NI Centre for
Pharmacy Learning & Development

REPORT

Contents

1 Introduction to this report

This report presents an overview of the roundtable event held on 18 November 2025. It includes links to the presenters' slides, a summary of stakeholder perspectives shared during the discussions, and key insights from the closing Q&A session.

The agenda for the day is shown below.

NI Centre for **Pharmacy Learning & Development**

Post-Reg Pharmacist Pathways
'round table' event

Date: Tuesday 18th November 2025

Venue: Maldron Hotel, Belfast International Airport

Time	Topic	Lead
10:00am – 10:15am	Welcome + introduction	Lisa Smith Pharmacy Dean, NICPLD
10:15am – 11:00am	Current post-reg pathways – why do they need to change?	Laura O'Loan Associate Pharmacy Dean, NICPLD
11:00am – 11:30am	Tea/Coffee	
11:30am – 1:00pm	Enhanced Pharmacy Practice	Claire McKeown + Leona Rogers Senior Leads for PRFP, NICPLD
1:00pm – 1:45pm	Lunch	
1:45pm – 2:15pm	Advanced Pharmacy Practice	Anna Fay Senior Lead for Advanced Practice, NICPLD
2:15pm – 3:15pm	RPS credentialing	Joseph Oakley Associate Director, Assessment + Credentialing, RPS
3:15pm – 3:45pm	Discussion/Q+A	All
3:45pm – 4:00pm	Summary + close	Lisa Smith Pharmacy Dean, NICPLD

2 Introduction to the Roundtable (Lisa Smith)

Welcome and introduction slides

Summary of stakeholder perspectives:

Who needs to understand that from summer 2026, newly qualified pharmacists will be prescribers?
• Patients, the public and service users. • Employers. • Pharmacy teams. • Other healthcare professions who work alongside pharmacists in all sectors. • Policy makers. • NIMDTA. • Unions/Indemnifiers. • Education providers.
What message(s) needs to be communicated effectively?
• Explanation of the drivers for this change. • Description of how this change will be implemented each sector. • Description of scope of practice and boundaries. • Beginning/novice prescribers at point of registration. • Public and professional understanding that some pharmacists are IP annotated and some are not. • How the public safely access a pharmacist prescriber. • Management of expectations of the groups identified in question 1. • Tailored messages for each group identified in question 1. • Expectations on newly qualified prescribers. • Governance structures and support available for new prescribers. • Feedback mechanisms.

What action is needed and by whom?
• Messaging should be led from DoH, CPO. • Messaging should be evidence based and part of cohesive communications plan. • PSNI. • Pharmacy Forum. • Public Health Agency. • SPPG. • CPNI. • Universities. • NICPLD. • NIMDTA. • Unions. • Patient organisation. • Health Trusts. • Trust research and audit departments. • GP Federation. • Development of mentoring and peer support. • Protected learning time.

3 Current post-reg pathways – why do they need to change? (Laura O'Loan)

Why do post reg dev pathways need to change slides

A recorded lecture 'NICPLD Post-Registration Workforce Development Pathways, past, present and future' is now available on the NICPLD website: https://vimeo.com/1139305934/e0a0013da7

A Guide to Developing the Role of Advanced Practice Pharmacists in NI is available on the DoH website: A Guide to developing the role of Advanced Practice Pharmacists in Northern Ireland.pdf

4 Enhanced Pharmacy Practice (Claire McKeown + Leona Rogers)

Enhanced Pharmacy Practice slides

Summary of stakeholder perspectives:

Who will benefit from newly qualified pharmacist prescribers undertaking a structured development programme?
• Newly qualified pharmacists - structure, support, clearer supervision, improved confidence. • Patients/service users - better access, safer care, improved decision-making. • Employers - stronger governance, service provision, financial and reputational benefits. • Educational supervisors - clearer guidance, accountability structures. • The profession - more attractive career pathway, improved public perception. Overall message: Everyone benefits if the programme is well scoped, supervised, and supported.
How will they benefit?
• Patients: Better service accessibility, safer prescribing, improved continuity of care. • Pharmacists: Career progression, expanded scope of practice, increased confidence, structured learning. • Employers: Stronger governance, improved service delivery, financial gains. • System-wide: Improved accountability, feedback loops, clearer structure and reassurance.

