guidelines.

The clinical pathways were approved by the National Medical Director at NHS England and the Chief Medical Officer for England. The NHS England AMR (antimicrobial resistance) Board was involved in service development and NHS England outlines that the AMR Board will continually scrutinise this service.

2. Pharmacy First Scotland (14,41)

For Pharmacy First Scotland, the Approved Products List was developed by representatives from all of the 14 NHS Health Boards in Scotland and with input from Community Pharmacy Scotland and other key stakeholders. Pharmacy First Scotland replaced a previous service in Scotland called the Minor Ailments Service which used local minor ailment service formularies. Patient group directions used as part of the service were developed nationally for NHS Pharmacy First Scotland in collaboration with the Scottish Antimicrobial Prescribing Group and the Primary Care Community Pharmacy Group.

3. Common Ailments Service Wales (42)

The formulary for the Welsh Common Ailments Service was developed using recognised resources and involved multi-professional consultation to ensure the provision of consistent advice by pharmacists and GPs. The formulary was prepared by the Welsh Medicines Advice Service, with support from the All Wales Prescribing Advisory Group and All Wales Therapeutics and Toxicology Centre and was subsequently endorsed by the All-Wales Medicines Strategy Group.

4. Minor Ailments, Ontario (30,43)

The Ontario College of Pharmacists (pharmacy regulator for Ontario) were asked by the Ontario government in 2019 to make regulations to authorise pharmacists to prescribe for minor ailments, while ensuring that patient safety was not compromised. The Ontario College of Pharmacists established a Minor Ailments Advisory Group of key stakeholders including experts in medicine, public health, health systems research, community pharmacy and patient advisors to inform and guide these changes. The advisory group also included Ontario leads on antimicrobial stewardship.

In addition to expert input, the schedule of minor ailments conditions was also determined through stakeholder engagement and feedback from registrants and the public.

Considerations that guided the selection of the medication categories included recent evidence, clinical practice guidelines, best practices, and antimicrobial stewardship. Emergency department visit data from the Institute for Clinical Evaluative Sciences (ICES) was also analysed to understand the impact pharmacist prescribing for minor ailments could have if this type of routine care were moved into the community pharmacy setting.

Discussion and Analysis

This discussion aims to provide context for what a Common Conditions Service would look like in Ireland following review of similar programmes in other jurisdictions.

Taskforce Terms of Reference

Two points in the Taskforce TOR make specific reference to the development of a "Minor Ailments Scheme".

- Agree a process to be used for identifying the minor ailments, including criteria for inclusion/exclusion.
- Create a list of these minor ailments, which can be expanded upon over time.

It was agreed that "Minor Ailments" will now be referred to as "Common Conditions".

Objectives of the service

The objectives of the Common Conditions Service are to utilise the skills and knowledge of community pharmacists to:

- Offer patients the opportunity to access the right care, in the right place, at the right time under the principles of Sláintecare.
- Free up capacity in A&Es, GP surgeries and other settings for the treatment of patients with higher acuity conditions

This service will enable community pharmacists to manage common conditions by offering self-care advice, safety-netting, and, when appropriate, supplying certain over the counter (OTC) and prescribing prescription-only medicines (POM) through established protocols. In this way, the Common Conditions Service builds on the work of community pharmacists, allowing them to utilise their skills as medicines experts to benefit patients and the public within the healthcare service.

Process for identifying Common Conditions

International schemes such as common condition services in England and Ontario have been developed with input from multiple experts and stakeholders. Following its review of similar schemes internationally, the Taskforce has compiled and agreed upon an initial list of conditions, taking cognisance of their commonality across multiple jurisdictions. These eight conditions were deemed to be safe and suitable for a pharmacist to manage and treat in a community pharmacy setting.

Inclusion and Exclusion criteria

Conditions to be included in this service must be those that can be treated in a community pharmacy setting, as shown by the evidence base.

Clinical inclusion and exclusion criteria will differ for each condition, and this will be set out in the protocol for the condition itself.

Communication with GPs

Pharmacists may use their professional judgement to contact a patient's GP, in collaboration with the patient, when required to do so. It is the case that not all prescribing activity by a pharmacist under the common conditions service will require notification to the patient's GP. There are certain instances in which communication with the patient's GP may be appropriate.

With the further development of eHealth and ePharmacy, prescribing activity will, in time, be visible across the shared care record and will allow for seamless communication with prescribers such as GPs.

Person-centred care

Pharmacists must follow the same standard when prescribing as other prescribers by taking responsibility for monitoring and assessing the patient's response and following up with the patient as needed to ensure continuity of care.

Recommendation

1. That pharmacists be enabled to exercise independent, autonomous prescriptive authority within and related to the individual practitioner's scope of practice and competence.
2. This should be implemented in a stepwise manner, commencing with the introduction of a common conditions service, with pharmacists provided with prescriptive authority linked to the service and its parameters.

Any of the conditions listed in Table 4 could be considered for inclusion as part of the development of a common conditions service. Considering the available background and evidence in the context of the Irish healthcare service, the Taskforce recommends the following as an initial list of conditions to be included in a Common Conditions Service:

1. Allergic Rhinitis
2. Cold Sores
3. Conjunctivitis
4. Impetigo
5. Oral Thrush
6. Shingles
7. Uncomplicated UTI / Cystitis
8. Vulvovaginal Thrush

Recommendations on the requirements for introduction, implementation, and operationalisation

1. Preparation of protocols

a. Protocol development

Prior to the inclusion of a condition in this service, a protocol should be developed for use in practice. This should be developed by the HSE, in collaboration with the PSI, and in consultation with the DoH, using clinical experts to determine, at a minimum, the appropriate clinical inclusion and exclusion criteria, formulary, and referral pathways. These should be made available to pharmacists for use and should be kept up to date. An example of a clinical pathway used in other jurisdictions can be found in appendix two.

It is recommended that a multidisciplinary working group be established within the HSE to develop a clinical framework for the service, including clinical protocols, to ensure that they are based in the most up-to-date evidence and are in line with national guidelines. The membership of this multidisciplinary working group should include, at a minimum, GPs, medication safety experts, relevant clinical leads, and a practicing community pharmacist. Similarly to schemes in England and Ontario, experts in antimicrobial use should be included in the development of the clinical framework, including clinical protocols which include the use of antimicrobials, to ensure that these are in line with best practice, adhere to antimicrobial stewardship policies, and are consistent with existing national guidelines.

b. Approved list of medicines

Community pharmacists may prescribe prescription only medicines or recommend appropriate over the counter medicines from an approved list of products developed by the multidisciplinary working group alongside the common conditions' protocols.

2. Education and Training

Pharmacists must undertake educational courses and training prior to being enabled to participate in the Common Conditions Service. Pharmacists will be required to follow approved protocols when prescribing prescription only medicines or recommending appropriate over the counter medicines for common conditions.

The PSI, in conjunction with the HSE, will arrange for the development of training programmes for pharmacists on each of these conditions, and will signpost to these protocols for use in their practice. It is the responsibility of pharmacists seeking to provide this service to ensure that they have completed the training to ensure that they can deliver safe person-centred care. This will be appropriately regulated and governed by the PSI, the pharmacy regulator.

3. Reimbursement

Reimbursement for this service is not within the scope of this Taskforce or this report. Any decisions pertaining to funding or reimbursement are matters of Government policy.

4. Operational aspects of the service

a. Record Keeping

Record keeping, including documenting the decision to prescribe, must be maintained by each pharmacist who participates in the common conditions service.

b. Regulation

The service will be regulated by the PSI, ensuring all pharmacists are practicing within their scope of practice.

c. eHealth

The Common Conditions Service is not contingent on the future development of eHealth infrastructure, and it is expected to operate within the current structure already in place. However, the future development of the eHealth infrastructure should streamline the operational processes for the Common Conditions Service.

5. Future of the service

It is expected that this service will expand over time to meet the needs of the healthcare service. In this case, the above inclusion and exclusion criteria should apply.

The governance of this service should be overseen by the Department of Health, in collaboration with the HSE and the PSI, ensuring that it operates in accordance with regulatory standards and best practices.

To adapt to evolving healthcare needs, the criteria and conditions for the service should be periodically reviewed and updated. This process should involve input from a panel of healthcare professionals, physicians, and healthcare policy experts. By doing so, the service can incorporate new conditions and treatments as required by the healthcare service.

Chapter Seven: Pharmacist Prescribing in Secondary Care

Introduction

Pharmacist prescribing in secondary care offers many opportunities to the healthcare service in terms of patient safety and reduction in medication errors. This chapter highlights the international evidence, discusses pharmacist prescribing in secondary care in Ireland, and makes recommendations for how to introduce this in Ireland.

Background and Evidence

International evidence

Independent prescribing is routine in countries such as Northern Ireland, England, Scotland, Wales, and Canada, and pharmacist prescribing through collaborative models is routine in New Zealand and the United States of America (USA). The aims of pharmacist prescribing in these countries are variably focused on improving patient care outcomes without compromising patient safety, increasing patient access to medicines, and making better use of the skills of health professionals(1).

The Scottish Government had one of the most ambitious plans for pharmacist prescribing to ensure that *'all patients, regardless of their age and setting of care, will receive high-quality pharmaceutical care using the clinical skills of the pharmacist to their full potential'*. "*Prescription for Excellence: a Vision and Action Plan for the right pharmaceutical care through integrated partnerships and innovation*" was published by the Scottish Government in September 2013. The vision articulated within this document was that by 2023, 'all pharmacists providing National Health Service (NHS) pharmaceutical care will be NHS accredited clinical pharmacist independent prescribers working in collaborative partnerships with medical practitioners who will continue to have overall responsibility for diagnosis'(2). Progress in Scotland is reflected in a survey of pharmacists in Great Britain in 2019. Overall, 17% of the respondents were prescribers, but the highest percentage, 30%, were in Scotland. The survey also reported that 48% of pharmacist prescribers were practicing in secondary care, in particular, hospital pharmacy (45%) and that there were 45% practicing in general practice, with only 8% prescribing in community pharmacy(3).

