General Pharmaceutical Council

Queen's University Belfast, independent prescribing programme reaccreditation event report, June 2026

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Event summary and conclusions

Provider: Queen's University Belfast

Programme: Independent prescribing programme

Event type: Reaccreditation

Event date: 18 June 2026

Approval period: August 2026 – August 2032

Relevant requirements: **Standards for pharmacist independent prescribers, January 2019, updated October 2022**

Outcome:

The accreditation team has agreed to recommend to the Registrar of the General Pharmaceutical Council (GPhC) and the Council of the Pharmaceutical Society of Northern Ireland (Pharmaceutical Society NI) that the pharmacist Independent Prescribing programme provided by Queen's University Belfast should be reaccredited. There are no conditions or recommendations.

Reaccreditation is recommended for a period of six years, with an interim event to take place in three years' time.

The team's recommendation includes approval for a maximum intake of 1 cohort per year, with a maximum of 30 students (30 pharmacists) per cohort.

The team's recommendation includes approval for:
Maximum number of all students per cohort: 30
Number of pharmacists per cohort: 30
Number of cohorts per academic year: One
Conditions:

There were no conditions.

Standing conditions: Find here **the standing conditions of accreditation**.

Recommendations:

No recommendations were made.

Minor amendments:

- The webinar slides and any other relevant material should be amended to remove the statement that it is a GPhC requirement for a trainee to be withdrawn from the programme with no opportunity for a second attempt for any act of patient harm.

Registrar[1] decision: Following the event, the Registrar is satisfied that the Queen's University Belfast has met the requirement of continued approval in accordance with Part 5 article 42 paragraph 4(a)(b) of the Pharmacy Order 2010, and in line with the Standards for the education and training of pharmacist independent prescribers, January 2019, updated October 2022. The Registrar confirms that Queen's University Belfast is approved to continue to offer an Independent prescribing programme for a period of 6 years with an interim event in 3 years. A copy of this report will be shared with the Council of the Pharmaceutical Society of Northern Ireland (Pharmaceutical Society NI).

Key contact (provider): Dr Mairead McGrattan, Programme Lead, Lecturer (Education) in Postgraduate Pharmacy Practice

Provider representatives:

Dr Mairead McGrattan, IP Programme Lead, Lecturer (Education)
Dr Paul McCague, Director of Education (Pharmacy), Reader (Education)
Professor Sharon Haughey, Associate Dean of Education (Faculty of Medicine, Health and Life Sciences), Professor (Education)
Professor Lezley-Anne Hanna, Professor (Education)
Dr Fiona Hughes, Senior Lecturer (Education)
Dr Mary-Carmel Kearney, Senior Lecturer (Education)
Clare Murray, Lecturer (Education)
Dr Carole Parsons, Senior Lecturer
Dr Chris Spence, Lecturer (Education)

Accreditation team:

Dr Gemma Quinn (event Chair - academic), Head of School of Pharmacy, Optometry and Medical Sciences, University of Bradford
Danny Bartlett (team member – pharmacist), Clinical Lead, Kent, Surrey & Sussex Primary Care School, within NHS England Workforce, Training and Education Directorate
Andrew Middleton (team member – lay), Independent Non-Executive Director, Barnsley Healthcare Federation
GPhC representative: Rakesh Bhundia, Quality Assurance Officer (Education) General Pharmaceutical Council

PSNI representative: Laura Hughes, Registrar and Director of Regulation, Pharmaceutical Society NI

Rapporteur: Professor Brian Furman, Emeritus Professor of Pharmacology, University of Strathclyde

[1] Registrar or appointed delegate

Introduction

Role of the GPhC

The General Pharmaceutical Council (GPhC) is the statutory regulator for pharmacists and pharmacy technicians and is the accrediting body for pharmacy education in Great Britain. The accreditation process is based on the GPhC's standards for the education and training of pharmacist independent prescribers, January 2019, updated October 2022.

The Pharmacy Order 2010 details the GPhC's mandate to check the standards of pharmacy qualifications leading to annotation as a pharmacist independent prescriber. It requires the GPhC to 'approve' programmes by appointing 'visitors' (accreditation and recognitional panel members) to report to the GPhC's Council on the 'nature, content and quality' of education as well as 'any other matters' the Council may require.

The GPhC undertakes accreditation of pharmacy education in Northern Ireland on behalf of the Pharmaceutical Society of NI (PSNI). This accreditation process was undertaken by a GPhC accreditation team on behalf of the Pharmaceutical Society of NI. The event was overseen by a representative from each of the respective pharmacy regulators.

The powers and obligations of the GPhC in relation to the accreditation of pharmacy education are legislated in the Pharmacy Order 2010. For more information, **visit the Legislation page on our website**.

Background

Queen's University Belfast was accredited by the GPhC in 2019 for a period of three years to provide a course to train pharmacist independent prescribers. This course had been re-designed to meet the 2019 GPhC standards. The course was reaccredited by the GPhC in 2023 without conditions and no recommendations were made. In line with the standards for the education and training of pharmacist independent prescribers (January 2019, updated October 2022), an event was scheduled on June 18, 2026, to review the programme's suitability for reaccreditation, and the following is a report of that event.

Documentation

Prior to the event, the provider submitted documentation to the GPhC in line with the agreed timescales. The documentation was reviewed by the accreditation team, and it was deemed to be satisfactory to provide a basis for discussion.