What should educational supervision look like for the Enhanced Pharmacy Practice programme?
• Not limited by workplace location - supervisors do not need to work in the same sector/place. • Regular contact + protected time - similar to medical models (e.g., weekly 4 hours). • Supervisors should be trained - clear definitions of ES vs. CS, capability training, possibly requiring IP. • Mentorship over assessment - focus on guidance, not paperwork. • Feasible workload - current systems are too supervisor-heavy. Need reduction in burden. • Flexibility - different supervisors for different learning pillars. • Funding needed - protected time, especially in community. • Cross-sector supervision should be supported and funded. • Move from “supervision” to “support” to reduce pressure and manage expectations.
What will NQPP be doing that is different from current newly qualified pharmacists?
• More autonomous decision-making and clinical reasoning. • Holistic patient care and greater MDT involvement. • Acting as prescribers - making final decisions rather than passing to medics. • Enhanced responsibility & leadership skills. • Potential to supervise others later in development. • Greater empowerment and scope of practice, though limited by: • workforce pressures, • contractual frameworks in community, • high workload, • organisational culture. • Strong message: Change may be limited initially without wider system and workload reform.

What practice-based activities should NQPP undertake to demonstrate the clinical pillar?
• Active prescribing and deprescribing decisions. • Participation in MDTs, ward rounds, clinics (live or virtual). • Mini-CEX, DOPS, and other direct observation activities. • Case-based discussions and supervisor feedback. • Reduced “box-ticking” reflection, more focused on real feedback. • Evidence-based prescribing, including off-label decisions, risk management. • Patient counselling, cost-effective switching, liaison across sectors. • Teaching junior staff and students. • Research skills and working with wider teams to build clinical evaluation skills. Important principle: Activities should be flexible, sector-appropriate, and not overly burdensome for supervisors.

5 Advanced Pharmacy Practice (Anna Fay)

Advanced Pharmacy Practice slides

Summary of stakeholder perspectives:

What is Advanced Pharmacy Practice?
• Agree RPS APP definition is realistic and comprehensive. • Complex patients. • Knowing when appropriate to deviate from guidance. • 4 pillar working. • Need strong evidence of previous prescribing to move into APP. • Need to build tiers in CP and Primary care – too flat structure. • Need framework for all sectors to fulfil workforce development and this new approach – vital. • Autonomous working with MDT and patients in shared decision making. • Can work as a generalist i.e. specialist generalist mostly. • Facility for some to do specialism e.g. mental health.
Is credentialling a suitable approach for Advanced Pharmacy practice?
• Feel more confident with RPS credentialling. • Yes – application in practice to evidence learning outcomes.
What benefits does Advanced Pharmacy Practice credentialling bring?
• Assurance for patients, colleagues, employers. • Enhanced patient care. • Better skill mix. • Job satisfaction. • Application of post grad experience and skills gained. • Increased accessibility to care.
What should an Advanced Pharmacist role deliver?
• Autonomous care delivery (clinics etc). • Specialist role.

- Improved patient and service outcomes.
- Differences between sectors.
- Education and research delivery – training/mentoring.
- Continuity of care-access to more specialist prescribed meds.
- Evidence based medicine-improved outcomes.
- Targeted service delivery.
- Driving service improvement – budget.
- Different in every sector.
- Dependent on funding.
- Clinics within community pharmacy settings.
- Medicines optimization and polypharmacy review (savings may be reinvested to develop further initiatives).
- Development of pathways/guidelines.
- Formulary reviews.
- Education and research roles.
- Input into workforce development.
- Employers need to define roles.

6 RPS credentialing (Joseph Oakley)

RPS credentialing slides

7 Q&A – key insights

Question	Answer
What would the gap be between Enhanced Practice and Advanced Practice?	Enhanced Practice will be defined in the new RPS Enhanced Pharmacy Practice curriculum (due to be published in summer 2026). Advanced Practice is defined in the RPS Core Advanced Pharmacist curriculum. The RPS post-reg curricula are designed as a continuum of learning. In this instance, the learning outcomes in each of the 5 domains of the curricula can be compared at Enhanced Practice and Advanced Practice levels.
Is there a risk that we are leaving behind the non-prescribing pharmacists?	The NICPLD Independent Prescribing (IP) course will continue to be available for legacy pharmacists who are not yet qualified prescribers.
Given all post-reg pathways require IP, what plans are in place to support the pharmacists in all sectors who are not yet IP?	
What will the pathway be for legacy pharmacists to obtain IP?	
How will you define active prescribing?	

