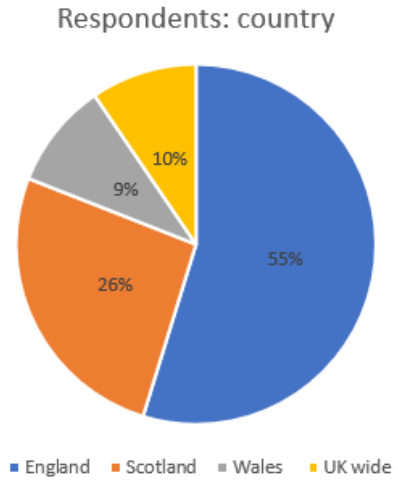
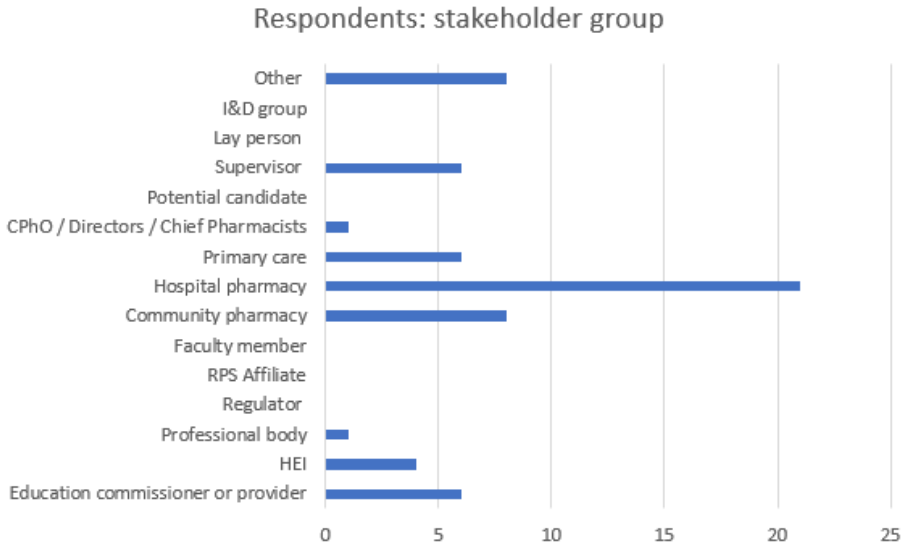
Introduction

- The consultation was open for six weeks and closed on the 18th June 2021.
- A broad range of relevant UK stakeholder groups were identified prior to launching the consultation and these organisations were targeted with specific comms (full list available on request). We also held informal drop in Q&A sessions for specific stakeholder groups (HEIs, hospital, primary care, community pharmacy) and promoted the consultation through our social media and direct member communications.
- We actively promoted those with inclusion & diversity perspectives to contribute; we sent out a targeted social media message for views from those with the nine protected characteristics, carers and welsh speakers, as well as considering socio-economic consequences. I&D stakeholders were also directly contacted and encouraged to engage with the consultation via the RPS I&D co-ordinator.
- Respondents were able to provide feedback either via a webform or by completing a word document template.
- In total, we received 42 responses to the consultation and the breakdown between individual and organisation respondents, countries, and stakeholders is presented below.
- We received a high volume of comments and have triaged them to identify those which require decision making by the ESC to inform our consultation response and revisions to the curriculum. We have presented these overleaf and following ESC decisions about the escalated areas, we will draft a response to these and the more minor comments internally, before circulating to ESC remotely for review prior to publication.





Themed feedback summary

	Feedback	Proposed RPS response
	Purpose statement	
1	The scope should include 'Contributing to protecting and improving the health of their local population' and include reference to improving health inequality and reducing service/care variations.	We will amend the wording in the purpose statement
2	The purpose statement should include quality management principles which underpin innovation and change. There is no mention of quality assurance /governance activities which post-registration foundation pharmacists should have a clear understanding of within the context of patient safety, as well as knowledge and experience of technical services, aseptic manufacture and dispensing, medicines information and clinical trials, medicines procurement and assessment. It should include knowledge and skills within technical services.	The curriculum needs to be achievable across all sectors and we haven't included any content relating to specialist services delivered in a single sector e.g. aseptic manufacturing. Several of the descriptors throughout the domains include examples which require application of quality management, quality assurance and governance activities. Individuals who have rotations in technical services will be able gather evidence of learning across all of the domains to support achievement of the curriculum outcomes. We will change 'Contribute to medicines and clinical governance to improve patient safety' in the scope of practice to include application of quality management principles.
3	Lack of commissioned services in community pharmacy means some may not be able to deliver the services and scope of practice described in the purpose statement. This may lead to an ever-increasing gap between the clinical development of community pharmacists versus hospital/ PCN/ GP pharmacists and others.	The curriculum was developed with both employer and learner representatives from community practice to ensure the content was achievable across all settings of practice. The aim of the curriculum is to avoid the siloization of the workforce and to create pharmacists across sectors with common clinical capabilities. We recognise that IP-related services in some community settings are not as available as in others. To help address this, we have allowed for the use of simulation to demonstrate the clinical skills if it is not possible to demonstrate them in an authentic workplace setting. The pandemic has highlighted the pivotal role community pharmacy has in delivering person centred care and we hope that developing a workforce who have enhanced clinical skills will be an enabler for expanding clinical services.
4	Suggest changing one of the scope of practice points from '*support new models of care which are delivered in primary care and closer to people's homes'* to *'support new integrated models of care, designed to deliver care closer to people's homes'*.	Agree with this suggestion, we will change