Pharmacist prescribing is widespread in hospital practice and within General Practice, where there are models for integrating pharmacists within the team. This takes place in Canada, Australia, the UK, the USA and Hong Kong(4). There are a number of factors that facilitated the introduction of pharmacist prescribing in hospitals(3).

These included:

- Established governance structures, including Drugs and Therapeutics Committees
- Hospital pharmacists already formed part of multidisciplinary teams
- Access to patient health care records, including laboratory results and other diagnostic tests
- Experience of hospital pharmacists, with the majority having post-graduate qualifications and many undertaking advanced specialist roles
- Evidence for the safe, effective and economic prescribing by pharmacists in the acute setting.

Scientific evidence

A systematic review of the effect of pharmacist prescribing in the hospital setting, published in 2018, identified 16 articles describing 15 studies that reported on pharmacist prescribing undertaken across five countries: Canada, Australia, the UK, the USA and Hong Kong(4). The studies involved the care of patients in a variety of hospital settings, including patients admitted to hospital (5–12), outpatient clinics (13–17) and preoperative/preadmission clinics(18–20). The care was typically provided to adult patients only. The model of pharmacist prescribing used in the studies included prescribing by protocol, (5–9,12,13,16) supplementary prescribing, (11,15,18,19) and collaborative prescribing(14,17). Pharmacists prescribed a range of medication types, including anticoagulants(5–10,12,13,18) and medication used to treat high blood pressure(14,16), diabetes(14,15), and high cholesterol(14,17). In multiple studies, pharmacists were not restricted and could prescribe across the patient's medication regime(11,18,20). In all studies, pharmacists were prescribing autonomously, either according to available guidelines, clinical judgement or following discussion with a doctor. In a few of the studies, a counter signature of a prescription by a doctor was required(18).

The findings of this systematic review (4) demonstrated that for those patients who had a pharmacist prescribe their medication, their blood pressure readings were as good as that for patients with doctors prescribing; their blood sugar and cholesterol levels were better, and pharmacists were better at adhering to warfarin dosing rules than other prescribers and more patients remained in therapeutic anticoagulant range. The findings provided strong evidence about medication safety, with pharmacist prescribers being shown to make 20 to 25 times fewer medication errors and up to 116 times fewer omissions when prescribing medication for patients on admission to hospital or before or after having surgery. Since then, other systematic reviews have corroborated this finding that pharmacist prescribers in the hospital setting have a beneficial effect by reducing the prevalence of medication errors(21,22). There is also more recent evidence that having a pharmacist prescribe (charting and monitoring) an anticoagulant called warfarin reduced warfarin-related errors during the hospital stay and improved the communication about warfarin care at hospital discharge(23).

In the above-described jurisdictions, hospital pharmacists are typically involved in prescribing in both generalist and specialist roles, for example, oncology, kidney disease, emergency care, surgical care and critical care including neonatal intensive care, (24–30). Additional benefits to hospital pharmacist independent prescribing have been reported: improved prescribing safety, more efficient pharmacist medication reviews, increased scope of practice and enhanced professional or job satisfaction(31). Challenges have also been described: lack of support (financial and time resources), medical staff acceptance and the pharmacy profession itself (adoption, implementation strategy, research resources, second pharmacist clinical check). High quality research studies to explore the merit and implementation of hospital pharmacist prescribers are needed, as is strategic and strong pharmacy leadership to optimise the integration of hospital pharmacist prescribers into future health service and workforce planning(31).

Ireland

In Ireland, there is evidence available about a model of pharmaceutical care that sees hospital pharmacists integrated into the medical team and undertaking collaborative prescribing, which means being empowered to collaboratively prescribe in the form of making major and minor changes to the patient's inpatient prescription and discharge prescription. This model, known as PACT, sees pharmacists aligned to one or more consultant medical or surgical teams, working interprofessionally and collaboratively. The findings of the three studies investigating this intervention demonstrated that compared to usual care, it decreased medication error rates during admission and at discharge, enhanced uptake of pharmacist suggestions to optimise care, increased appropriateness of prescribing and represented value for money(32–34). A further Irish study identified hospital doctors' support for hospital pharmacists deprescribing inappropriate stomach acid suppressants(35).

Discussion and Analysis

Medical prescribing in Irish hospitals

In Ireland, primary medical education involves undergraduate university training followed by a postgraduate 12-month internship(36). These medical interns, or foundation doctors, have autonomous prescriptive authority (37)and are responsible for the majority of prescribing in the hospital setting(38). Intern training involves a minimum of three months in general medicine and general surgery, with a further two 3-month training periods required, which may be in specialist areas such as paediatrics or emergency medicine. The intern year is the first of several years training for non-consultant hospital doctors (NCHDs). NCHDs progress through a journey from intern to Senior House Officer (SHO) to registrar, with the ultimate potential to become a consultant. NCHDs typically work under a lead consultant and are supervised in their work either by the consultant themselves, or by a more senior NCHD within the team. This supervision may include oversight of an intern's prescribing, and this context and structure are important to consider in the introduction of pharmacist prescribing in Ireland.

Current practice in Ireland

Although there is limited published evidence in Ireland, there is some degree of collaborative prescribing currently being undertaken in hospitals under local clinical governance arrangements. Pharmacists in some hospitals are empowered to change prescriptions in certain circumstances, e.g. following admission medication reconciliation. Pharmacists also run warfarin or anticoagulant clinics in some hospitals, adjusting dosing in line with laboratory results and clinical data. This typically happens within a consultant team, as described above, with the pharmacist having access to the consultant, NCHDs and other interprofessional team members to facilitate patient care.

Although within the current regulatory and legislative framework pharmacists can alter the hospital prescription chart, i.e. for medications to be administered in the hospital setting, they cannot prescribe medication to be dispensed in a community pharmacy on foot of a valid prescription. This is a major limitation to the evolution of safer hospital discharge prescribing interventions in the hospital context, and this is a major public health concern in Ireland.

The pharmacist's access to the patient's healthcare record, including prescribing and laboratory data, is routine in hospitals in Ireland, whether those hospitals have evolved to the use of electronic health records or not.

The main barrier to implementing and expanding these services is that pharmacists do not currently have prescribing rights. Extending prescribing rights to pharmacists enables them to contribute more to healthcare, benefitting the healthcare system and patients receiving care in Ireland. There is also a benefit to pharmacists in terms of career progression. There is already progress within the HSE to create Advanced Specialist Pharmacist roles, and these pharmacists are particularly well placed to undertake prescribing given their well-developed skill set and established relationships within the multidisciplinary team. The credentialling of Hospital Pharmacy Technicians would further support the expansion of the role of the pharmacist, ensuring appropriate skill mix and enabling all members of the pharmacy team to operate at the top of their scope of practice.

Advanced Specialist Pharmacist

The HSE has begun to welcome applications from Hospital Pharmacists in an Acute Setting who want to become an Advanced Specialist Pharmacist in certain named patient-facing and non-patient facing specialities.

The patient-facing Advanced Specialist Pharmacist will have responsibility for pharmacy services to defined clinical areas providing a high level of expertise, competence and performance e.g. oncology/haematology, antimicrobial, infectious diseases, cardiology, intensive care, transplant, respiratory disease, care of the elderly, paediatrics, neonatal, mental health, and perioperative care in in-patient, out-patient care and others. It may be appropriate to initially implement pharmacist prescribing in secondary care for pharmacists working in these posts.

Enabling pharmacist prescribing in hospitals in Ireland

The enabling actions and developments to create a safe environment for pharmacist prescribing in hospitals in Ireland include:

- The provision of dedicated training and assessment of pharmacist independent prescribers, including the postgraduate independent prescribing qualification (see Chapter Five)
- The provision, for other secondary care staff and stakeholders, of training to support the implementation and integration of this novel pharmacist role.
- The optimisation of collaboration and communication between pharmacist independent prescribers and the healthcare team.
- The planning and delivery of the supporting infrastructure to facilitate successful delivery of the expanded role of pharmacist prescribers, including physical infrastructure such as clinic space, access to patient records, and dedicated time to communicate interprofessionally.
- The development of a funding model to support pharmacist independent prescribing activity in secondary care.

In addition, the organisation of pharmacist prescribing activity should occur within the structure of the consultant led medical or surgical team described above, consistent with the PACT model of service delivery described in the literature(32,34). Pharmacist prescribing should be facilitated within the current information and communication infrastructure, whether that is manual or electronic. As more hospitals in the country move to the introduction of electronic health records and electronic prescribing systems, pharmacist prescribers, as with all other prescribers, should be facilitated to operate optimally within the digital space.

Recommendation

Considering the available evidence and analysis in the context of the Irish healthcare service, the Taskforce recommends:

1. The development, over the coming years, of models of pharmacist prescribing within secondary care settings, recognising the requirements for specific enablers.

Chapter Eight: Pharmacist Prescribing in Primary Care

Introduction

Internationally, pharmacist prescribers work in a variety of settings, using their medicines expertise, training, and particular skillset to provide patient services across health systems, including prescribing a wide range of medicines within their scope of practice. This chapter reviews the international scientific and policy evidence for pharmacist prescribing in three primary care settings

(1) community pharmacy
(2) general practice and
(3) residential care.

Background and Evidence

The basis for pharmacist prescribing in primary care is to optimise prescribing, ensuring the quality use of medicines.