The event

The reaccreditation event was held remotely by videoconference on 18 June 2026 and comprised meetings between the GPhC accreditation team and representatives of Queen's University Belfast prescribing programme. Students who were currently undertaking the programme, or who had completed it in the last three years, contributed to the event by completing a qualitative survey, responses to which were reviewed by the GPhC accreditation team. A qualitative survey was also sent to Designated Prescribing Practitioners (DPPs) currently supervising students on the programme, or who

had supervised students in the past, the responses to which were also reviewed by the GPhC accreditation team.

Declarations of interest

There were no declarations of interest.

Schedule

Meeting 1: Meeting with course provider representatives

Meeting 2: Learning outcomes testing session

Meeting 3: Deliver outcome to the provider

Attendees

Provider/Awarding organisation representatives:

Dr Mairead McGrattan, IP Programme Lead, Lecturer (Education)
Dr Paul McCague, Director of Education (Pharmacy), Reader (Education)
Professor Sharon Haughey, Associate Dean of Education (Faculty of Medicine, Health and Life Sciences), Professor (Education)
Professor Lezley-Anne Hanna, Professor (Education)
Dr Fiona Hughes, Senior Lecturer (Education)
Dr Mary-Carmel Kearney, Senior Lecturer (Education)
Clare Murray, Lecturer (Education)
Dr Carole Parsons, Senior Lecturer
Dr Chris Spence, Lecturer (Education)

Key findings - Part 1 Learning outcomes

The team reviewed all 32 learning outcomes relating to the independent prescribing programme. To gain additional assurance the team also tested a sample of **three** learning outcomes during the event was satisfied that **all 32 learning outcomes continue to be met** to a level as required by the GPhC standards.

The following learning outcomes were tested at the event: **12, 22, 26**

Domain: Person-centred care and collaboration (learning outcomes 1 - 6)

Table 1: Learning outcomes' assessment decision for learning outcomes 1 to 6

Learning outcomes	Met	Not met
Learning outcome 1 - 6	✓	☐

Domain: Professionalism (learning outcomes 7 - 15)

Table 2: Learning outcomes' assessment decision for learning outcomes 7 to 15

Learning outcomes	Met	Not met
Learning outcome 7- 15	✓	☐

Domain: Leadership and management (learning outcomes 16 - 26)

Table 3: Learning outcomes' assessment decision for learning outcomes 16 to 26

Learning outcomes	Met	Not met
Learning outcome 16 - 26	✓	☐

Domain: Leadership and management (learning outcomes 27 - 32)

Table 4: Learning outcomes' assessment decision for learning outcomes 27 to 32

Learning outcomes	Met	Not met
Learning outcome 27 to 32	✓	☐

Key findings - Part 2 Standards for the initial education and training of pharmacists

Standard 1: Selection and entry requirements

Table 5: Standard 1 – outcome decision

Standards	Met/will be met	Not met
Standard 1	✓	☐

The team was satisfied that all six criteria relating to selection and entry requirements continue to be met.

The documentation described how the selection process ensures that only applicants who meet the GPhC's and the University's defined entry requirements are admitted to the programme. The website defines these criteria and informs applicants that the course requires a five-day residential period in Belfast. Each application is screened individually by a designated, appropriately trained member of the Application Review Team, with the Programme Lead having full oversight of this process. A standard scoring rubric is utilised to ensure a consistent and fair application of the course entry requirements to each applicant. The rubric addresses all the entry requirements of the programme. Following individual review, the programme team meets to consider all applications. This team-based approach ensures a consistent interpretation of the entrance requirements ensuring an unbiased approach and internal verification of application of the admissions criteria. Where applicants are rejected, the rationale supporting this decision is clearly documented and the applicant is provided with meaningful feedback explaining the reasons for rejection and advice and guidance about the personal development activities the applicant could undertake to support a future reapplication. In response to the team's wish to know how the School ensures that the more subjective aspects of applicants' responses, such as 'prescribing skills and attributes', are scored consistently across the selectors, the staff explained that the rubric used is helpful and that applicants must provide concrete examples of their prescribing. All staff members are experienced pharmacist prescribers, who work effectively as a team and as indicated above, meet to discuss the applications once all have been assessed.

Noting that each application must be accompanied by a form from the applicant's workplace organisation confirming the organisation's support for the applicant to undertake their training as an independent prescriber, the team asked who would sign this form for self-employed or locum pharmacists. The staff explained that this situation had not yet arisen, but where there was uncertainty, the applicant would discuss this with the Programme Lead, whose contact details are provided in the 'Information for Pharmacists' document. The team agreed that while this aspect of the application process is clear for hospital and primary care pharmacists, the School should consider developing clearer processes for dealing with community pharmacists and locums, applications from whom will increase in number.

Where the number of eligible applicants exceeds the maximum course capacity, applicants are ranked according to their total score, and places are offered to the highest-scoring applicants. If two or more applicants achieve the same score at the selection threshold, a pre-defined tie-break process is applied.

Probing this further, the team was told that the tie-break process is based on the applicants' response to a specific question on the application form focussing on how they will use their prescribing qualification to optimise patient care in their practice.

Standard 2: Equality, diversity and inclusion

Table 6: Standard 2 – outcome decision

Standards	Met/will be met	Not met
Standard 2	✓	☐

The team was satisfied that all five criteria relating to equality, diversity and inclusion continue to be met.