How will employers gauge active prescribing, what are prescribers fit to do?	The RPS definition of active prescribing will be used: 'An active prescriber consults with patients and makes prescribing decisions based on clinical assessment with sufficient frequency to maintain competence. Reflects and audits prescribing practice to identify developmental needs.'
How can a community pharmacist demonstrate active prescribing? Does sporadic UTI prescribing count?	
Are we advising those who have completed FP1 / SPE to go straight to IP? This will be logistically very difficult.	FP1 candidates should still be able to progress onto FP2 if they wish – the final FP1 intake will be in March 2026, and the final FP2 intake will be in September 2026.
If all hospital based newly qualified prescribers are doing enhanced pharmacy practice programme should Trusts have a regional policy to manage their entry on NMP trust registers?	This will be a matter for Trusts / employers. In other regions in the UK, for example North West England, chief pharmacists have developed regional scope of practice setting out the types of prescribing activities that newly qualified pharmacist prescribers will be supported to undertake.
How can we support community pharmacy to become autonomous prescribers and not only via PGD? Funding issues.	From summer 2026, pharmacists will be prescribers at the point of registration. To facilitate this transitional period as pharmacy becomes a prescribing profession, the new NICPLD Enhanced
Where do community pharmacists fit into these proposals? If they are not actively prescribing then is this route closed to them? Therefore	

these career advancements are suited to hospital career only?	Pharmacy Practice programme will be for qualified prescribers. Any non-prescribers will have to complete the IP course first. The Advanced Practice programme will continue to be for active prescribers. The NI pharmacy contract (covering the services that community pharmacies provide) is negotiated and managed by DoH, SPPG and CPNI.
As a community pharmacist this feels very remote from the reality of current practice. Fundamentally without significant contractual change how will NQPP use their skills?	
What does the pathway look like for pharmacists who have been IPs for some time. Will they need to complete enhanced practice (EP) to proceed to AP credentialling?	It is envisaged that the entry criteria for the new Advanced Practice (AP) credentialing pathway will be very flexible, enabling all experienced pharmacist prescribers to apply without having to do EP first. In addition, the timeframe for completion of AP credentialing will be flexible (unlike the APP MSc course).
Do pharmacists who have completed IP need more time to do APP? Life gets in the way and many people defer.	
Can someone still skip EP to move to APP if further in their career?	
After last cohort for "old" MSc would new program exclude any of those who graduated against old standards even if now IP?	
What would be the pathway for those who have completed MSc to undertake credentialing?	There is no need for pharmacists who have completed the APP MSc to undertake AP credentialing. However, the AP credentialing pathway will be available to them if they wish to build on the MSc and gain the credential.
Do you need to undergo credentialing if you have already completed the MSc APP?	
This change is welcomed as a way of assuring quality and moving away from tick box of just	

doing the next step, irrespective of whether the pharmacist is ready for it. APP outcomes very similar to a current 8a job description.	This is reassuring to hear, and we are grateful for the support in the change.
Will pharmacists have to become members of the RPS to use their frameworks?	Currently the RPS frameworks and credentialing assessments are available to non-members. We don't know if this will change when the RPS becomes the Royal College of Pharmacy.
What is the role of the Pharmacy Forum NI here?	The Pharmacy Forum NI does not provide any post-reg pharmacist development frameworks or credentialing assessments. The RPS frameworks and credentialing assessments are available to pharmacists in NI.
Where will credentialing sit in Royal College plans?	It is envisaged that the new Royal College will continue to provide credentialing assessments.
How many pharmacists from each part of the profession complete the Advanced Pharmacy Practice programme?	Currently approximately two thirds of APP participants are from the hospital sector and one third from GP practice. There are no participants from community pharmacy. There are however two community pharmacists in Scotland who are credentialed as advanced pharmacist practitioners.
Can the credentialling start at any time or will there be set intakes?	Pharmacists can start their RPS portfolio and credentialing journey at