This may involve the pharmacist prescriber making an independent decision, after a diagnosis, to supply or refuse to supply a prescription-only medicine on prescription. Pharmacist prescribers may prescribe for people who walk in, or have been referred, for a range of minor conditions and short-term illnesses as well as for some long-term conditions.

It can also include giving advice and information on the person's medicines.

Following a review of the person's repeat medicines, the pharmacist prescriber may, following discussion with the patient, make recommended changes to the prescription e.g. consider when it may be appropriate to withhold medicines, deprescribe or alter a prescribed dose. This may occur as a result of up-to-date blood tests, compliance, safety (adverse drug reactions, drug-drug interactions) etc. Pharmacists should assess and monitor the outcome of the prescribing activity to make sure safe and effective care is provided especially in the context of polypharmacy.

Prescribing should be in line with clinical, national (best-practice) guidelines.

Pharmacist prescribers should communicate effectively, and work in collaboration with other healthcare professional colleagues as part of a multi-disciplinary team within Primary Care to deliver safe and effective care to patients.

Pharmacist prescribers would be responsible for the prescribing decisions they make.

International scientific evidence

A systematic review of the accessibility of pharmacist prescribing and its impacts on medicines access, published in 2024, which included 47 studies from four countries (United Kingdom, United States of America, Canada, New Zealand), reported that pharmacist prescribing in multiple settings in primary care enhanced access to medicines in multiple ways: increasing the proportion of eligible people receiving medicines, increasing the number of overall dispensed prescriptions, and reducing time to receipt of prescriptions(1). The included studies involved a mixture of dependent, collaborative, and independent prescribing models.

Community pharmacy

A systematic review examining community pharmacist prescribing of systemic antimicrobials, published in 2021, included 14 studies undertaken in the same four jurisdictions(2) (UK, USA, Canada, New Zealand). The studies described community pharmacist prescribing for multiple conditions (uncomplicated urinary tract infection (UTI), cold sores, otitis media, acute and chronic bacterial sinusitis, chronic obstructive pulmonary disease exacerbations, pinworms and threadworms. The included studies reported a mixture of independent and protocol-based prescribing models. Overall, community pharmacist prescribing was found to be safe, effective and associated with a positive patient experience. The studies reported high rates of clinical cure or symptom improvement. For patients with UTI, low rates of recurrence or need for retreatment, compared to physician prescription, and no difference in time to symptom resolution were reported. In addition, there was evidence that patients presented sooner to pharmacists than to physicians for treatment, and they described better access to treatment and greater convenience than for physician prescribing.

There was also evidence that pharmacist-led care, including prescribing, was associated with less healthcare utilisation. Two included economic analyses demonstrated that the community pharmacist involvement in antimicrobial prescribing represented good value for money. These findings are further supported by more recent evidence(3).

There is evidence from Alberta, Canada, that independent prescribing by pharmacists practicing in community pharmacy has a beneficial effect on blood pressure control(4), glycaemic control in people with type 2 diabetes(5), target serum lipid concentrations(6), the risk for cardiovascular disease (CVD) events in people at high risk for CVD events(7), and in the management of urinary tract infections(8). There is also positive evidence of the cost effectiveness and the patient experience of these interventions(9–11).

Although the general public were generally supportive of pharmacist prescribing in a community pharmacy setting, especially for management of minor ailments and repeat prescribing, they were concerned about pharmacist's competence to diagnose, access to healthcare records and the potential for privacy and confidentiality within a community pharmacy setting(12). Patients who had experienced pharmacist prescribing reported satisfaction with the consultation and the pharmacist's competence and capability and regarded pharmacist prescribing to be as effective and safe as their physician(12,13). Patients were less concerned than the public about privacy and confidentiality. Both the public and patients expressed concerns about the pharmacist's access to the patient's healthcare information, and lack of access to additional staff to support dispensing activity, seeing both as factors that might influence the safety of community pharmacist prescribing.

General practice

An international systematic review that aimed to explain what works well, and what does not, about pharmacists working within general practice identified that collaboration and communication between the GPP and GP are critical, and pharmacist independent prescribers are particularly valued by patients in this setting (14).

Across the UK, the involvement of pharmacists within general practice is becoming increasingly routine(13,15,16), and since 2015, the NHS has funded pharmacists to work in general practice(17). There is evidence that most GP pharmacists are independent prescribers and are currently using their independent prescriber qualification in their role(16,18). Medication reconciliation, medication reviews and reauthorising repeat prescribing are the activities undertaken by most GP pharmacist survey respondents across the UK, and some undertook acute prescribing. GP pharmacists in Northern Ireland expressed a view that their role helped to address work pressure within primary care, reduce prescribing errors, save NHS resources by freeing up GPs' time and minimising medicine waste(19). GPs themselves reported that GP pharmacists contribute positively to patient outcomes and enhance communication and integration between general practices and community pharmacies(20).

However, in Northern Ireland, a significant proportion of GP pharmacists reported that they were not utilising their independent prescribing qualification in their GP role. Research has identified challenges to the uptake of pharmacist independent prescribing as inadequate training and prescriber competence, insufficient support from authorities and stakeholders insufficient funding, lack of GP confidence in the pharmacist's prescribing competence, lack of awareness of the role and lack of pharmacist prescriber clinical decision-making confidence. Despite these implementation challenges, there is good evidence of the positive effects and experience of pharmacist prescribing from GPs, pharmacists, and patients (17,20–23).

Residential care homes and other settings

There is also growing evidence to demonstrate positive outcomes by integrating independent pharmacist prescribers into residential care teams internationally. In Northern Ireland, it has been shown that regular medication reviews by pharmacist-independent prescribers in nursing homes improve the quality and safety of prescribing whilst realising substantial prescribing savings and indirect savings through more cost-effective and appropriate prescribing(24). The Care Home Independent Prescribing Pharmacist Study (CHIPPS) study in the UK showed that interventions by independent pharmacist prescribers significantly reduced polypharmacy and improved quality of life for care home residents, as well as enhancing medicines management practice (25,26). In addition to their independent prescribing qualification, bespoke training and competency assessment for CHIPPS pharmacists has been designed and evaluated(27). This involved training days, professional development, maintenance of a portfolio of competence, mentor support, and an in-person examination with an independent GP. The training was perceived as fit for purpose, resource intensive and appropriate. The role of a pharmacist independent prescriber has also been recognised in the area of learning disability, especially in relation to medicines optimisation(28). Pharmacist prescribing has also been reported in addiction services (UK NHS)(29), urgent care (USA) (30), hospices and prisons(31).

Policy evidence

Several examples of the types of patient services provided by pharmacist prescribers in community pharmacies and primary care settings are provided below from the jurisdictions of Northern Ireland, Great Britain, New Zealand, California, and Alberta.

There are many varied models of pharmacist prescribing internationally, including those that take place under specific protocols. Models include independent, supplementary, or collaborative prescribing.

1. Northern Ireland

Community pharmacy

Independent prescriber pharmacists working in community pharmacies may provide private patient services or services funded through the NHS.

Currently, NHS-funded pharmacist prescribing in community pharmacies is through the Pharmacy First Service, where pharmacist prescribers may prescribe prescription- only medicines for certain conditions - Emergency Hormonal Contraception, antibiotics for urinary tract infections (UTIs), and as part of a pilot scheme, antibiotics for patients who test positive via swab for a bacterial sore throat (32). This service is free at the point of access for patients (33).

Pharmacist prescribers working in the community may also offer patient services privately in areas within their competence, such as private travel vaccination clinics.

General practice

Almost 400 pharmacists work in general practice in Northern Ireland. Every general practice in Northern Ireland has a pharmacist as part of the clinical team, working alongside GPs and other healthcare professionals to improve the safety and quality of prescribing and improve patient outcomes (34).

The core general practice pharmacist role is still being defined by the Department of Health, which aims to have General Practice Pharmacists more firmly established as the clinical leads for medicines within the general practice team (34). Some examples of how General Practice Pharmacists support medicines optimisation and prescribing safety for patients in Northern Ireland include undertaking medication review, medicines reconciliation, prescribing system management, achieving a more consistent approach to prescribing, formulary implementation, reducing prescribing expenditure and releasing GP capacity. They may also lead in the management of long-term conditions(34). The Department of Health, Northern Ireland (34) considers that "the key role of pharmacists, as distinct from other healthcare professionals, is their expertise in medicines". According to the Department, the initial rollout of the general practice pharmacist service has saved 4,212 hours of practice time per week, and there has been a 34.2% reduction in antibiotic prescribing, among other benefits (34).

2. Great Britain

a. Areas of Practice

Pharmacist independent prescribers in Great Britain work in hospital pharmacy, community pharmacies and primary care, including general practice, urgent care provider settings, care homes and hospices, as well as prison pharmacies (31). Pharmacist prescribers, as part of their role, may also clarify and amend prescriptions, make dosage adjustments, deal with referrals and test requests and carry out follow- up care.

The governments and health systems across Great Britain (England, Scotland and Wales) have invested in a substantial number of new roles for pharmacist prescribers, including in general practice (35) though national pharmacy strategies vary across the three countries (35).

b. Community pharmacies

Pharmacist prescribers in community pharmacies across Great Britain may prescribe for people who walk in or have been referred for a range of minor conditions and short-term illnesses as well as for some long-term conditions (36).