5	Suggest changing the statement 'the curriculum will develop early careers pharmacists who **can** work across a range of sectors/settings including new areas such as urgent care and care homes' to '**could** work across a range of sectors/settings…' - could be achieved following relevant supplementary training if being transferred from one sector/setting to another as each may have very different operational requirements.	We agree that additional training is usually required when any member of the pharmacy teams moves to a different area of practice and/or sector. The curriculum aims to develop the core capabilities required for patient care and service delivery across all sectors (at post-registration foundation level); we recognise induction training will be required when pharmacists move sector/setting. We will change the wording to "who have the core capabilities to work across".
6	Purpose statement is too detailed. A short summary aimed at staff who are not immersed in the programme would be helpful. There is repetition with the services and scope of practice.	We appreciate the purpose statement is detailed. We have structured the content around the RPS curriculum development guidance which ensures it is developed in line with the RPS curriculum quality framework. We think it is important to include the specific services that can be delivered so it is clear to the wider healthcare team.
7	Need to define the term 'research' to be clear what is expected.	We defined research in section 4.2 but realise it should be defined in the purpose statement, so the expectation is clear from the outset. We will move the definition to the purpose statement.
8	Recommend changing the term 'post-registration foundation' which is confusing with use of the term 'foundation' in the year 5 programme.	The term was discussed at the Post-registration Foundation Pharmacy Forum which included representation from key stakeholders including statutory education bodies, Pharmacy Schools Council and employers and was deemed to be the most appropriate terminology in the absence of any more appropriate suggestions.
9	Useful to have a statement to address the alignment of foundation and advanced practice curricula to enable development continuum across the training/career pathway and clarify if this supersedes the 2014 foundation framework.	We will include a simple visual which summarises the continuum across the different domains e.g. level of complexity, autonomy and boundaries
	Programme of learning	
10	The curriculum should include more emphasis on safety of medicines in pregnancy and breastfeeding	We understand the importance of the safety of medicine in pregnancy and breastfeeding but have not included an exhaustive list of conditions and presentations in the curriculum or topic guide. Pregnancy is included in one of the descriptors for outcome 2.1 and we will add breastfeeding.
11	The curriculum requires the individual to have developed capabilities across the range of domains and become all-rounders. It doesn't allow an individual's strengths to be fast tracked to the most suitable area of work e.g. research	The capabilities and outcomes reflect the evidence based role analysis for foundation pharmacists across the UK; it reports the clinical and non-clinical capabilities which are required to create a generalist pharmacist who is able to provide person centred care and deliver services. We recognise that some pharmacists may wish to take an alternative career pathway to pursue specific areas of practice.
12	Could include a little more detail and cross-relevance with other members of the MDT	We believe this adequately covered primarily by outcomes 1.7-1.10 and also in domains 2-4.