The documentation described how the principles of equality and diversity are embedded in, and promoted throughout, the design and delivery of the programme. Material is presented in multiple forms on the Canvas virtual learning environment, with videos automatically having transcripts to improve accessibility. The University has systems and policies for capturing equality and diversity data, including those relating to protected characteristics, these data being requested annually by the Programme Lead. As most trainees are under the age of 35, with representation across a wider range of age groups, the design of the programme avoids assumptions about prior experience and ensures transparency in learning activities, assessment formats and expectations. The ethnic diversity of trainees is reflected within learning materials and assessments, and practical arrangements during residential teaching accommodate cultural and religious considerations. The University has established processes to support reasonable adjustments in learning and assessment in line with institutional policy. In the 'Professionalism' module, trainees learn, through patient-based case studies and assessments, how to apply a professional decision-making model to a range of prescribing dilemmas, including applying their knowledge of equality and human rights legislation to these dilemmas. Trainees learn the importance of respecting cultural differences and diversity when dealing with aspects of prescribing and patient-centred care.

Noting that the submission stated that no patterns/trends had been identified in terms of protected characteristics in relation to progression or module failure, the team asked about the processes for monitoring and identifying how attainment and progression are impacted by protected characteristics. The staff described how the processes also include scrutiny of admissions. Overall, the pass rates are high within cohorts, and the processes involve examination of performance according to the nine protected characteristics including age, disability, sex, sexual orientation and religion. So far, no EDI issues have been identified. However, if any trends are seen, the School will produce an action plan which would be escalated through the Distance Learning and Education committees. All trainees are treated equally and if trainees appear to be underperforming, they would be offered a meeting and support. If the School identified a subgroup within a cohort that seemed to be underperforming, additional support would be offered where required and progress would be monitored.

The team noted that disability data showed variation across cohorts, with 13.3% of students declaring a disability in 2023/24 and 2025/26 compared to 3.1–3.4% in adjacent years and asked if this reflects year-on-year fluctuations, changes in disclosure rates, or a systemic factor. The staff explained that it is hard to draw any conclusions because the absolute numbers are very small in each case. However, if this increase in students with a disability is seen in the next cohort, the School will investigate further. Wishing to understand how reasonable adjustments are operationalised in a predominately distance-

learning, time-pressured programme, the staff described how the Adviser of Studies deals with requests for exceptional circumstances and extension of deadlines, for which trainees must give a reason. The process for declaring disabilities occurs at the time of application and the University has frameworks and support for flexible learning. Trainees are signposted to the central Accessible Learning Support service, following which the School Disability staff consider any reasonable adjustments required through direct liaison with the trainee to ensure that they meet the learning outcomes. Recent examples of adjustments during the residential week include the provision of a modified stethoscope for a trainee with hearing impairment and of laptops for students with dyslexia.

Standard 3: Management, resources and capacity

Table 7: Standard 3 – outcome decision

Standards	Met/will be met	Not met
Standard 3	✓	☐

The team was satisfied that all six criteria relating to management, resources and capacity continue to be met.

The documentation described the management plan for the programme, in which a tripartite learning agreement clearly sets out the roles and responsibilities of the University, the student and the designated prescribing practitioner (DPP), and whom to contact if there are concerns about safety in the learning in practice environment. The Head of School has overall responsibility for the School's educational portfolio, with management of accredited pharmacy courses devolved to the Director of Education (Pharmacy). In response to the team's wish to know who is responsible for monitoring the completion of the tripartite learning agreement and about the process if it is not completed on time, the staff described how this is one of the admission criteria and is reviewed as part of the application process. The trainee is not accepted until this has been completed. Asking about the process for identifying risks and adding them to the Faculty risk register, the team was told that the School's risk register is updated by members of the School Management Committee in response to issues identified by the Education Committee. Only very significant risks are reported to the Faculty. No significant programme-specific risks requiring escalation had been identified in relation to the IP programme, although staffing capacity is routinely monitored and managed through appropriate mitigation measures and access to resources.

The documentation stated that there are sufficient appropriately qualified and experienced professionals to deliver the course and provide support. The Programme Delivery Team is supported by the wider administration team and an e-learning developer. The Programme Lead is a qualified independent prescribing pharmacist with extensive experience of general practice and is supported by five other pharmacist staff members within the School of Pharmacy, three of whom are qualified independent prescribers. Noting the role of the Programme Lead and wishing to know what contingency and/or succession planning is in place if the Programme Lead is unavailable, the team was told that the programme is planned so that it does not rely on a single individual. Delivery and oversight sit with the wider programme team, who are all pharmacist independent prescribers and are familiar with the programme and its standards The School's Director of Education could step in in the event of an emergency, but there are several other staff members who could deputise and whose responsibilities would be reallocated accordingly. Course delivery is also supported by four external pharmacists, all of

whom are independent prescribers, and a nurse, who work on a sessional basis to deliver the programme and provide support. Asking how new staff members are inducted into the programme and supported to mark effectively, the team was told that there is a formal induction process and new members of academic staff undergo training to achieve Fellowship of Advance HE through a portfolio that demonstrates their proficiency in assessment and teaching. Peer review of teaching includes new staff members, who also receive mentorship. For teaching clinical skills, new staff members shadow an experienced member of staff, and double marking is undertaken for at least 10% of assessments for those who are new to marking and assessment. There is a recorded webinar on assessing the portfolio, and marking of portfolio evidence by new assessors would be checked through double marking.