Pharmacist prescribing in community pharmacies appears to be more established in Scotland than in Wales and England. A 2019 survey of pharmacists (31) showed that 14% of pharmacist prescribers who had prescribed in the last 12 months were based in community pharmacies in Scotland versus 7% in England and 5% in Wales. Since then, an expanded NHS community pharmacy service called Pharmacy First Plus has been launched in Scotland that aims to "grow and nurture" independent prescribing in community in a gradual, supportive manner (37). Under this service, the initial core use of Independent Prescribing in community pharmacies will be for the management of acute common clinical conditions. Scottish Government strategy envisions that over time, community pharmacists will be enabled to play a greater role in managing people with long-term conditions by prescribing, monitoring and adjusting medicines, working alongside pharmacists in GP practices, GPs and other members of the multidisciplinary team (38).

NHS Wales has recently launched a publicly funded Pharmacy Independent Prescribing Service (PIPS) in community pharmacies that is free of charge for patients to access. The scheme provides funding for approved pharmacist-independent prescribers to provide a patient consultation service for a range of clinical conditions and circumstances and to prescribe if necessary (39).

NHS England also intend to make greater use of community pharmacists' skills and opportunities to engage patients while also exploring further efficiencies through reform of reimbursement and wider supply arrangements (40).

The General Pharmaceutical Council (GPhC) guidance for pharmacist prescribers outlines that "pharmacist prescribers should keep the initial prescribing separate from the supply of medicines prescribed" for patient safety and to minimise risk (36). A recent position statement from the Royal Pharmaceutical Society/ Royal College of Nursing on prescribing and dispensing by the same healthcare professional (41) outlines that "wherever possible, the actions of prescribing and dispensing are performed by separate healthcare professionals. Where there is a risk assessment in place and in the best interests of the patient, the same healthcare professional can be responsible for the prescribing and dispensing/supply/administration of medicines."

c. Primary care

Across Great Britain in primary care, pharmacist independent prescribers work as part of wider multi-disciplinary teams such as GP practices, as well as exercising their prescribing role in other settings such as care homes and substance misuse clinics(42).

In Scotland, pharmacist prescribing activities in general practice teams include medication/polypharmacy reviews, contributing to prescribing efficiency, interpreting prescribing data, audit/service improvement, medicines reconciliation, hospital discharge letters, monitoring/review of high-risk medicines, hospital outpatient requests, medicine safety reviews/recalls and chronic disease clinics(43).

The Scottish Government (38) considers that pharmacist prescribing in general practice, including prescribing, monitoring and adjusting treatment where appropriate, frees up GP time to spend with people with more complex care needs and supports multidisciplinary team working and improved medication management.

c. **Primary care** (continued)

Scottish Government strategy (38) has also identified a role for GP practice-based pharmacist independent prescribers at the "interfaces of the profession", working closely with hospital pharmacists, community pharmacists and care homes to ensure seamless care and reduce potential medication-related problems and errors, including on hospital admission and discharge. The Royal College of General Practitioners and the Royal Pharmaceutical Society in Scotland released a joint policy statement about GPP describing their guiding principles which includes that pharmacists should be professionally autonomous, included in local health board governance arrangements (whether employed by the health board or privately by the GP practice), professionally accountable, primarily patient-facing and undertaking roles that are directly linked to improving the pharmaceutical care of patients(44).

In England, pharmacist-independent prescribers work as clinical pharmacists as part of general practice teams (45). As highly qualified experts in medicines, clinical pharmacists carry out structured medication reviews for patients with ongoing health problems and improve patient safety, outcomes and value from medicines through a person-centred approach (46). Clinical pharmacists consult with and treat patients directly, including providing extra help to manage long-term conditions, advice for those on multiple medicines and better access to health checks. NHS England (46) describes the role as pivotal to improving the quality of care as well as releasing GP capacity.

There are currently over 1,000 clinical pharmacists working in General Practice in England (46) and this is planned to be substantially expanded under the NHS Long Term Plan (40) which sees clinical pharmacists as a "key part" of the general practice team in primary care networks working alongside GPs and nurses (46).

3. New Zealand

a. Areas of Practice

In New Zealand, pharmacist prescribers may work in a number of areas of practice, including hospitals and primary care. Examples of pharmacist prescriber roles in non-hospital settings in New Zealand are:

- Working as a generalist pharmacist prescriber in primary/ambulatory care, such as a GP practice, prescribing in a broad range of therapeutic areas like polypharmacy, chronic disease management (including repeat prescribing) and addressing specific areas such as gout and diabetes.
- Working as an aged care facility pharmacist (47).

Pharmacist prescribers in New Zealand can write a prescription for a patient in their care to initiate or modify therapy (including discontinuation or maintenance of therapy originally initiated by another prescriber).

They can also provide a wide range of assessment and treatment interventions, including ordering and interpreting tests, assessing and monitoring a patient's response to therapy and providing education and advice to a patient on their medicine therapy (47). Prescribing pharmacists must apply to the pharmacy regulator where they have a financial interest in a pharmacy (48).

4. USA

The American College of Clinical Pharmacy define Collaborative Drug Therapy Management (CDTM) as "a collaborative practice agreement between one or more physicians and pharmacists wherein qualified pharmacists working within the context of a defined protocol are permitted to assume professional responsibility for performing patient assessments; ordering drug therapy-related laboratory tests; administering drugs; and selecting, initiating, monitoring, continuing, and adjusting drug regimens(49). The Centers for Disease Control, in 2012, reported that the majority of states permit CDTM for health conditions as specified in a written provider protocol in any setting (Alaska, Arizona, Arkansas, California, Colorado, Connecticut, District of Columbia, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kentucky, Louisiana, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Jersey, New Mexico, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Utah, Vermont, Virginia, Washington, Wyoming). Some States limit it to certain health settings (New Hampshire, New York, Nevada, North Dakota, Texas, West Virginia) while others permit more restricted collaborative practice for pharmacists under protocol such as immunizations and emergency contraception regardless of setting (Delaware, Illinois, Kansas, Maine, Wisconsin)(22,49,50).

a. Areas of practice including community pharmacy and non-hospital settings

The Advanced Practice Pharmacist licence allows pharmacists to provide services in community-based settings that have traditionally been limited to hospitals and clinics (51) however, medication therapy management services for patients by community pharmacists would appear to be still emerging (52). As of September 2023, there were 1,210 licenced Advanced Practice Pharmacists in California. This is in comparison to a total of 49,906 licensed pharmacists (53).

The first Advanced Practice Pharmacist licences were issued in California in 2017. Legislation was amended in 2021 to expand the authority for Advanced Practice Pharmacists to initiate, adjust, or discontinue drug therapy beyond health care facilities "without specifying the manner of such actions" (54). Previously, prescribing by Advanced Practice Pharmacists was on a collaborative practice basis under a Collaborative Practice Agreement with a prescriber (53). Legislation appears to emphasise that the pharmacist is not the "diagnosing prescriber". Pharmacists must also register with the federal Drug Enforcement Administration prior to initiating or adjusting a controlled substance therapy (55).

Pharmacists with this licence may, within or outside of a licensed pharmacy:

- perform patient assessments,
- order and interpret drug therapy-related tests,
- refer patients to other health care providers,
- participate in the evaluation and management of diseases and health conditions in collaboration with other health care providers, and
- initiate, adjust or discontinue drug therapy (as long as they notify the diagnosing prescriber (56).

Other forms of pharmacist prescribing also exist in California, including initiating, adjusting, or discontinuing drug therapy under a collaborative practice agreement with an authorised prescriber (57).

5. Canada

In Canada, pharmacists in several provinces can independently prescribe most schedule 1 drugs (excluding those regulated under the Controlled Drugs and Substances Act). Pharmacists in Alberta can independently alter another prescriber's original prescription. Through collaborative agreements in Alberta, Saskatchewan, Manitoba, New Brunswick, and Nova Scotia, pharmacists can also modify original prescriptions written by other prescribers. They may change a medicinal product's dosage, formulation or regimen across the country, except in Northwest Territories, Yukon and Nunavut. In Alberta, Manitoba, Quebec and Nova Scotia, pharmacists are allowed to order and interpret laboratory tests(22,58).

a. Alberta, Canada

Pharmacists in Alberta with Additional Prescribing Authorisation (APA) may prescribe Schedule 1 (prescription only) medicines in accordance with the restricted activity regulation (59) and pharmacist standards of practice. Under the current standards of practice pharmacists must not prescribe controlled drugs (60).

Pharmacists also must only prescribe in Alberta:

- based on their assessment of the patient, a recommendation from a prescriber or consultation with another regulated health professional, and
- where they have an adequate understanding of the medicine and condition and adequate information about the patient's health status and condition, among other requirements (60)

Community pharmacies and other settings

Pharmacists with additional prescribing authorisation work in community pharmacies, clinic settings, continuing care settings, and hospitals as part of interdisciplinary teams and primary care networks (61) where they assess health and drug therapy needs, work with patients to develop health plans, educate and support patients to use treatments properly, coach patients about healthy living, direct pharmacy teams (including registered pharmacist technicians) (62) and manage drug therapies for chronic conditions (61). Standard 15 of the pharmacist standards of practice sets out when it is appropriate for a pharmacist to both prescribe and dispense the same medicine for a patient (60).

Additional prescribing authorisation activities include:

1. Initial access prescribing – prescribing when a patient chooses a pharmacist for advice about and treatment of conditions that have not been previously assessed by another health professional.
2. Prescription modification – modifying a prescription written by another prescriber to alter dosage, formulation, regimen or duration of the prescribed drug or provide a therapeutic alternative to improve drug therapy or provide continuity of therapy.
3. Drug therapy management – initiating, maintaining, modifying or changing drug therapy (61).

Pharmacists in Alberta generally work in private pharmacies and are paid out of the income generated from the sale of prescriptions (63). Pharmacists also receive remuneration through the Alberta Blue Cross Pharmaceutical Services Provider Agreement, which includes funding for certain primary care services, such as authorisation to prescribe certain types of drugs and administer drugs by injection (63).