13	There are concerns amongst existing staff practising at a high level that they would not meet many of the curriculum outcomes for a variety of reasons around their practice models. The descriptors don't reflect the current level of post-registration foundation practice across all settings / sectors.	The outcomes have been informed by an evidence based role analysis and the descriptors were developed through a collaborative process which included representatives from all countries, all sectors and academia. The outcomes are at a higher level than those in the RPS Foundation Pharmacy Framework (2014) and the majority are aligned to the RPS Advanced Pharmacy Framework Stage 1 (2013). This reflects the requirement for post-registration foundation pharmacists with enhanced skills to meet service demand and improve patient care, and that the output from initial education and training is going to be at a higher level following implementation of the revised GPhC standards.
14	It would be worthwhile having a reminder at the top of each page that it is not mandatory to collect evidence for all of the descriptors – they are a guide as to how to demonstrate that the outcome has been met.	We will make it clearer that the descriptors are a guide and the individual is not required to evidence all of them.
15	Some descriptors are more challenging to meet in the different sectors and it would be helpful to have a guide for each sector of practice that suggests, in relevant and practical terms, what sort of evidence may be appropriate to demonstrate competence. This would be simple to produce if created in partnership with each sector and would go a long way to help pharmacists and employers alike understand the framework in the context of their operating environment.	In the topic guide we have included examples of the types of evidence learners could use for the curriculum outcomes that were highlighted as being potentially more challenging to achieve in some sectors. We have tried to make generic and / or include examples from different sectors. We will now look to develop the examples further by engaging with colleagues from different sectors and create more fulsome sector guides.
16	Learners may not have the opportunity to demonstrate all of the descriptors within their scope of practice. For example, the following descriptor will depend on role and opportunities: 1.6. Manages situations where care is needed out of hours and enables the necessary arrangements.	We have tried to ensure the descriptors are generic and relevant to all sectors, and reflect the core knowledge, skills and attributes required to deliver person centred care and other services. We don't expect evidence for all of the descriptors and we expect individuals will also include evidence for other activities that demonstrate the outcome and are relevant to their own practice. We will make the definition of 'out of hours' clearer.
17	Some of the outcomes and descriptors outlines may not be relevant in all pharmacists. Could some of the outcomes relating to clinical skills be revised or implemented in a staged approach to reflect current services?	The curriculum needs to define a consistent standard that describes post-registration foundation level practice across sectors; the curriculum task and finish group felt the outcomes are achievable in all sectors, albeit some may be more challenging in certain sectors. The revised GPhC IET standards require a higher level of clinical practice which is being phased into the MPharm and Foundation Year over the next few years. Any phasing within this curriculum risks it being at a lower level than what will be delivered in initial education and training in the coming years.
18	Some of the descriptors are too subjective including words like 'considers', 'uses' and 'identifies'. They should be more objective to ensure clarity in what is required.	We have used active verbs aligned to Bloom's taxonomy and will review to make sure they are as clear as possible.

19	Recognising limitations is not so clear.	We feel this is covered in outcome 2.12.
20	There is a greater degree of detail on outcomes relating to research. As it is currently presented, it seems that there is a heavy requirement for self-motivated research. For example, the research domain will potentially require the candidate to actively search out research opportunities. The need for robust practice-based research for pharmacists is something that needs to be nurtured in all areas of the profession.	We are building research capabilities in a spiral manner throughout our post-registration as there is a strong desire for pharmacy to be an active research profession. In a lot of situations, individuals will need to actively seek research opportunities which will encourage working with a wider range of people from both the pharmacy and wider multidisciplinary team. We encourage training programmes to help signpost individuals to research projects that they could get involved with. We anticipate that as more pharmacists undertake the RPS Advanced and Consultant pathways, there will be more opportunities to participate in pharmacy practice research.
21	How will the RPS review the curriculum to ensure the outcomes continue to meet the future needs as the service evolves, and keeps up to date with implementation of the revised IET standards	The RPS will review the programme of learning annually to ensure it is relevant, fit for purpose, and aligned to the evolving needs of patients and the service. This will be done by the Post-registration Foundation Pharmacist Assessment Panel (PFAP). The programme of assessment will be formally reviewed at the end of its first year by FPAP to assess its effectiveness in line with the RPS assessment principles and the RPS curriculum quality framework. As the initial education and training reforms are implemented, a task and finish group will be convened to ensure the clinical component of the curriculum evolves to support new prescribers develop their confidence, competence, and if required, extend their scope of practice
	Clinical assessment skills	
22	Including core clinical assessment skills training requires appropriate funding and time to acquire and develop the skills. The service, statutory education bodies and the learners themselves must decide together what is mandatory for them to be able deliver services.	We recognise the funding and resource required but we have had lots of positive feedback from employers and learners about including a core list to ensure consistency at this level of practice to support workforce portability and mutual recognition. We hope it will also be an enabler for commissioning services. Additional skills can also be included in local/regional training programmes to meet local service delivery requirements.
23	It is not clear where the core clinical assessment skills fit in addition to those taught and assessed on IP courses.	We have included further information about this in the APCL section of the curriculum. The individuals will be required to undertake DOPS for the clinical assessment skills in the core list that have not been assessed during the IP course.
24	The following should be added to the core list due to frequency of presentation in general practice settings and community pharmacy. • Chest examination	Chest examination and ENT will be added to the core list.