Trainees are supported by various learning materials, which are reviewed annually and delivered through Canvas, the University's virtual learning environment. In addition to course specific learning materials, trainees have access to numerous other online resources and learning materials via the University library. Trainees complete the modules on the course using e-learning, webinars, in-practice learning and a one-week residential course in Belfast. In addition, trainees document evidence of their competencies using an e-portfolio throughout the course. They are supported by regular webinars, which are recorded, and have access to the same clinical skills resource materials as the University's medical students through the Clinical Skills Education Centre (CSEC) website. Here, trainees can access learning materials on background anatomy and videos for performing a wide range of physical examination skills. The residential week is held within the University's interprofessional simulation centre, in which there is ample space and clinical resources to accommodate the cohort. Trainees have access to simulated wards, acute care and general practice environments, which all contain equipment normally used in clinical practice, including high fidelity computerised mannequins. During the five-day residential course, students work in small groups to practise undertaking physical examinations on healthy volunteers. The GPhC's survey of trainees showed a very high level of satisfaction with the resources available to them.

Noting the requirement of criterion 3.6 for regular liaison between designated prescribing practitioners (DPPs) and course providers, the team asked about the contact that DPPs receive after modules 1, 3 and 5 and if they are required to submit any documentation at these points. The staff explained that contact at scheduled checkpoints is via an email asking DPPs about any concerns or need for support. The process of liaising with DPPs has been enhanced since Queen's has been approved to use non-medical DPPs. The new process requires trainees to submit records of their meetings with DPPs. The team noted that according to the GPhC's survey of trainees, some students had not seen their DPP frequently. The staff described how trainees are constantly reminded of the importance of informing the School of any problems such as the frequency of meetings with their DPP. The new system will allow staff to follow up if trainees have not uploaded their records of DPP meetings. Additionally, requests for time extensions by students will trigger follow up.

Standard 4: Monitoring, review and evaluation

Table 8: Standard 4 – outcome decision

Standards	Met/will be met	Not met
Standard 4	✓	☐

The team was satisfied that all six criteria relating to monitoring, review and evaluation continue to be met.

The documentation described how the programme is monitored through a quality-assurance framework that operates at module, programme, School and University levels. All relevant aspects of the course are reviewed systematically, and any issues identified are documented and addressed within agreed timescales. Each module undergoes a formal module review following every delivery. This structured process ensures continual evaluation of learning outcomes, assessment methods, teaching activities and student support, drawing on multiple approved evidence sources such as student evaluation data, student feedback, external examiner commentary, performance trends, and reflections from the module team and Programme Lead. Trainee feedback on teaching quality, course organisation, assessments, learning resources and on in-practice learning is gathered systematically; feedback is also obtained from DPPs. In addition to module-level monitoring, the programme is reviewed holistically through the School's annual quality cycle, which collates findings from module reviews, progression data, and feedback from stakeholders including DPPs. Enhancement actions arising from this monitoring are recorded and revisited through School committees to ensure timely completion and impact. The programme also participates in the University's Targeted Enhancement Approach (TEA), an evidence-led enhancement model that uses student-success indicators and risk-based analysis to identify areas requiring focused quality-improvement work. The GPhC's survey of students showed a very high level of satisfaction with the quality of the teaching.

In response to the team's wish to learn what has been the most significant recent change made to the programme as a direct result of the monitoring and evaluation cycle and how the impact of that change was subsequently measured, the staff stated that this was the introduction of non-medical DPPs, although this has not yet been evaluated. Evaluation will include feedback through monitoring the mandatory uploads of meetings between DPPs and their trainees, as well as the usual end of cohort feedback. Another change is the introduction of town hall meetings during the residential week to obtain student feedback. Previously, student feedback had depended on student voice meetings, but this mechanism had proved problematic because of the difficulty in obtaining course representatives, as well as representatives' difficulty in obtaining feedback from their peers. The town hall meetings had been well attended and fruitful.

The School ensures that the programme content and delivery remain aligned with developments in national policy, contemporary pharmacy practice, changing clinical roles and evolving patient needs. The teaching team includes practising pharmacist independent prescribers and staff with active research interests in clinical pharmacy, prescribing and healthcare education, enabling the curriculum to remain current. Feedback from external stakeholders, including DPPs, employers, alumni and patient-facing contributors, is gathered routinely and informs curriculum development and the design of in-practice learning experiences.

Standard 5: Course design and delivery

Table 9: Standard 5 – outcome decision

Standards	Met/will be met	Not met
Standard 5	✓	☐

The team was satisfied that all ten criteria relating to the design and delivery of the course continue to be met. Criterion 5.8 required a minor amendment.

The submitted documentation described the course teaching and learning strategy, which shows how trainees will achieve the GPhC's 32 learning outcomes**.** The course comprises six modules (Evidence-based medicine and safe prescribing; Consultation and communication skills; Clinical skills, patient monitoring and onward referral; Disease management; Professionalism; Influences on and psychology of prescribing and patient-centred care) delivered over a nine-month period, together with 90 hours of in-practice learning. The programme is delivered primarily through distance learning, with trainees engaging in asynchronous online learning activities. Academic teaching, for the most part, does not involve direct, in-person supervision, but trainee participation is actively supported through structured learning activity and scheduled online interactions, including monthly webinars. Teaching is provided through a blend of e-learning and webinars, along with live training in the form of a mandatory residential week. Wishing to learn about the contingency arrangements to address the situation where a trainee is unable to attend the residential week, the team was told that as this is an essential course requirement, the dates are communicated in advance of application process. If exceptional circumstances arose, the School would ensure that appropriate arrangements could be made through direct liaison with the students. These would be addressed on a case-by-case basis to develop a framework for the trainee's continuing study. The School would endeavour to avoid a total withdrawal from the programme, but the plan could include a temporary withdrawal and completion of the residential week with the next cohort.