The Alberta Ministry of Health plans to fund community pharmacies to support new ways of working that are patient and outcome-focused, that help fill gaps in the health care system, for example, community pharmacy as a health hub and that support community pharmacists to use their full scope and contribute to overall increased capacity of the health system and population health (63).

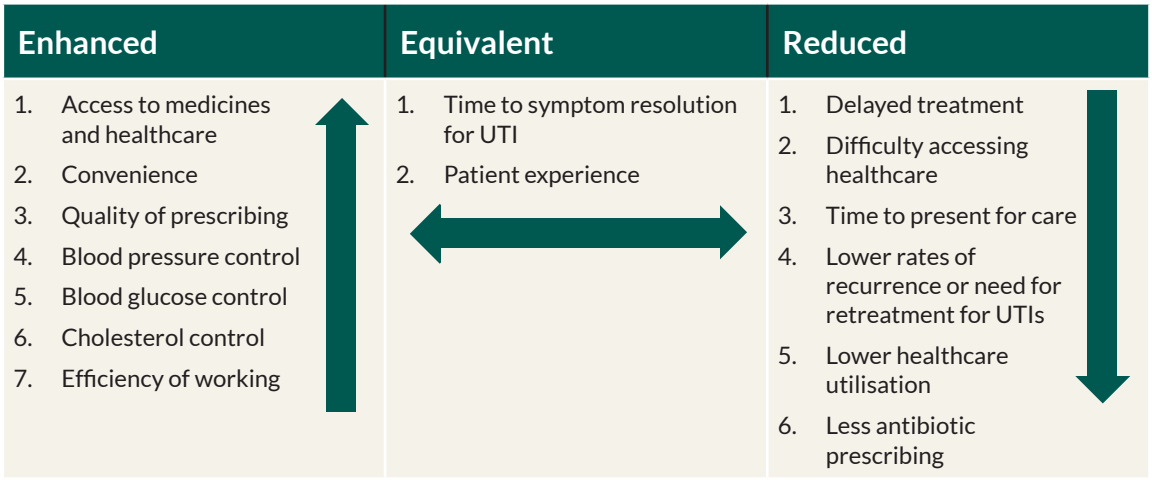


Figure 2: Summary of the evidence of the effect of pharmacist prescribing across primary care settings

Discussion and Analysis

Experience with General Practice Pharmacists in Ireland

Several scientific studies have reported on two research interventions to assess the benefit of a general practice pharmacist (GPP) in Ireland (64–66). One of these was a descriptive service evaluation (64) and the other involved a feasibility study (65) and a service evaluation (66).

Both interventions involved pharmacists working within a general practice, contributing to a variety of medication optimisation activities, including medication review and recommendations to the GP. This model of medication review and recommendation could be regarded as a form of dependent or collaborative prescribing, although all prescription changes needed to be implemented or signed off by the GP. The studies reported that both interventions were positively associated with rationalising the number of medicines used per patient, reducing the indicators of potentially inappropriate prescribing, and identification of high-risk medication issues.

Both Cardwell's and O'Ciardha's studies of GP pharmacists suggested that their input was beneficial in identifying and resolving medication-related problems; however, both studies also named the absence of pharmacist prescribing authority in Ireland as a limitation on achieving the full clinical benefit of the pharmacist's involvement in the patient's care.

A service evaluation of the iSimpathy service delivered across Scotland, Northern Ireland and the Republic of Ireland provides further insights into the feasibility and potential benefits of a pharmacist working collaboratively within a general practice to optimise medication for patients with complex medication regimes(67). The iSimpathy evaluation reported that GPPs in Ireland caring for patients with complex medication needs contributed positively to rationalising the number and appropriateness of medicines used per patient, and the identification of high-risk medication issues that required review. Most patient respondents themselves reported improvements in their understanding of their medication and their experience of adverse effects (ADRs, adverse drug reactions).

Interestingly, however, there were notable differences in the nature of the intervention, the baseline medication use characteristics and the benefit derived from the service between Ireland and the other jurisdictions. In both Scotland and Northern Ireland, the pharmacist exercised prescribing authority, but in Ireland did not. The appropriateness of medication use before the service was delivered was statistically significantly lower in Ireland than in Scotland or Northern Ireland, suggesting a lower quality of prescribing in Ireland than elsewhere. Finally, the findings suggest that the ultimate appropriateness of prescribing after the service was delivered was better in Scotland and Northern Ireland than in Ireland. Despite these differences, an economic cost-benefit analysis of the iSimpathy service delivered in Ireland reported it to contribute to substantial cost savings for the health service(68). A possible reason for the intervention being less effective in Ireland than in Northern Ireland or Scotland is the absence of the Irish pharmacists' independent prescribing authority.

The resources required to staff such a service would be considerable and would require significant investment in development of the workforce over a number of years. There are currently over 7000 pharmacists on the PSI register, a number which has been rising for the last several years. There are plans in place to increase places for pharmacists in universities across Ireland, but this will take time to be realised and will require significant investment.

Experience with Prescribing in a Community Pharmacy in Ireland

Studies have explored GP's and community pharmacist's perceptions of expanding the role of community pharmacists in Ireland. Hansen et al surveyed community pharmacists on their role in rationalising potentially inappropriate prescribing (PIP). Moore et al surveyed community pharmacists and GP's opinions on the expansion of the role of the pharmacist, including prescribing; and Cadogan & Ryder surveyed community pharmacists on their contribution to the management of people using long-term benzodiazepines(69-71).

The findings of these studies suggested that GPs were concerned that community pharmacist prescribing would result in cross-prescribing, fragmentation of care and problems in record keeping. Community pharmacists in 2019 perceived their need to prioritise their time and focus on more immediately unsafe issues, such as major drug- drug interactions, rather than reviewing medication lists for PIP, which they felt have more medium or long-term implications for the patient's safety. An earlier survey reported that 95% of community pharmacist respondents favoured increasing their prescribing power (70). Pharmacist's perceived challenges to their contribution to reduce inappropriate prescribing included their existing workload and the need for protected time to perform medication review. Community pharmacists reported that their existing knowledge and train ing would support their expanded role to pharmacist prescribing and to identify PIP (69,71).

Consideration of the evidence in an Irish context

There is international evidence, mostly from the UK, USA, Canada and Australia of models of pharmacist independent prescribing in a variety of primary care settings, including (1) community pharmacy, (2) general practice and (3) residential care. The available evidence largely supports this role expansion, showing positive effect on patient safety and healthcare utilisation, and acceptability by key stakeholders, including patients. There was no evidence identified that described harm or inferior outcomes associated with pharmacist prescribing in primary care, as compared to traditional prescribing. Notably, in all circumstances, the pharmacist independent prescriber's activity was within their scope of practice and clinical competence, and a strong enabler was communication within the healthcare team, and often with the traditional medical prescriber. The evolution of these models across the UK, Canada, USA and New Zealand has seen the development and implementation of both public and private service delivery.

The evidence also suggests that the positive implementation of such role expansion is dependent on several key enablers, which will likely also be of critical importance for Ireland. These include:

- The provision of dedicated training and assessment of pharmacist independent prescribers, including both the postgraduate prescribing qualification (this is described in Chapter Five) and further training to support their induction and integration into the primary care practice setting.
- The provision, for other primary care staff and stakeholders, of training to support the implementation and integration of this novel pharmacist role.
- The optimisation of collaboration and communication between pharmacist independent prescribers and the healthcare team.
- The planning and delivery of the supporting infrastructure to facilitate successful delivery of the expanded role of pharmacist prescribers, including physical infrastructure such as clinic space, access to patient records, and dedicated time to communicate interprofessionally.
- The development of a funding model to support pharmacist independent prescribing activity in primary care.

eHealth Transformation Programme Underway

The DoH and HSE are implementing a significant eHealth transformation programme within the Health Service. This includes the development and introduction of the Shared Care Record, ePrescribing and ICT communications between professionals, which will be essential to the long-term delivery of a safe and patient centred expansion of the independent autonomous prescribing role for pharmacists. These transformation initiatives together are a key enabler to support the implementation timeframe outlined in this report and will provide for the contemporaneous and secure access to national shared care records both at an interprofessional and patient level, to support clinical decision making and patient care transitions within the healthcare system, while reducing the administrative burden for pharmacists and other stakeholders.

The information and communication technology infrastructure in the primary care setting is a key consideration. In community pharmacy, there will be a greater degree of dependency on the introduction of the national eHealth projects to facilitate pharmacist access to the necessary clinical data to support safe prescribing. However, in general practice and in residential care settings, the prescribing pharmacist should be facilitated to have access to the existing health information that exists within those settings to support safe prescribing.

Recommendations

Considering the available evidence and analysis in the context of the Irish healthcare service, the Taskforce recommends:

1. That pharmacists be enabled to exercise independent, autonomous prescriptive authority within and related to the individual practitioner's scope of practice and competence.
2. The development, over the coming years, of models of pharmacist prescribing within primary care settings, recognising the requirements for specific enablers, including the development of a plan which may facilitate the participation of pharmacists within General Practice.
3. Educational courses of training underpinned by legislative and regulatory authority must be undertaken to facilitate this expanded scope of practice.
4. The eHealth transformation initiatives are a key enabler to support the implementation of models of independent prescribing within primary care.

Chapter Nine: Communication and Engagement

Introduction

As discussed in the document, the role of pharmacists in Ireland is expanding, necessitating a strong emphasis on effective communication and engagement with both the public and stakeholders. This chapter explores the critical importance of ongoing communication and engagement and makes recommendations to support this.