	• ENT • Paediatric gait arms legs spine • Body systems	
25	The following should be removed from the core list: • Capillary refill time in isolation from other cardiovascular examination	Capillary refill time will be removed from the core list
26	The list is very basic to meet the future direction of service and pharmacist prescriber-led care. Is this list intended for 2021/2022 cohorts, with the intention it will be reviewed?	This is the starting point for defining a core list of clinical assessment skills and it needs to support service delivery across most countries / sectors. We recognise some roles at this level of practice will required additional / more enhanced skills and this can be incorporated into training at a programme or individual pharmacist level as appropriate. The list of skills sits out with the curriculum document to enable it to be reviewed and updated iteratively to keep pace with service delivery.
27	We are unsure how individuals demonstrate the evidence for clinical assessment, in terms of progression of complexity (moving from simple assessment to more complex) and frequency of application (e.g. rarely applies clinical assessment, sometimes to always applies) In the acute setting other members of the team are usually better placed to make these assessments through appropriate skill mix and multidisciplinary teamwork	We have specified the requirement for three DOPS at 'meets expectations' to be undertaken longitudinally to provide evidence that the individual is able to perform the skill in different situations with a range of patients over a period of time. We recognise that, in some work settings, other members of the healthcare team may undertake the clinical assessment skills but upskilling our workforce will support transformation of services and help our pharmacists to be more confident to work in extended clinical roles.
28	There needs to be consistency in what core clinical assessment skills are appropriate for a non-medical prescriber. Would certain assessments be vital e.g. for some NMP courses, cardiovascular examinations, gastrointestinal and respiratory examinations have to be passed (full exams e.g. precordial exam for cardiology – not just BP and HR). If pharmacists qualifying as 'IP' cannot do these exams, would they be competent to prescribe?	The core clinical assessment skills describe the skills that are currently most commonly used in practice, to support the services which required pharmacist independent prescribers. As these services evolve, the list will be reviewed to keep pace with service demand. Pharmacists should undertake additional clinical assessment skills training as appropriate to their scope of practice.
	Supervision and support	
29	**Supervision roles and responsibilities** More clarity is required around: • the differences between each role and if three separate roles are required • if a learner can have multiple practice supervisors • how the educational supervisor, DPP and practice supervisor should work together to ensure consistent and appropriate assessment of outcomes.	The curriculum defines the roles and responsibilities of the different supervisors, but we will try to make this clearer. The educational supervisor role is more holistic and pastoral compared to the practice supervisor who provides day to day oversight of the individual in the workplace. The educational supervisor will be the constant throughout the training programme and will seek the input of others (e.g. practice supervisors) when required. We believe it is important to have three separate roles but acknowledge some of these roles may be undertaken by the same person. The DPP role is mandated because of the

	• how the supervision model will be achieved in all sectors • if supervisors can supervise multiple learners • if the educational supervisor and practice supervisor roles can be delivered remotely	independent prescribing regulations. The DPP is required during the period of learning in practice (PLP) and depending on the programme structure and how long the PLP spans, it would make sense to free up the DPP when we know there are concerns about DPP capacity. There is no limit on the number of practice supervisors an individual can have. We anticipate that individuals undertaking a training programme which includes placements or rotations may have a different practice supervisor for each one. The DPP and educational supervisor will assess the individual using SLEs but will also rely on feedback from multiple colleagues (including practice supervisors) to ensure a holistic approach to assessing the individual. We have tried to be as flexible as possible, recognising that in some work settings it will be more difficult to have the different supervision roles fulfilled by different people. We anticipate remote supervision using video technologies will help mitigate some of the challenges. Educational supervisors and practice supervisors may supervise multiple learners providing they have capacity to do so. We anticipate some training programmes may develop a peripatetic supervision model. Both roles can be delivered through a combination of remote and face to face supervision. There are a small number of outcomes where there is mandatory requirement for face to face observation but this is the only activity that can't be done remotely. We will review the wording in the curriculum to make sure this is clear.
30	**Supervisor training:** • What training/support will be provided to educational/practice supervisors? • DPPs don't tend to get supervision training so will be useful to have specific supervision training for them to build confidence and improve competence in supervision • Who is responsible for supervision training? • Requires funding	We anticipate training programmes will use the section of the curriculum which describes the roles and responsibilities of the different supervisors to inform supervisor training and / or adapt existing training. The GPhC IP standards state that course providers must provide training for DPPs and lists the content which must be covered in the training. This includes assessing performance, giving feedback, supporting IPs in training, and raising concerns. The RPS DPP framework can also be used to inform training. Supervisor training, recruitment and resource will be managed differently across different training programmes. Responsibility for the quality management of supervision including training is the role of the statutory education bodies, training