The programme is built on trainees' existing knowledge, and information gathered from their applications enables learning activities, assessment, and learning in practice to be appropriately aligned to each trainee's prescribing scope while maintaining consistent standards and outcomes across the cohort. The expertise and experience of the staff involved in delivering the programme ensures that the programme is informed by current prescribing standards, professional expectations, and real-world clinical experience, supporting safe and effective prescribing practice. Thus, the course content is updated when there are significant changes in prescribing practice, professional guidance, or the wider healthcare environment.

Clear supervision and governance requirements are in place to ensure patient safety during trainees' period of learning in practice, with trainees only undertaking tasks at which they are competent; trainees may contribute to consultations and propose management plans, but all clinical decisions must be reviewed and approved by their DPP. Although the submission stated that supervision requirements during training are formally defined within the tripartite learning agreement between the University, the trainee and the DPP, the team noted that neither this agreement nor the webinar explicitly mention the supervisory role of the DPP and asked how the need for supervision is made clear. The staff described how this is made clear during the webinar, as well as being included in the information provided for DPPs, where their supervisory responses are stated explicitly, along with the GPhC guidance on supervision. In this context, the team asked how the School is assured that trainees are supervised effectively to ensure that they deliver patient-centred care at all times, as specified in criterion 5.7. The staff reiterated that details of the supervisory requirements are provided in the information for DPPs together with reference to the GPhC guidance. Trainees must undertake 90 hours of learning in practice, with at least 30 hours directly under the supervision of the DPP. Where supervision is delegated to others, the supervisors must be appropriately qualified and experienced. Assessments of learning in practice are verified by the DPP but marked and quality assured by University staff. Members of the School staff review the portfolio, which is expected to include records of at least five supervised

consultations. If concerns are identified, this would lead to discussions with the DPP and the trainee. The staff told the team that the only issues with the portfolio had been the provision of insufficient evidence on consultations provided by the trainee, although the portfolio had been verified by the DPP. This had led to a meeting with the trainee and the DPP, following which the trainee had been required to undertake three further supervised consultations before being signed off.

The submission emphasised patient safety as of the utmost priority. Should a patient safety issue arise either in an assignment, objective, structured clinical examination (OSCE) or during in-practice training, a formal mechanism is used; this includes applying the National Patient Safety Agency risk analysis to determine the potential level of harm. Potential harm at or above a 'moderate' level may require removal of a trainee from the course. There are clear procedures for raising, escalating, documenting and resolving concerns and these are communicated to all trainees and staff involved in programme delivery. Trainees are advised that any concerns arising during learning in practice, including issues related to DPP supervision, engagement, or the quality of the learning environment should be reported to the Programme Lead. DPPs are advised to raise any concerns about trainees directly with the Programme Lead. Early reporting enables concerns to be addressed promptly, for example through a meeting involving the trainee, the Programme Lead and the DPP. Where appropriate, concerns are escalated to the Director of Education for Pharmacy in line with programme governance processes. All concerns raised and actions taken are documented to ensure a clear record of review and outcome. The staff provided the team with an example of a patient safety issue that had been identified in a case study and how this had been addressed and resolved. Asking for confirmation that any act of patient harm would result in the withdrawal of a trainee with no opportunity for a second attempt, the team was told that if a safety issue is flagged, staff members would convene as a group to discuss and review the issue. The group would consider the level of harm to the patient that could or had taken place and where the action had occurred, for example, in an OSCE rather than in the portfolio. If the issue had or could have resulted in patient harm, the trainee would be withdrawn and would not be awarded the certificate (see also the narrative under standard 7). The team noted that the webinar slides had included the statement that this is a GPhC requirement, although this is no longer the case; the team therefore required a minor amendment to remove this statement from the webinar.

The School has a dedicated Pharmacy Independent Prescribing stakeholder group which meets annually, and includes DPPs, experienced independent prescribers, recent alumni and a patient representative. The programme continues to be developed in collaboration with this group, with stakeholder feedback directly informing course content and delivery. Structured feedback from DPPs indicates that the programme content is appropriate and that trainees are well prepared to undertake their prescribing role. Wishing to learn of any changes made to the programme to reflect changes in clinical practice in healthcare, the team was told that the increased prevalence of remote prescribing had led to preparation of trainees for this activity. Accordingly, the School had improved e-learning materials on remote consultations and had incorporated a workshop into the residential week to address remote triage and the need for appropriate onward referral. Remote prescribing is also now assessed in a specific OSCE station. In response to the team's wish to learn more about the updating of materials and the frequency of which updating was undertaken, the staff described how all staff members receive information and keep up to date to inform course development, and how there is also input from external practitioners. The School reviews the course and its constituent modules annually and the modules are updated after each month of delivery. Were some important developments to emerge during the course, trainees would be informed via the virtual learning environment.

Standard 6: Learning in practice

Table 10: Standard 6 – outcome decision

Standards	Met/will be met	Not met
Standard 6	✓	☐

The team was satisfied that all five criteria relating to learning in practice continue to be met.

The documentation described how trainees must complete a minimum of 90 hours of learning in practice in a patient-facing clinical environment under the supervision of an appropriately qualified and approved designated prescribing practitioner (DPP). Asking for an example of where the School had not approved a proposed DPP, the staff described a case where there was concern that a locum consultant psychiatrist would be unable to supervise for the whole period of practice and a more appropriate DPP was found, and another case where the proposed DPP was unsuitable because of working in a remote online service with no face-to-face consultations, no facility for physical assessment of patients and no multidisciplinary team. During their learning in practice, trainees must undertake prescribing-related activities under the supervision of their DPP, while developing competence in their chosen clinical area. The expectations for learning in practice are emphasised to students; these include the requirement that most of the evidence they record should come from five 'Patient Consultation Reflective Records' within their chosen scope of practice, demonstrating their prescribing competencies via direct patient-facing activities. Trainees document their patient-facing activity through their 'Summary of Clinics' log which is submitted alongside their portfolio.