Evidence, Background, Discussion and Analysis

Communications with Stakeholders

The Terms of Reference of the Taskforce specifically call out the responsibilities of the Taskforce and include "... be guided by a holistic approach which encompasses wide ranging perspectives to focus at a minimum on best practice principles in … engagement and consultation." Engagement is also one of the fundamental principles of Sláintecare(1).

Appropriate engagement, communication and consultation with relevant stakeholders are essential to ensure the successful implementation of the recommendations of the Taskforce.

Aims

- Work in partnership with stakeholders to make sure their voices are heard in our work.
- Support healthcare professionals through changes to their roles and changes to the roles of their healthcare colleagues.

Challenges

- Developing and distributing pertinent information to stakeholders at appropriate times, providing time for feedback.
- Ensuring stakeholder concerns are heard, understood and addressed in implementation where possible.
- Ensure that healthcare professionals are up to speed on changes to their roles and the roles of their healthcare colleagues.

Stakeholders

Stakeholders include Government Department(s), Healthcare Providers, Healthcare Professionals, Industry Regulators, Industry Bodies, Advocacy Groups, interested Bodies & Organisations and interested members of the public and individuals. Key stakeholders include:

Healthcare Service

Internal communications between key players in the HSE and Department of Health must be initiated and remain ongoing. It is important to implement a schedule of engagement and consultation with internal and external stakeholders to ensure all aspects of the recommendation are considered. As the role of pharmacy becomes more prominent in the Irish healthcare service, key members of the healthcare service must remain engaged with one another.

Pharmacists

"Communicate effectively" is a principle in the pharmacy code of conduct(2). Pharmacists must be able to communicate effectively with patients and other healthcare professionals regarding any changes to their scope of practice. This will require detailed and consistent communications from the PSI to all pharmacists at the earliest opportunity, with support and input from the Department of Health.

Patients and the Public

"The inclusion of patients and the public in the implementation, research and review of the recommendations made by the Taskforce" is one of the main recommendations made by the Taskforce. Accessible communications such as videos, the use of sign languages, with inclusive language that is easy to understand is a critical part of communication with patient and the public. This is discussed further in the "Communications with the Public" section below.

Regulators

The regulation of medicines, pharmacists, pharmacy practice and healthcare is overseen by several key organisations including the HPRA, PSI and HIQA. These bodies ensure the safety, efficacy, and quality of medicines, while also setting standards for pharmacy practice and healthcare delivery. Effective communication amongst these regulators is paramount for patient safety and pharmacy practice as the scope of practice of pharmacy is expanded.

Stakeholder Engagement is made up of 4 complementary streams of activity, with an optional fifth stream:

Stream 1:
Ongoing communications with key stakeholders (DoH, HSE & Regulators). This process helps identify and understand relevant concerns and identify actions. Explanatory information will be developed and shared with key stakeholders at appropriate times. A timeline will be provided for review and feedback to minimise impacts on the implementation programme. Where possible, the input of key stakeholders will be incorporated within the boundaries of a managed consensus.

Stream 2:
Outreach to Healthcare Professionals via representative organisations. Led by DoH, this will require the cooperation and support of some key stakeholders. This process helps identify Healthcare Professionals' concerns and needs. Explanatory information and a survey to structure feedback will be shared with Healthcare Professionals via key stakeholders at appropriate times. A timeline will be provided for feedback to minimise impacts on the implementation programme. This information will be used to inform the communications and training materials for Healthcare Professionals.

Stream 3:
A Public Consultation for stakeholders in the public domain without a relationship with DOH or key stakeholders. This includes known industry bodies, other interested bodies/organisations, advocacy groups and interested members of the public. The Public Consultation will provide some explanatory information and prompt feedback via a survey to structure feedback. An email contact will also be provided for more extensive feedback should an organisation or individual wish to do so. Various known organisations will be contacted to prompt their engagement. Selected public communications will be implemented to bring this to the attention of interested organisations and members of the public. This Public Consultation will be time-limited to minimise impacts on the implementation programme. This process helps identify the concerns of interested organisations and interested members of the public.

Stream 4:
Pharmacist Training and Communications Support via the PSI and the HSE. The PSI and HSE will arrange for the development of training for pharmacists. This training programme will provide pharmacists with a clear understanding of the day-to- day operation of their new responsibilities. It will also guide them in how best to communicate this change to their support staff and their customers. This will be supported by a suite of materials that pharmacists can use to help them communicate the change to their customers.

Ascertaining Public Opinion (continued)

It should be noted that Public Consultation is very effective in gathering the opinions of interested organisations and individuals and, in this way, identifying concerns and issues. However, it may not provide an understanding of the opinions of the general public as it is biased by interested parties self-selecting when engaging. One other stream of activity is also recommended.

[Optional] Stream 5:

A national population survey of a population-representative sample of the general public via a consumer research agency. The survey would ask a series of questions to understand the public awareness of the change, their opinion of the change and their comfort engaging with and any barriers to the change. This survey would be conducted quickly to minimise impacts on the implementation programme. This process helps identify the opinions of the general public and gauge public support for the change.

Table 5: List of Stakeholders

Department of Health [Key Stakeholders]	• Medicines, Controlled Drugs and Pharmacy Legislation Unit • Community Pharmacy, Optical and Aural Policy • GP Services Unit
Health Service Executive [Key Stakeholders]	• HSE Primary Care Reimbursement Service ((PCRS) • HSE National Medication Safety Programme (NMSP) • HSE Antimicrobial Resistance and Infection Control (AMRIC
Regulators [Key Stakeholders]	• Pharmaceutical Society of Ireland (PSI) • Irish Medical Council • Dental Council of Ireland • Nursing and Midwifery Board of Ireland (NMBI) • Health Products Regulatory Authority (HPRA) • Health Information Quality Authority (HIQA
Healthcare Professionals	• Pharmacists • Doctors • Pharmacy technicians • Nurse Prescribers • Midwives • Dentists • Nurses • Administrative Personnel
Healthcare Bodies	• Irish Pharmacy Union (IPU) • Irish Institute of Pharmacy (IIOP) • Irish Pharmaceutical Healthcare Association (IPHA) • Hospital Pharmacists Association of Ireland (HPAI) • Irish College of General Practitioners (IGCP) • Irish Medical Organisation (IMO) • Medicines for Ireland (MFI) • Irish Hospital Consultants Association (IHCA) • Irish Medication Safety Network (IMSN) • Pharmacists in Industry, Education and Regulatory (PIER)
Business	Interested Bodies & Organisations
Advocacy Groups	Examples would include: • Cairde • Citizens Information • Croí • Diabetes Ireland • Irish Cancer Society • Irish Heart Foundation • Irish Patients' Association
Public	Interested members of the public

Table 6: Stakeholder Communications

Who?	Why?	What?	How?	When?	Who? responsibility
DoH HSE Regulators	To identify related concerns and actions	Consultation	Outreach via business-to-business communications	Ongoing (as appropriate)	DoH [primary] HSE PSI Medical Council Dental Council NMBI
Healthcare Professionals	To identify related concerns and needs	Consultation	Outreach via Industry organisations	Ongoing (as appropriate)	DoH [primary] PSI Medical Council Dental Council NMBI HSE
Industry Bodies Interested Bodies & Organisations Advocacy Groups Interested members of the public	To identify related concerns	Consultation	Public Consultation	Q2 2024	DoH
Healthcare Professionals	To support change	Training and Support	Training and Communications Support via the PSI and HSE	Timed to support go- live	DoH PSI

Communications with the Public

Introduction

The concept of pharmacist prescribing is a step forward for the Irish healthcare service, offering potential cost and time savings for the general public.

The successful implementation of pharmacist prescribing will require buy-in from the public. Over time, the public will have the opportunity to build trust in a wider group of prescribers, including pharmacists, expanding their options for obtaining prescriptions beyond the traditional reliance on doctors. This is a significant change in public behaviour. To secure public buy-in, the public must be aware of the change, understand the change, and have a positive attitude toward the change.

Approach

Changing public behaviour takes sustained communications and time; it is best practice to run bursts of behavioural change communications over a period of years to build awareness, understanding, prompt behaviour, and normalise behaviour.

A public communications campaign to deliver behavioural change requires a number of iterative steps.

Initiation & Development:

- Conducting research to understand general public awareness, perceptions, and opinions and identify motivations to change and any barriers
- Identifying goals, objectives and target market
- Identifying budget and timing

Implementation & Go-Live:

- Developing a campaign that will reach the maximum amount of the target market in the most effective manner
- Developing creative and conducting research to identify creative that will engage and persuade the target market
- Producing all creative collateral for all channels
- Setting up communications across all channels

Activation:

- Launching communications on all channels
- Running communications on all channels for the duration of the campaign
- Adapting communications where need arises and channels allow
- Administering budget and timely payments

Measurement:

- Conducting research to understand changes in general public awareness, perceptions, opinions, motivations and barriers
- Measuring the effectiveness of communications on all channels
- Conducting outreach via key stakeholders, ideally reach research tools, to ascertain buy-in from the public

The indicative timeline for a behavioural change campaign is 18 months. This includes 5-6 months for initiation and development, 6 months for implementation and launch, 3 months of activation, and 4 months for measurement.

Best practice is to run bursts of behavioural change communications over a period of years. The outputs of the measurement phase are used to adapt communication strategy and materials if necessary for following bursts.

Recommendations

Considering the available evidence in the context of the Irish healthcare service, the Taskforce recommends:

1. A centrally coordinated communication plan, cognisant of the distinct roles, accountabilities, and expertise of identified stakeholders should be developed, both to explain the changes linked to the introduction of pharmacist prescribing to pharmacists, other healthcare professionals and members of the public, and to facilitate support for and uptake of pharmacist prescribing.
2. Regular engagement should occur between and with relevant stakeholders, including pharmacist representatives, representatives of other existing prescribers, and patients and the public, to provide updates and obtain input to inform the implementation of pharmacist prescribing.