		provider and / or employers and should be formally agreed within the programme governance structure.
31	**Supervisor capability** Concern around examination, assessment and diagnostic skill training and whether suitable supervision can be given for these activities given the current competency of the pharmacy workforce and the busy environment they are to be delivered in.	We are aware that some individuals may not have access to healthcare professionals in their workplace who are competent at performing, providing training, and assessing the clinical assessment skills. In these cases, individuals will need to be supported to access learning opportunities in alternative settings. We recognise the process of upskilling our pharmacy workforce is going to be challenging but this will support the strategies which require pharmacists with enhanced clinical skills and these pharmacists will develop their competence and confidence to support others in the future. Simulation is acknowledged within the curriculum as an option for those who cannot access clinical skills training and assessment in the workplace, although experience with real life patients is strongly encouraged, where possible.
32	**Supervisor capacity** • Concerns that senior staff won't have the capacity to support post-registration foundation pharmacists in addition to the changes that are coming in the initial education and training programme and other post-registration pathways • Concerns about DPP capacity and infrastructure for supervision and assessment	We understand the demands on the workforce to support the education reforms and the post-registration development pathways; the RPS has strongly recommended the IET reforms are adequately resourced. We recognise the requirement for significant upskilling of the workforce over the next few years to be able to provide the volume of supervision and support required. Completing learning against this curriculum will help to equip post-registration foundation pharmacists with the skills to support the development of the cohorts that follow them. The education reforms and RPS post-registration curricula will help to enable service transformation and deliver improved patient care in more efficient and innovate ways. We understand that the statutory education bodies, HEIs and employers are considering how to address DPP capacity and develop the infrastructure to support early career pharmacists and the existing workforce undertake their IP training.
33	It would be helpful if there is a register of supervisors.	This is something that statutory education bodies, training provider and/or employers may wish to consider as part of their quality management process.
34	Need to include learning from patients and patient support groups, and from a diverse range of colleagues.	We agree and will include.
35	Considering the ongoing challenges with inclusion and diversity stating all supervisor roles should have an awareness of their	We will amend the wording to strengthen this.

	responsibilities for promoting equality and diversity should be strengthened to ensure awareness is acted upon	
36	May need a more formal relationship between DPP and educational supervisor rather than relying on the learner to be the link between these roles. Formal structure to allow communication between DPP and practice supervisor would be useful (especially for pharmacists who are struggling/need extra support).	We recommend training programmes provide guidance to individuals and supervisors about communication structures as these are likely to differ between training programmes. In the absence of more formal communication structures between ES/DPP, the learner may act as the go-between.
37	The list of 'learning' types is not captured in the document. Employer concern is how to support the delivery of these learning activities, especially those labelled 'learning with others' and what that might look like in practice?	We have not included learning preferences within this document and training programmes may wish to consider incorporating this into supervisor training. We have provided a guide to help individuals, statutory education bodies, training providers and employers consider the types of learning activities that support developing the requisite knowledge, skills and behaviours to achieve the curriculum outcomes. We recommend individuals set up peer networks to facilitate learning and utilising remote technology when working in more isolated environments. This is a requirement within IP courses and will also help with learning across all domains.
38	Community pharmacy sector may not be in a position to have a work-based supervisor alongside them and it would be clearer if this was stipulated more clearly in 4.3.3.	We will review section 4.3.3 to make it clearer that practice supervisors are not expected to work alongside the individual but are required to observe the individual (face to face or remotely) in their day to day practice to be able to provide feedback through SLEs.
39	Monthly meetings with educational supervisors may be necessary at start of the programme i.e. first 3-4 months but could then drop to every 6-8 weeks with the ability for the ES to contact the learner if any concerns are identified.	We have recommended scheduling monthly informal meetings to try to ensure that the individual has some quality time with a supervisor to focus on their development and progress. We think this is an important and valuable part of a structured training programme. However, this is not mandated as part of the curriculum and it is at the discretion of individual training programmes.
40	Need to be explicit that an educational supervisor is required even if individual is self-directed in working through this programme as realistically, without an ES, it will not lead to completion or submission of robust evidence for credential award.	We recognise the importance of an educational supervisor and strongly recommend that any individual undertaking this curriculum has access to high quality educational supervision. However, we recognise that some pharmacists may not have access to education supervision and do not want to exclude them from accessing the curriculum.
41	It is confusing to include DPP in relation to prescribing but exclude educational supervisor from prescribing when HEIs will	We will make it clearer in the curriculum that the educational supervisors may be involved in supporting the full programme and not just the non-prescribing part.