The submission described how the Programme Lead ensures that learning in practice requirements are being met by contacting DPPs at three scheduled points, inviting them to get in touch should they have any concerns about the trainee's progress. Trainees can also raise issues with the Programme Lead at any point during the course. The tripartite learning agreement outlines supervision expectations; this is signed by the trainee, the DPP and the Programme Lead. Asking how the effectiveness of DPP support is evaluated, the team was told this is undertaken by looking at student feedback at the end of the programme; Student Voice meetings also provide the opportunity for trainees to voice concerns. Triangulation with students is undertaken to ensure that learning outcomes are being met. The process will be enhanced by the requirement of trainees to upload records of their DPP meetings. Any issues with DPPs are addressed through putting in place an appropriate action plan.

The DPP is responsible for ensuring that all prescribing-related activities are supervised at an appropriate level, providing close oversight early in the trainee's development and allowing increased autonomy as competence grows. This includes supervision of clinical assessment, diagnostic reasoning, and prescribing decisions to ensure patient safety. A minimum of 30 hours of learning in practice must be directly supervised by the DPP, who remains responsible for the overall sign-off of the trainee's competence. Where other healthcare professionals contribute to day-to-day supervision, the DPP retains primary responsibility for oversight of the trainee's progress, ensuring that supervision is appropriate, consistent, and aligned to the trainee's intended scope of practice. In response to the team's wish to learn about the communication mechanisms ensuring that the DPP is clear on what learning activities have taken place where trainees are supervised by someone other than their DPP, the staff explained that it is made clear that supervision can be delegated by the DPP and that it is beneficial for trainees to work with different practitioners as supervisors within their scope of practice. The DPP

ensures the appropriateness of the supervisor and the trainees submit documentation of their activities and who supervised them, with the sign-off undertaken by the DPP. When asked if the School had a policy on remote supervision by the DPP or other supervisors, the staff explained that while there was no policy, they would expect the trainee to have face-to-face meetings with their DPP and there are requirements for such meetings, for example, for the sign off of clinical skills; there are many processes in place to ensure face-to-face contact between trainees and their supervisors.

At the end of the course, DPPs must sign and declare that the trainee has undertaken the required 90 hours of learning in practice, has demonstrated clinical competence in their intended area of practice, and in the DPP's professional opinion is suitable for annotation as an independent prescriber.

Standard 7: Assessment

Table 11: Standard 7 – outcome decision

Standards	Met/will be met	Not met
Standard 7	✓	☐

The team was satisfied all eleven criteria relating to assessment continue to be met.

The documentation described how the programme's assessment strategy is designed to ensure robust, reliable and valid assessment of trainee performance. A range of assessment methods are employed to ensure that all GPhC learning outcomes are assessed to the appropriate standard, with all assessments mapped to these outcomes and undertaken by appropriately qualified healthcare professionals with a wide range of clinical experience, many of whom are qualified independent prescribers. Structured written assignments are used to assess trainees' knowledge, clinical reasoning, treatment planning, monitoring and application of evidence. Summative online situational judgement tests (SJTs) are used to assess individuals' reactions to several hypothetical role-relevant scenarios, which reflect situations likely to arise in practice. A six-station objective, structured clinical examination (OSCE) is used to assess knowledge application, clinical decision-making, risk management, and consultation and clinical examination skills. Noting that a modified Angoff procedure is used to set minimum safety standards for OSCE stations, the team asked who participates in this exercise, how often it is reviewed, and whether external pharmacist independent prescribers are involved in standard-setting. The staff described how the OSCEs are written within the School by staff members who are experienced independent prescriber pharmacists and standard set using the modified Angoff procedure to determine a minimally competent student. Each station is reviewed independently, and the staff meet to reach a consensus agreement on the whole OSCE with the full panel looking at the competencies being assessed. Although all the staff members are internal, additional external feedback is received on the stations, with patients being involved in those relating to consultations.

During their time in practice, DPPs support their trainees to develop and demonstrate competence in prescribing practice under their supervision. The DPP assesses the trainee against the Royal College of Pharmacy 'Competency Framework for all Prescribers'. This framework should be used as a self-assessment tool, enabling the trainee to evaluate their own level of competence in conjunction with their DPP at several time intervals during training. The evidence for competence is presented in the trainee's 'Learning in Practice Portfolio' and is submitted to the University for final assessment. Direct observation of practice is used by the DPP to assess if trainees can perform the physical examination skills relevant to their chosen area of practice. The team asked about the specific requirements of the

practice portfolio and how it is assessed, including the type of evidence required for each competency, whether all competencies need to be passed and if the RPS competency framework is the only thing that is assessed in the portfolio. The staff explained that the portfolio is a mixture of mandatory evidence along with any other evidence that demonstrates meeting competencies, which are all mapped against the RPS Framework, although some competencies, such as safeguarding, can be met only outside of the course. Trainees are expected to provide two pieces of evidence for meeting each competency. However, a maximum of one piece of this evidence can be provided via the trainee's 'summary of previous experience' (SPE), which includes evidence from before the trainee has commenced their learning in practice. Trainees undertake an initial self-assessment against the Royal College of Pharmacy competencies, and evidence from previous practice can be signed off if specific examples have been provided. Evidence presented in the portfolio must include records of consultations and must show at least five consultations with individual patients along with prescribing decisions covering various competencies. Trainees are provided with templates in which to record the evidence.