	any time. However, the new NICPLD AP credentialing supported pathway is likely to have set intakes.
Is it likely that active prescribing will be a requirement in the advanced specialist pathway when it is in place? Not all roles allow this active prescribing requirement to be achieved.	A recommendation in A Guide to developing the role of Advanced Practice Pharmacists in Northern Ireland.pdf is for the DoH to consider development of funding pathways to support development of pharmacy professionals working in specialist areas where the core advanced curriculum may not be the most appropriate pathway. Not all specialist pharmacists will need to be prescribers.
What about pharmacists that are not patient facing - eg academia?	
How can we ensure non patient facing pharmacy roles are promoted as a career pathway?	
Difficult to define what is considered advanced as different roles have different opportunities.	A recommendation in A Guide to developing the role of Advanced Practice Pharmacists in Northern Ireland.pdf is for NICPLD to support the development of a Multi-professional Advanced Practice Academy in Northern Ireland. It is envisaged that this academy will consider advanced roles across all healthcare professions in NI.
With only <20% of current PG pharmacists confident in research - and a removal of a research aspect of the programme - what are the plans to address this?	In the current APP MSc courses, the universities deliver the research pillar, and NICPLD delivers the clinical, leadership and education

How will pharmacists learn to do research if they don't follow a high quality university programme?	pillars. Discussions will be taking place in the New Year to consider whether the universities will be able to continue to deliver the research pillar on a modular basis in the new AP pathway.
Research is the weakest pillar. Completing a masters project can help. How will this gap be filled?	
Who will primarily drive the “research” pillar? Currently the MSc would support this.	
What are plans for supporting pharmacists at all stage of development journey with research given this is where confidence is already low. How are we scaffolding research? What comes before MSc in terms of research capability?	
Research has to be robust and supported by employers. It doesn't happen organically.	
Given research is a primary activity of our universities important to keep them involved to support / drive this pillar.	
Will there be less input from the universities with the new model?	
Research is no longer part of undergrad- training gap?	This is incorrect – research is still included in the MPharm. Pharmacists who complete the enhanced curriculum will develop their research skills and knowledge in the research pillar of the enhanced curriculum before engaging with the advanced curriculum.
Have you considered modules in therapeutics/leadership/education/research for	Separate clinical, leadership, education and research modules are

staff to use as building blocks for both AP and consultant credentialling?	a possible option for the new AP credentialing pathway. Stakeholder and Task+ Finish groups will be convened to decide on the most appropriate model.
There is a lot of talk recently about "micro credential" modules. How do you see this sitting (if at all) within the new models?	
What are the plans for an educational supervisor/clinical supervisor workforce in practice? A departure from formal taught programmes to self directed will increase the need for clinical supervision and support in practice	Stakeholder and Task+ Finish groups will be convened to decide on the most appropriate model for supervision of learners.
We need to consider the change in what 'education' means in our profession eg supervision of learners in workplace	
Who is supporting with developing pharmacists' educational capability. Research from Scotland highlighted pharmacists did not feel confident with feedback or assessing learners. Do we do anything differently here?	
Some mentors will have 3-4 staff to mentor at any one stage. FTY, EP, AP (cross over due to length of courses). Where are we finding these mentors?	
An assessor is from the same sector but a different practice, where are the assessors coming from in community pharmacy?	Some of our current assessors have experience in community pharmacy. We would welcome experienced community pharmacists to become assessors (training is provided).
Although two tier is not ideal- surely needed to recognise those who are in the system and at	Pharmacists who have registered with the university and commenced the APP MSc course will be able to

different stages e.g. moving sectors or post Mat leave or career breaks.	complete it, in line with university procedures. The new AP credentialing pathway will be flexible with no defined time frame for completion and should be able to accommodate pharmacists moving sectors or post maternity leave or career breaks.
How will the costs of these programs be borne? Will it fall heavily on individual pharmacists?	The Enhanced Pharmacy Practice programme will be free of charge to individual pharmacists (as is the case with the current Post-reg Foundation Programme). There are likely to be some costs to individual pharmacists associated with AP credentialing (as is the case with the current APP MSc course). Stakeholder and Task+ Finish groups will be convened to decide on the most appropriate model.
Are we driving "advanced practice" in pharmacists who really don't have the experience to "walk the walk" could this be why many of pharmacists surveyed didn't feel confident?	The survey was quantitative and did not collect this qualitative data.
Have you considered the difference between confidence and competence? Pharmacists notoriously underestimate their ability. Those who say confidence is low are likely performing at a higher level.	Ideally, pharmacists should be both confident and competent.