	likely allocate an educational supervisor for the duration of the prescribing course. Suggest having prescribing as a separate entity to reduce confusion since RPS will likely not have control over the delivery of the prescribing element.	Prescribing is integrated throughout the curriculum and there should be a holistic approach to developing prescribing skills regardless of the training programme model (integrated or modular). Prescribing training provision will largely be delivered by HEIs and in integrated programmes the summative assessment for all outcomes will be undertaken by a joint RPS/HEI assessment using the RPS assessment strategy.
42	There needs to be an overarching curriculum and assessment plan for work-based learning with timeframe that can be adapted for local centres, as it is difficult to envisage what this means in practice.	Training programmes may develop a timetable to support individuals and employers. It is not possible for the RPS to provide a timetable that would be meaningful because there will be significant variation in how training programmes are structured across different sectors and nations.
43	Pharmacists should receive cross-sector training to bolster their experience and learning. There appears to be nothing to provide assurance that this will happen.	We recognise the value cross sector training may bring in allowing learners the opportunities to demonstrate the curriculum outcomes. However, for as many people to be able to engage with this curriculum a possible, it was felt that manding a cross-sector training model would be challenging at this stage; the task and finish group felt that the curriculum outcomes could all be demonstrated fully from working in a single sector of practice.
44	There the practice supervisor role describes providing 'a safe and confidential environment for pharmacists to reflect on and discuss their work', Duty of Candour and duty to inform GPhC of patient safety concerns overrides this.	Outcome 2.9 includes 'upholds a duty of candour' and raising safety concerns applies to all pharmacy professionals as part of our professional standards. We don't think is specifically a role of the supervisor.
	Prescribing	
45	Concerns that pharmacists working at this level of practice are too inexperienced to be able to prescribe safely and competently.	We understand there is some anxiety about pharmacists at this level having enough experience to be prescribers. However, we need to keep pace with the educational reforms resulting from the increasing demand for pharmacists who can prescribe as part of integrated multi-professional teams. In a few years we are likely to see the first cohorts come through the revised GPhC standards for initial education and training (IET) and be prescribers at the point of registration. Post-registration foundation pharmacists who complete their IP training either as part of a modular or integrated training programme are still required to demonstrate they meet the GPhC standards for IP. We recommend that the prescribing related activities foundation pharmacists undertake as qualified prescribers are within a narrower scope of practice initially and that they have access to supervision, mentorship and support to help develop their confidence as new prescribers as they develop their scope.

46	A period of further supervised prescribing experience is essential for safe and competent practice, and should encompass placements in both secondary and primary care to enable pharmacists to obtain a sound clinical basis for their practice in the same way that doctors do.	In the curriculum we recommend that post-registration foundation pharmacists have access to appropriate supervision and support as new prescribers. We will strengthen this to include peer support and mentoring. We would actively encourage those undertaking the programme to gain as much cross-sector experience as possible. Indeed, doing so would create rich evidence of learning against the curriculum outcomes. However, we recognise this may not always be possible for some roles or some geographies and would not want this to limit their ability to credential at this level.
47	There is lack of IP opportunities in community pharmacy compared to other sectors	We have tried to develop a curriculum that can be delivered in a single sector of practice, including community pharmacy. However, we understand some of the outcomes will be more difficult to achieve in different work settings and where learning opportunities don't arise in the individual's workplace, we encourage employers to ensure they are given the opportunity to undertake learning in different settings.
48	We would appreciate a definition of what 'prescriber ready' means in the context of the RPS programme (the term is often used across systems, but not defined / benchmarked).	We have not included a definition of 'prescriber ready' as this curriculum will output qualified independent pharmacists.
49	The IP components will be superfluous for graduates from 2026/27 onwards.	We realise some of the clinical content of this curriculum, particularly relating to prescribing, will be phased into the initial education and training period over the next few years. The clinical part (largely domains 1 & 2) will be reviewed annually to make sure it supports new prescribers develop their confidence, competence, and if appropriate, extend their scope of practice. We have stated this in the curriculum.
	Assessment	
50	There is no mention of EPA assessment as part of the supervision role and they may not be necessary on top of the outcomes and descriptors.	We agree that the priority for the assessment programme is ensuring staff are sufficiently trained and supported to use SLEs. EPAs will be optional. We will remove EPAs from the main curriculum document and plan to undertake a pilot to evaluate if EPAs add value or improve confidence and / or competence compared to SLEs alone.
51	It is not clear if supervisors will apply a summative approach to SLE tools	SLEs are formative but include ratings to help the individual to prioritise their learning needs and provide an indication of the level the individual is performing at. While the SLEs tool are not summative, they will be reviewed as part of the PFCC process. We will make this clear in our supporting guidance.
52	The assessment programme will require quality assurance systems in place to ensure consistency across sectors/settings and significant training and support to ensure supervisors and collaborators are competent in their role	The RPS will provide guidance on the use of SLEs for learners and supervisors when we launch the curriculum. This will include worked examples of when the different tools can be used to evidence learning. We will also be providing supportive webinars about the use of SLEs tools to evidence learning. We anticipate the organisations