Chapter Ten: Research and Review

Introduction

This chapter provides an insight into the establishment of the Research Sub-Committee, as well as some of the key areas of future research that will give an Irish evidence base for informing, enhancing and evaluating implementation.

Background and Evidence

The Taskforce was keen to understand how the evidence base for informing and implementing pharmacist prescribing was gathered in other jurisdictions. Prof Derek Stewart, Professor of Clinical Pharmacy and Practice, Qatar University, was invited to present to the Taskforce on the 19th of December 2023. Prof Stewart led the research that informed the introduction of pharmacist prescribing in Scotland and has published over forty research papers on pharmacist prescribing with his research group. Prof Stewart described the programme of research that informed the introduction, implementation and evaluation of pharmacist prescribing in Scotland.

This involved systematic review of the evidence of outcomes of pharmacist prescribing, along with gathering views of all stakeholders and conducting education research. He highlighted the importance of using underpinning frameworks and systematically planning the implementation. He is currently using this approach to develop a framework for pharmacist prescribing in Qatar. The Taskforce, in considering the approach taken in other jurisdictions, decided to set up a Research Sub-Committee.

Discussion and Analysis

The Research Sub-Committee was convened by the Chair of the Taskforce in February 2024. The subcommittee is chaired by a Taskforce member and includes three additional Taskforce members. Additional members were appointed from the research and practice communities to ensure diversity across professions and practice settings. The Sub-Committee's Terms of Reference were to develop a research agenda to (1) inform, (2) enhance implementation, and (3) evaluate the effectiveness of the recommendations of the Expert Taskforce to Support the Expansion of the Role of Pharmacy in Ireland.

The Research Sub-Committee supports the Taskforce recommendations that:

a. A programme of funded research should be implemented to monitor the implementation of these recommendations. There should be public and patient involvement in this research.

b. Appropriate robust governance arrangements should be put in place to facilitate, direct and support this ongoing research.
   - A key enabler to this research is access to appropriate data and the availability of indicator variables that (a) a pharmacist extended a 6-month prescription or (b) a pharmacist prescribed a medicinal product. It is recommended that steps should be taken to implement such indicator variables into prescribing and dispensing software.

c. The Department of Health should oversee a review of these recommendations at an appropriate interval of their practical implementation into practice to determine whether its goals are being achieved in accordance with good governance policies and procedures

The Research Sub-Committee considered national and international research findings relevant to the Taskforce's work. Building on this foundation, they collaboratively identified a number of topics for future research, which are presented below.

The Research Sub-Committee also undertook a prioritisation exercise to identify which research questions must be answered, which should be answered, and which could be answered to support the expanded role of the pharmacist. Those that were deemed questions that must be answered were identified below as 'Priority'.

The results of this exercise were further synthesised, taking into account previous and ongoing research projects nationally, current available research funding and the timeline for implementation. Those that were deemed questions that must be answered were identified below as 'Priority'. Those that are being answered through ongoing research projects were identified as 'Ongoing'. Those that need to be started first were marked as 2024, those that need to be done next are marked as 2025. Pre- and post-implementation refers to questions that require baseline data to be collected and then follow up when the role has been expanded.

Research Sub-Committee Recommendations for future research

Considering the available evidence in the context of the Irish healthcare service, the key recommendations for future research can broadly be considered under three headings – Inform, Enhance, and Evaluate.

1. Inform

a. What are the barriers, facilitators and enablers for all stakeholders including patients, public, pharmacists, other healthcare professionals and policy makers, to expanding the role of the pharmacist in Ireland, and how can these be addressed? What can we learn from how pharmacist prescribing has been implemented, and determinants of uptake in various settings, in other countries? (Priority – ongoing 2024)

2. Enhance implementation

a. How can the expanded role of the pharmacist be best integrated into the existing health ecosystem?

b. What is the "theory of change" (how is the desired change expected to happen) for expanding the role of the pharmacist?

c. How can the expansion of the role of the pharmacist be cost-effectively resourced? (ongoing 2024)

d. How can the training and assessment for, and the regulation of, expanded pharmacist roles be optimised?

3. Evaluate

a. What outcomes, such as access to care, quality of care, healthcare utilisation, adverse outcomes, and patient experiences, should be measured to assess the effect and impact of expanding the role of the pharmacist, and how can existing health data sets be managed to optimise data collection for this research? (Priority – 2024)

b. What is the impact of the expanded role of the pharmacist on patient outcomes, including patient self-care and patient/carer medicines optimisation? (Priority – 2025 pre and post implementation)

c. What is the impact of the expanded role of the pharmacist, including cost- efficiencies and effectiveness, on the health service? (pre and post implementation)

d. What is the impact of the expanded role of the pharmacist on General Practitioner, hospital doctor and other prescribers' workload? (pre and post implementation)

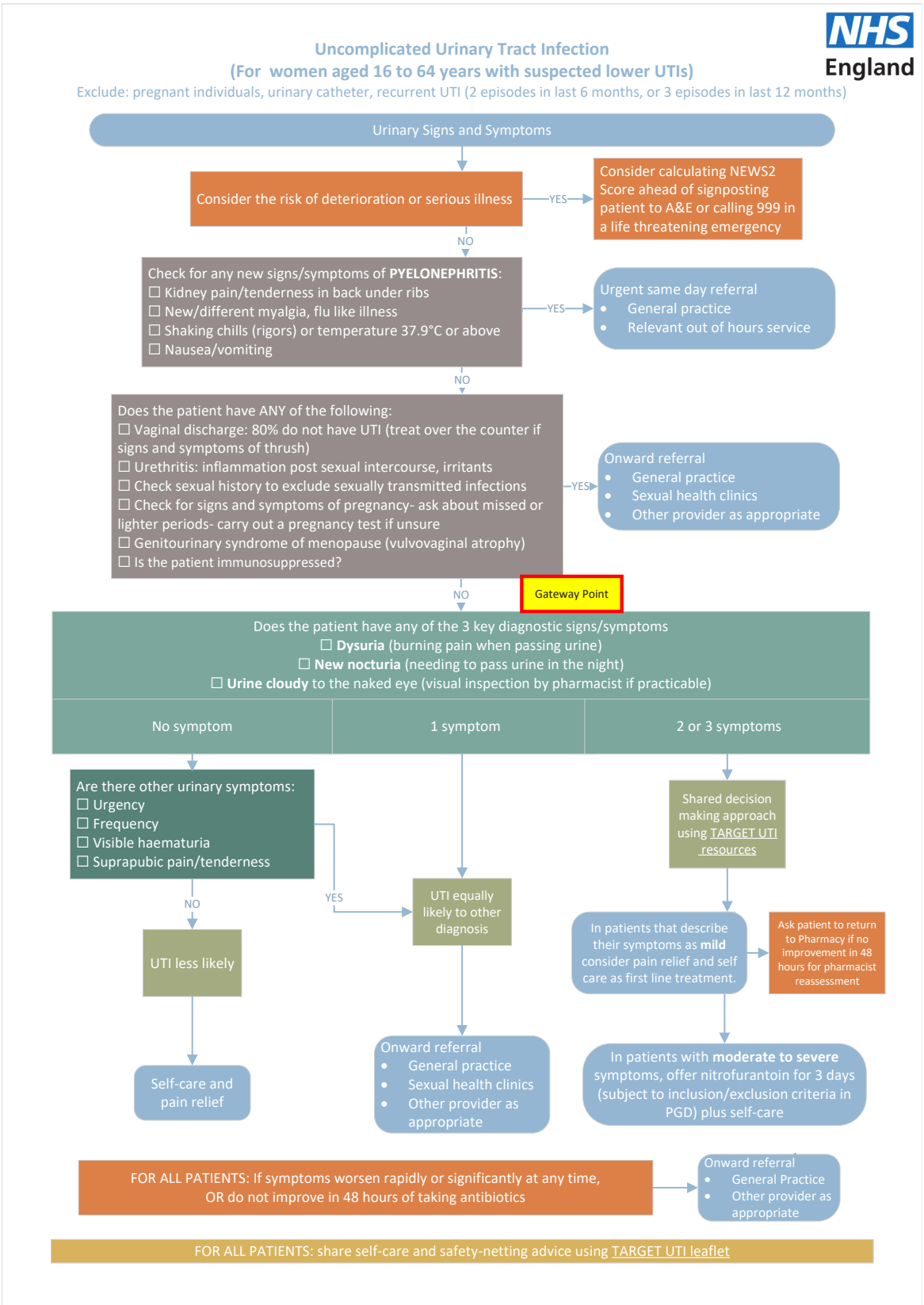
e. What is the impact of the expanded role of the pharmacist on pharmacist role satisfaction, workload and career prospects? (pre and post implementation)

The Research Sub-Committee recommends that given the importance of research, the next priority for 2024 is to identify what outcomes should be measured to capture the effect and impact, and the value of expanding the role of the pharmacist. It is important to concurrently determine how existing health data sets can be optimised to facilitate this research given the considerable personnel resources associated with manual data capture. This is reflected in the Taskforce recommendations that a key enabler to the research will be access to appropriate data, and the availability of indicator variables that are integrated into prescribing and dispensing software.