Patient-safety considerations are central to all assessments and monitoring processes operate across both taught and practice environments to ensure trainees practise safely and appropriately. Trainees must demonstrate through assessments their ability to practise safely. Concerns regarding patient safety can be raised and addressed through the 'Dealing with Concerns' policy. Cases of unsafe practice leading to potential patient harm are addressed through a 'Risk Analysis Matrix'. If the potential harm is classified at or above a 'moderate' level unsafe practice is confirmed. In this case, no assessment resit will be allowed, and the student will fail the programme (see also the narrative under standard 5). Module coordinators and the Programme Lead have oversight of all assessments and trainees failing to progress can be identified easily. Those trainees whose progress is unsatisfactory are offered a meeting with the Programme Lead and are provided with appropriate support and guidance. Trainees are offered formative learning opportunities at various times throughout the course, including the residential week. Structured monitoring systems are also embedded within the learning in practice environment. Regular reviews take place between the trainee and DPP. Trainees must meet formally with their DPP on at least four occasions during their period of learning in practice, allowing the DPP to assess their progress, provide feedback, and plan further development. There is also regular contact between the Programme Lead and DPPs. Any issues identified in academic or practice-based assessments are followed up promptly with assessors or DPPs to ensure clarity, consistency, and adherence to programme standards. These combined processes ensure that all assessments, regardless of setting, meet the required quality standards. The team noted results from the GPhC's survey of students, which suggested a wide variation in the frequency of meetings with DPPs, and asked if there is any evidence that there should be more frequent supervision of trainee progress, particularly at the start of the programme. The staff described how the introductory webinar emphasises the need for meetings and discusses what an appropriate frequency should be. At the beginning of the programme, trainees are observed more closely and spend more time shadowing their supervisors, subsequently developing more confidence and competence to take the lead in patient consultations.

Trainees receive detailed feedback across all assessments, including formative and summative tasks. Feedback, provided by tutors via Canvas, the University's virtual learning environment, is constructive, developmental and linked to module learning outcomes. All written summative assessments are returned with detailed feedback from the assessors within 20 working days of the submission deadline. There are also numerous activities and multiple-choice exercises within the modules that provide trainees with immediate formative feedback. Trainees receive detailed formative feedback from tutors when practising various clinical and examination skills and simulated consultations

during the face-to-face residential period. Results from the GPhC's survey of students suggested high levels of satisfaction with both the quality and timeliness of the feedback they receive.

Every assessment must be passed independently, including the practice portfolio and in-practice clinical skills. Trainees who successfully complete the course are awarded a Practice Certificate in Independent Prescribing, the recognised qualification required for annotation with the GPhC. Noting that the progression policy states that a trainee who fails more than two modules (20 credits) during the PG Certificate will be withdrawn, the team asked how many students had been withdrawn from the programme or had discontinued in the last two cohorts. The staff stated that nobody had failed two modules in the last two cohorts, although very small numbers had failed one assignment and one module. The most common failure is on the treatment plan within their own scope of practice. Those in danger of failing are offered a meeting to discuss remedial action.

Standard 8: Support and the learning experience

Table 12: Standard 8 – outcome decision

Standards	Met/will be met	Not met
Standard 8	✓	☐

The team was satisfied that all four criteria relating to support and the learning experience continue to be met.

The documentation detailed the support provided for students on the independent prescribing programme, starting with an induction webinar, along with introducing staff who deliver the course, ensuring students know whom to contact for support and providing an overview of the Canvas virtual learning environment, as well as covering the IP programme. The webinar also covers academic integrity, the importance of professionalism, and how feedback will be provided, as well as defining student responsibilities and effective approaches to studying online. Noting that the coverage of academic integrity also includes guidance on the use of artificial intelligence (AI), the team asked about the safeguards in place to ensure that AI assistance is not being used inappropriately by trainees in this predominantly distance learning programme. The staff explained that the School recognises the increasing use of AI and takes steps to ensure its appropriate use, including providing trainees with the University and GPhC guidance, which encourages its application to support learning while prohibiting its use in preparing assignments for submission. This topic is kept under constant review and is discussed at the Education and Management committees. AI literacy is important and trainees must be aware of the potential inaccuracy of AI-generated material that could impact on patient safety. AI does not impact on assessments, which are all authentic, including a treatment plan based on trainees' own specific patients, and trainee competence is confirmed in practice by the DPP.

Students are introduced and signposted to wider University support and services, such as Learning Development Service, Student Wellbeing, Accessible Learning Support and Library services, as well as to the support provided through the Student's Union. Students are presented with an overview of the requirements for learning in practice and the associated e-portfolio. The role and responsibilities of the DPPs are explained, alongside how clinical skills will be taught, supported, and assessed throughout the programme. Students are assigned an Adviser of Studies who works with the Programme Lead to ensure trainees receive consistent academic and pastoral support.

During periods of learning in practice, the DPP plays a central role not only in supervision but also in providing support, and mechanisms are in place to ensure that trainees meet regularly with their DPP. Noting that the tripartite learning agreement requires DPPs to commit to a minimum of four formal meetings with the trainee and that, according to the submission, DPPs are contacted formally by the School only three times during the course, the team asked how the School verifies that the four-meeting commitment has been honoured in practice, and about what happens if a DPP does not fulfil this obligation. The team also noted results from the GPhC's survey of students, which showed a wide variation in the frequency of trainee engagement with their DPPs. The staff explained that this is now addressed through the mandatory uploads of records of meetings with the DPP, which gives confidence that meetings have taken place. The programme staff will intervene where insufficient meetings have been held; this may also be identified through requests for extensions through exceptional circumstances procedures.