		with overall responsibility for training programmes will also develop guidance and training material on SLEs.
53	A very academic student may “pass “ more easily than a “hands on / practical” student.	The programmatic approach to assessment provides a more holistic view of the individual and their application of knowledge, skills, behaviours and attributes in real life authentic situations which is better for a hands-on and practical learner.
54	How to avoid the assessment process being too onerous or becoming a tick box exercise	Throughout the curriculum we have tried to make the process of learning as flexible and embedded into day to day practice as possible to mitigate assessment burden. It is important that learners and supervisors see the value in SLEs as a tool to improve performance, which will ultimately improve patient care. We need a collective effort to develop a culture of using assessment for learning.
55	The assessment process needs to be clearer for the integrated model. There should be joint responsibility with the learner and ES that they are ready to submit their portfolio.	We will make this clearer in the curriculum. Following discussion at our e-portfolio user group (UK wide stakeholder representation) it was agreed formal sign off for the outcomes will not be a requirement for submitting the portfolio for final assessment. We need to be inclusive to learners who don’t have an educational supervisor. The submission process will prompt the learner to consider if they have sufficient evidence to demonstrate the curriculum requirements and their submission is supported by their supervisor.
56	Is there an expectation for HEIs to run part of the assessment?	For modular training programmes, the HEI will undertake the assessment for the IP outcomes against their own assessment strategy. For integrated training programmes, HEIs will follow the assessment programme outlined in this curriculum. HEIs wishing to include additional assessments as part of their IP course (e.g. OSCEs, written case studies), are required to do this separately to the final joint RPS/HEI assessment. Any additional assessments must be concluded before the joint assessment.
57	It would be helpful for the curriculum to recognise more explicitly that some assessment types will be more difficult to achieve in certain settings, particularly community pharmacy, and may require backfill.	Throughout the curriculum we have tried to make the process of learning as flexible and embedded into day to day practice as possible to be achievable in any setting. We hope that remote technology can be used as much as possible to mitigate some of the challenges but we don’t understand it will be more challenging in community pharmacy and small workplace settings to be able to undertake face to face SLEs, particularly for pharmacists who work as lone practitioners. We encourage engaging members of the multidisciplinary team and are going to include an additional SLE tool (ACAT) which we hope will be more efficient in community pharmacy. We also recognise that resource is required to ensure all learners have access the learning and assessment opportunities.

58	Need to consider how skills such as emotional intelligence are taught and evaluated	We anticipate learner's will receive feedback on their emotional intelligence through the SLEs and will also self-reflect on it. The components of emotional intelligence are likely to be developed using various formats and introduced in different areas of the curriculum domains.
59	The assessment programme should include a minimum number of SLEs, including when direct observation is mandatory	We recognise that learners and supervisors prefer to be provided with a prescriptive number of pieces of evidence for each outcome. However, given the diversity of roles, learning experiences, and individual development within post-registration foundation it would be challenging to set a number that is meaningful to all. Setting a number also carries the risk that the assessments become a tick box. Instead, learners should be encouraged to include a range and breadth of evidence that is relevant to their role and learning needs. We have suggested a minimum of three pieces of evidence mapped to each outcome, with more pieces for the higher stakes outcomes. Where the assessment blueprint specifies 'direct observation' for outcomes, we would expect a range of direct observation evidence mapped to the outcome to assure competence.
60	Should include 360 feedback and patient testimonials (not just the patient survey)	We have included multi-source feedback as an assessment tool which is similar to 360 degree feedback. Learners will be able to upload anonymised patient testimonials to their e-portfolio and we have included that as an example of 'other evidence types' within the curriculum document.
61	Curriculum should state the minimum requirements for assessors to standardise practice.	We request that everyone completing a SLE as an assessor has read the RPS guidance so they understand their role. We accept that there will be some variability in judgments across workplaces as the judgments recorded on the SLE tools are subjective. In programmatic assessment programmes, however, subjective bias and inter-assessor variability is mitigated by the fact that each outcome is assessed using a breadth of different assessment tools; no individual decision is high-stakes and assessment data is aggregated and viewed holistically by the final competence committee.
62	Doing something three times doesn't necessarily mean you are competent - it is subjective and could vary between pharmacists.	We agree with this and recognise that evidence for the 'does' level in Miller's triangle requires the individual to demonstrate the outcomes repeatedly and reliably. It is not possible to provide a meaningful number for this and we encourage quality over quantity when it comes to evidence. We have included the requirement for three DOPS to encourage these to be undertaken longitudinally throughout training.