Appendix 1
Glossary of Terms

AMRIC	Antimicrobial Resistance and Infection Control
BP	Blood Pressure
CCS	Common Conditions Service
CPD	Continuing Professional Development
CPO	Chief Pharmaceutical Officer
CVD	Cardiovascular Disease
DoH	Department of Health
EU	European Union
GPhC	General Pharmaceutical Council
GPP	General Practice Pharmacist
HIQA	Health Information Quality Authority
HPRA	Health Products Regulatory Authority
HSE	Health Service Executive
ICT	Information And Communication Technologies
IIOP	Irish Institute of Pharmacy
IPU	Irish Pharmacy Union
NHS	National Health Service
NMBI	Nurse and Midwifery Board Ireland
PCRS	HSE Primary Care Reimbursement Service
PIER	Pharmacists in Industry, Education and Regulatory
POM	Prescription Only Medicine
PSI	Pharmaceutical Society of Ireland
PSNI	Pharmaceutical Society of Northern Ireland
RPS	Royal Pharmaceutical Society
UK	United Kingdom

Appendix 2
Common Conditions Clinical Pathway Example



Appendix 3
Terms of Reference

Purpose

The purpose of the task force is to support the delivery of specific policy decisions, which will serve to align services and practices that can be delivered by pharmacists, and pharmacies, with the needs of the health service and patients.

Pharmacists are highly trained, valued healthcare professionals. They have extensive training and expertise in medicines. A number of jurisdictions have implemented changes that better enable pharmacists to use their expertise. The Minister for Health wants to ensure pharmacists are empowered to work to the top of their license in Ireland for the benefit of patients and the wider health service.

This Taskforce will examine how to enable pharmacists to use their expertise to operate as independent prescribers. It will initially be requested to consider options to establish a formal mechanism and framework to enable pharmacists to extend prescriptions for a range of medicines and medical conditions where appropriate.

The Taskforce will also advise on a comprehensive approach to facilitate pharmacist prescribing. This will include, but not be limited to, empowering pharmacists to assess and prescribe for common minor ailments within a community pharmacy setting.

Scope

Phase 1 - Empowering Pharmacists to Extend Prescriptions

The Taskforce will:

- Determine the appropriate medicines and conditions for prescription extension;
- Determine the associated maximum extension period;
- Recommend the supporting regulatory, legal, governance and clinical framework;
- Advise on enabling factors including, but not limited to. IT infrastructure, record keeping and data sharing;
- Establish supporting clinical guidance and criteria for application.

Phase 2 - Empowering Pharmacists to Prescribe within their scope of Practice

The Taskforce will:

- Consider the approaches adopted by other countries/healthcare services;
- Recommend the supporting regulatory, legal, governance, training and education and clinical framework that must be established to safely deliver;
- Identify and recommend minimum enabling tools and processes including but not limited to IT infrastructure, records and data management tools;
- Establish clinical guidance, criteria and relevant standards, including education standards for pharmacist prescribing;
- Agree a process to be used for identifying the minor ailments, including criteria for inclusion/exclusion;
- Create a list of these minor ailments, which can be expanded over time.

The Taskforce will leverage, as appropriate, resources, stakeholders, and expertise across the health service.

Responsibilities of the Taskforce

The responsibilities of the Taskforce are to:

- act as a collective group, and at all times be guided by the primacy of patient safety and best patient outcomes;
- support the delivery of strategic projects identified by the Minister, and in such a sequence as the Minister deems appropriate;
- identify and advise on additional strategic projects to mitigate capacity and access challenges within the health system if requested by the Minister;
- be guided by a holistic approach which encompasses wide ranging perspectives to focus at a minimum on best practice principles in
    a. Patient safety
    b. Clinical support and governance
    c. Legislation, regulation, and liability
    d. Infrastructure and resources
    e. Education and training requirements
    f. System viability and coherence
    g. Engagement and consultation.

Taskforce – Working Methodology

The Taskforce will be chaired by Dr Pat O'Mahony, with the membership consisting of experts on capacity, access, pharmacy, and wider health services.

The Taskforce will meet as frequently as the Chair deems necessary to fulfil its objectives having regard to the timeframes outlined above, either by videoconference or face-to-face meetings, as appropriate, and be constituted in the first instance for a period of 26 weeks.

If necessary, and based on a competency gap, the Chair will expand the membership of the Taskforce, subject to the agreement of the Minister for Health.

It will establish expert working groups to support the development and delivery of the aims of the Taskforce as required. Administrative support will be provided by the Department of Health who will work in close cooperation with the Taskforce to achieve its goals.

Appendix 4
Taskforce and Secretariat Members

Dr Pat O'Mahony
Former CEO of the HPRA and a former Deputy Secretary General at the Department of Health, Pat was also Chairman of the Management Board of the European Medicines Agency and the former CEO of Clinical Research Development Ireland (CRDI). Pat is currently Chair of HIQA and Chair of the IMVO

Ms Joanne Kissane
Pharmacist and the Registrar and Chief Officer of the Pharmaceutical Society of Ireland

Ms Kate Mulvenna
Pharmacist and Former Head of Pharmacy Function/Corporate Pharmaceutical Unit PCRS, HSE

Prof. Judith Strawbridge
Deputy Head (Education) of the School of Pharmacy and Biomolecular Sciences at the Royal College of Surgeons in Ireland (RCSI)

Mr Pat Healy
National Director, HSE National Services and Schemes

Mr Keith O'Hourihane
Community Pharmacist and Superintendent Pharmacist of the Pharmacy First Plus Group in Cork. He is also an adjunct Clinical Lecturer at the School of Pharmacy in UCC

Dr Diarmuid Quinlan
Medical Director, Irish College of General Practitioners

Ms Louisa Power
Pharmacist and a Medication Safety Specialist with the National Quality and Patient Safety Directorate of the HSE

Prof. Caitriona O'Driscoll
Professor and Chair of Pharmaceutics in the School of Pharmacy, University College Cork, Ireland

Prof. Michael Barry
Consultant Clinical Pharmacologist and Head of the Department of Pharmacology & Therapeutics at the University of Dublin, Trinity College. He is the Clinical Director of the National Centre for Pharmacoeconomics

Mr Laurence O'Dwyer
Pharmacist and the Scientific Affairs Manager in the Health Products Regulatory Authority (HPRA)

Dr Tamasine Grimes
Associate Professor in Practice of Pharmacy at the School of Pharmacy and Pharmaceutical Sciences at Trinity College Dublin and is a practicing pharmacist

Ms Anne Marie Seymour
Principal Officer, Medicines, Controlled Drugs & Pharmacy Legislation Unit, Department of Health [until January 2024]

Mr Kevin Warren
Principal Officer, Medicines, Controlled Drugs & Pharmacy Legislation Unit Department of Health [January 2024 –]

Ms Bevin Doyle
Assistant Principal, Medicines, Controlled Drugs & Pharmacy Legislation Unit, Department of Health

Ms Sarah Cullen
Pharmacist/Administrative Officer, Medicines, Controlled Drugs & Pharmacy Legislation Unit, Department of Health

Ms Emma Lyons
Executive Officer, Medicines, Controlled Drugs & Pharmacy Legislation Unit, Department of Health

Appendix 5
PPI Sub-Committee Members

Ms Nuala Ryan
Chair of Trustees and Scientific Advisory Board member. NCBRS Worldwide Foundation

Ms Mandy Daly
Director of Education and Research, Irish Neonatal Health Alliance

Ms Siobhán Freeney
Chair European Lobular Breast Cancer Advocates. Founder Lobular Breast Cancer Ireland

Mr Mark Byrne
Cancer Patient, Patient Advocate

Ms Jacqui Browne
EUPATI Fellow, Thalidomide Survivor

Ms Melody Buckley
Advocate for Ocular Melanoma Ireland, Patient Representative, University Limerick Hospitals Group Patient Council

Mr John Dowling
Patient Advocate

Prof. Judith Strawbridge
Deputy Head (Education) of the School of Pharmacy and Biomolecular Sciences at the Royal College of Surgeons in Ireland (RCSI)

Dr Tamasine Grimes
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Mr Laurence O'Dwyer
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Appendix 6
Research Sub-Committee Members

Ms Louisa Power (Chair)
Pharmacist, HSE National Medication Safety Programme (Taskforce Member)

Dr Tamasine Grimes
Associate Professor, Trinity College Dublin (TCD) (Taskforce Member)

Prof Judith Strawbridge
Deputy Head (Education), Royal College of Surgeons Ireland (RCSI) (Taskforce Member)

Mr Keith O'Hourihane
Practicing Pharmacist (Taskforce Member)

Ms Elizabeth O'Halloran
Strategic Policy and Research Coordinator, Pharmaceutical Society of Ireland (PSI)

Dr Kieran Dalton
Lecturer in Clinical Practice, University College Cork (UCC)

Ms Sarah Cullen
Pharmacist, Medicines Unit, Department of Health (DOH)

Dr Robert Murphy
Research Services and Policy, Department of Health (DOH)

Dr Caroline McCarthy
Clinical Lecturer and Research Fellow, Department of General Practice, Royal College of Surgeons Ireland (RCSI)

Ms Leonie Clarke
Chief Executive Officer, Irish Medicines Verification Organisation (IMVO)

Ms Patricia Heckmann
Assistant National Director, National Cancer Control Programme (NCCP)

Dr Catriona Bradley
Executive Director, Irish Institute of Pharmacy (IIOP)

Prof Brian Cleary
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Prof Molly Byrne
Professor of Health Psychology University of Galway, School of Psychology

Ms Claire O'Neill
Community Pharmacist and Boots Teacher Practitioner, Royal College of Surgeons in Ireland (RCSI)

Dr Cormac Kennedy
Clinical Senior Lecturer Trinity College Dublin (TCD), Consultant Clinical Pharmacologist and Physician, St. James Hospital

Appendix 7
Implementation Sub-Committee

The implementation sub-committee has oversight of the implementation of phase 1 recommendations from the Taskforce and is supported by representatives from the HSE, PCRS, Department of Health, PSI, NMBI, Dental Council and Medical Council.

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There are no references for this chapter.