The School ensures that trainees are supported to provide feedback and raise concerns about any aspect of the programme or their learning-in-practice experience. The team was told that the major point of contact for raising concerns is the Programme Lead, but trainees can contact other staff members. Results from the GPhC's survey of students showed that the majority were aware of how to raise concerns and whom to contact. Results from this survey also showed general satisfaction with the level of staff support, although there was some inconsistency across staff and settings.

Standard 9: Designated prescribing practitioners

Table 13: Standard 9 – outcome decision

Standards	Met/will be met	Not met
Standard 9	✓	☐

The team was satisfied that all five criteria relating to designated prescribing practitioners continue to be met.

The documentation described the mechanisms whereby the School ensures that prospective designated prescribing practitioners (DPPs) are suitably qualified to supervise trainee independent prescribers. This is done using a DPP Agreement Form completed at the time of the student's application; the agreement form captures information on professional registration, prescribing rights, practice setting, current prescribing practice, and governance arrangements, as well as confirming that the DPP meets the competencies required to supervise and assess clinical/diagnostic skills. Final responsibility for approval of a DPP lies with the Programme Lead, thus ensuring consistency, equity and appropriate oversight across all applications. In response to the team's wish to learn how the School gains assurance that each DPP is able to assess patient-facing clinical and diagnostic skills, the staff explained that this is achieved by robust checking of the DPP agreement. This is not simply a tick box exercise and the DPP must provide evidence of regular examinations and evidence of assessing skills, for example having undertaken direct observation of practical skills (DOPS) and conducted mini-clinical examinations (mini CEX). Clinical skills are assessed during the residential week while DOPS is undertaken in practice, with appropriate rubrics being used by the DPP. Records of DOPS are checked by the School staff and redone if necessary.

All DPPs undergo induction through an Introduction webinar, a recording of the webinar being provided afterwards for ongoing reference. The webinar provides training on all required areas, including the role of pharmacist independent prescribers, the structure and learning outcomes of the IP programme, the DPP's role in assessing clinical and diagnostic skills, the DPP's responsibilities assessment of trainee performance, how to provide trainees with feedback, and the process for raising and escalating concerns. The training webinar is supplemented by detailed written guidance on supervisory expectations, assessment requirements, governance responsibilities, and links to the GPhC guidance on supervising pharmacy learners in practice and the Royal College of Pharmacy DPP Competency Framework. The DPP Agreement Form requires DPPs to confirm that they understand their responsibilities in assessing clinical and diagnostic skills, supporting the trainee's learning, participating in the required supervisory meetings, documenting progress, and acting in accordance with the GPhC's guidance. Noting from the GPhC's survey of DPP opinion that a significant percentage had either not undertaken training or stated that training was not provided, and asking how the School is assured that all DPPs have successfully completed induction and training for the role, the team was told that this starts with the DPP agreement and the information provided to the DPP. The School offers flexibility in attendance at the webinars, which are held in evenings outside working hours as well as the webinar being recorded for later access. DPPs are monitored by scrutiny of the quality and completeness of their assessment decisions. The GPhC's survey of DPP opinion showed that DPPs were generally content with the training materials and the guidance documents provided.

DPPs are supported throughout the programme via a combination of structured training, regular contact opportunities, clear lines of communication, and responsive, individualised support. Where a DPP encounters challenges in supervising or assessing a trainee, additional support is provided by the Programme Lead. Results from the GPhC's DPP survey revealed general satisfaction with the support provided by the School and the ease with which DPPs could contact staff members.

Monitoring the quality of practice-based assessments by the Programme Lead enables the School to provide DPPs with feedback on their performance. The monitoring is undertaken through reviewing the DPP documentation submitted alongside the portfolio, including the DPP's direct observation of the trainee's practical skills, patient consultation reflective records, and competency ratings. If the portfolio indicates that a trainee has not been provided with sufficient supervised learning opportunities to demonstrate prescribing competence, this is addressed directly with the DPP and trainee. The DPP and trainee are advised of the specific areas requiring improvement, and additional portfolio evidence will be requested when required. Where significant concerns persist, the DPP may not be approved to supervise future trainees. DPP's receive anonymised end-of-course trainee feedback, as well as aggregated feedback that includes both positive supervision examples and areas for development. Wishing to learn of examples of how monitoring of DPP performance had led to the DPP ceasing to act in the role, the team was told that there had never been a need to replace a DPP due to issues between DPPs and their trainees that could not be resolved through discussion. The team noted from GPhC's survey of DPP opinion, that a number of DPPs indicated that they had not received feedback from the School on their performance, therefore team asked about the processes for providing such feedback. Expressing surprise at the survey findings, particularly given the School's existing feedback and monitoring processes, the staff stated that the School is proactive in looking for ways to provide feedback. The main approach, as described above, is to provide them with aggregated, anonymised feedback from the previous cohort. If a trainee raises concerns about their DPP, these would be discussed through feedback to the DPP. The new requirement for trainees to upload records of DPP

meetings will facilitate monitoring of DPP performance, as the system provides the facility for the trainee to make comments. The staff stated that the School will make feedback more explicit to DPPs; the team will monitor this at the three-year interim visit.

Annex A: Decision descriptors

Table 14: Decision making descriptors

Decision	Descriptor
Met/will be met	The accreditation team is assured after reviewing the available evidence that this criterion/learning outcome is met (or will be met at the point of delivery).
Not met	The accreditation team does not have assurance after reviewing the available evidence that this criterion or learning outcome is met.

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