Workload already impossible so will be interesting to hear how staff will be supported.	We acknowledge that the pharmacy profession is undergoing a phenomenal period of change at the moment. This is impacting on pharmacy professionals involved in programme delivery as well as practitioners. The new programmes are intended to be more flexible than the formal academic programmes, which we hope will make them more manageable for learners.
Pharmacists are already under a huge amount of pressure. Have you considered how you will support the wellbeing of pharmacists during all these changes?	
Considering that the latest RPS survey has shown 87% of respondents are at risk of burnout, how will removing formal programmes and formal support impact them? Early feedback from the Pharmacy forum survey mirrors the RPS survey.	
For a self-driven programme, how are you proposing we formalise protected development time for all pharmacists in any sector?	Protected learning time, job descriptions and job plans are matters for employers. The draft PSNI Code under standard 4 states that pharmacists must where appropriate 'Support the training and development of colleagues and trainees.'
How do ES have protected time to meet trainee's needs?	
Mentoring, education are not in GPP job descriptions - where do we find these mentors?	
How can the profession move towards job plans that include set aside time every week for professional activities?	
How can everyone get opportunities in 4 domains whilst balancing patient care, FTY, undergraduate supervision?	
Will there be work done with trust HR and agenda for change units to develop an equivalence for job evaluation when pharmacists no longer have MScs?	This will be a matter for employers. However, the Centre for Advancing Practice in England already recognises RPS AP credentialing as equivalent to an MSc, and it is hoped that the new Multi-professional

	Advanced Practice Academy in NI will do this too.

8 Next steps

Next steps for NICPLD include:

- Reflect on stakeholder perspectives gathered during the roundtable.
- Continue contributing to the RPS Enhanced Curriculum Steering Group and Task & Finish Group.
- Develop a roadmap for the launch of the NICPLD Enhanced Pharmacy Practice Programme (January 2026).
- Convene a Task & Finish group to collaborate with NICPLD on the development and implementation of the Enhanced Practice Programme.
- Develop a roadmap for the launch of a programme supporting credentialing for Advanced Pharmacy Practice.
- Convene a Task & Finish group to work alongside NICPLD in developing and implementing the credentialing support programme.

9 Appendix 1 - Post-Reg Pharmacist Development Round Table Event Register of Attendees

Jayne Agnew	Fiona Hughes	Maegan McGivney
Jay Badenhorst	Anne Keenan	Anne Marie McGrath
Helen Bell	Barry Keenan	Aileen McKenna
Joanne Brown	Fiona Kirkpatrick	Niamh McKinney
Esther Brownrigg	Judith Lambert	Maria McNally
Joanne Caldwell	Fran Lloyd	Laura Murphy
Daryl Connolly	Jonathan Lloyd	Roisin O'Hare
Maura Corry	Catherine Loughlin	Fiona O'Neill
Richard Dunn	Anne Lyttle	Sabrina Parkhill
Lesley Edgar	Jill Macintyre	Kathryn Sally
Lisa Ferguson	Anne McAlister	Louise Shephard
Glenda Fleming	Paudraig McAlister	Ennis Shields
Sara Gardner	Paul McCague	Andrea Shirley
Brendan Gilmore	Kate McComiskey	Nicola Smyth
Desmond Gourley	Ann McCorry	Lyn Stevenson
Jacquelyn Hanley	Eimear McCusker	Patricia Tennyson
Bronagh Hegarty	Claire McEvoy	Julia Tolan
Claire Hetherington	Rachel McGaw	Stephen Toner
Amy Hilbert	Brenda McGilligan	Stephen Ward
Donna Houston	Sarah McGinnity	