		We recommend a minimum of three pieces of evidence for each outcome and expect individuals and their educational supervisor / DPP to discuss where more evidence may be required to demonstrate achievement of the outcome.
63	Training will be required for staff on the use of different supervised learning event tools	The RPS will provide guidance for learners and supervisors / collaborators about SLE tools and will include general information and examples of when the different tools can be used to evidence learning. We will also provide supportive webinars about the use of SLE tools to enhance learning.
64	It would be helpful if the HEIs increased the use of SLEs to assess the IP course rather than the current case reports. This would support a consistent approach to training and supervision	HEIs who are delivering IP as part of an integrated programme will use SLEs in line with the RPS assessment programme. We hope that as SLEs become more widely used in practice by the profession, they will become more embedded in assessment strategies.
65	The costs to employers to undertake the SLEs cannot be underestimated and would welcome a funding model supported by national statutory education bodies that takes this revenue expenditure into consideration.	We will feed this back to the Statutory Education Bodies.
66	The SLEs should align with those used in other frameworks	The SLEs are drawn from validated tools used in other programmes and are consistent with those used in other RPS post-registration curricula. After the first year we will review the suite of SLE tools and consider if any others should be included
67	Some of the ambitions of engaging the wider health and social care team in SLEs may be possible in the medium to longer term but examples referring to care home managers and practice managers may not be so suggest removing to curriculum is inclusive to all pharmacists in all settings from the outset.	We have tried to make the assessment programme inclusive to all pharmacists by recognising that in some work settings, individuals will need to engage other members of the health and social care team to ensure their portfolio includes a range of assessors. We have provided examples to demonstrate how this could be achieved.
68	It is unrealistic to expect collaborators to provide detailed commentary in SLEs. In the main, theses should be short sharp encounters mostly carried out in the learner's workplace.	Through this curriculum, we are trying to make the process of evidencing learning as flexible and embedded into day-to-day practice as possible to mitigate overburden. We understand that the healthcare team is very busy and it takes time to undertake a SLE and document feedback. However, it is the quality feedback in the SLE that drives learning. We would expect the majority of SLEs to include narrative which can be aggregated to support the competency committee's final summative assessment of whether the outcomes have been met.
69	It is unclear if the DMP/DPP is required to review each piece of evidence or can they rely on the feedback from collaborators	The DMP/DPP will be directly observe the foundation pharmacist undertaking prescribing related activities but it will be common for other members of the healthcare team to carry out assessments and provide feedback. The DMP/DPP will review the learner's evidence from the period of learning in practice and use this information to inform their decision that the individual is competent to be an independent prescriber.

70	The DPP responsibilities seem overly complicated by the integrated model and it would be simpler to have one set of responsibilities	We recognise that the different models add complexity to the responsibilities of the DMP/DPP and this reflects assessment strategies will differ between the RPS and HEIs. We will try to simplify but need to ensure that the core clinical assessment skills are achieved regardless of the model.
71	The assessment process should be evaluated after a few years to mitigate any initial issues that pharmacists and their supervisors may come across.	The programme of assessment will be independently reviewed by an assessment expert after its first year to ensure it is valid and fit for purpose.
72	Not clear what other e-portfolio options there are if not using the RPS e-portfolio. Would an e-portfolio with differently formatted SLEs be accepted?	Statutory education bodies, training providers and/or employers may already have an existing online portfolio that can be used to record and compile evidence. Where this is the case, it is important the interfaces for the final portfolio assessment is as similar as possible to the RPS e-portfolio to ensure a consistent assessor experience. The SLE templates need to be consistent with the agreed format to ensure consistency with the assessment process. The SLEs templates were discussed through the e-portfolio user group and are aligned to those used in other RPS post-registration curricula.
	Stakes	
73	Outcome 1.7 should be 'high'. Teamworking and communication across the MDT is essential to positive patient outcomes	Agree – we have changed to high
	Outcome 3.7 should be 'high'. Staff wellbeing and support has been identified as a huge concern for the NHS workforce. To maintain a healthy and productive workforce which provides the highest standard of patient care, pharmacists must be equipped to look after their mental health and recognise when they are struggling.	We recognise the importance of wellbeing and the impact this could have on patient safety. However, this outcome also includes several descriptors relating to emotional intelligence and we have decided to maintain the medium stakes rating
	Outcome 3.8 should be 'high'. It is important the learner is able to recognise the limitations/boundaries in their actions and when to seek help	Agree – we have changed to high
	Outcome 5.1 should not be rated low as research is a vital part of learning and being able to apply evidence based clinical knowledge. Each pharmacist should be actively researching their field of practice.	We agree that research is important and the outcome is about participating in research. This outcome has less direct risk to patient safety and therefore the PFCC would expect to review fewer pieces of evidence than outcomes with a high risk to patients which require more data points to inform the final summative decision.

74	The stakes are based on patient safety risk, however, the labels (high, medium, low) intrinsically suggest they are not of equal importance. Do low and/or medium stakes outcomes need to be done at all?	The stakes ratings do not relate to the importance of the outcomes but the risk to patient safety. The role analysis which provided the evidence based for the outcomes, indicated all of the outcomes are important for post-registration foundation level practice. We will try to make this clearer
75	In community pharmacy outcomes 3.1, 3.2 and 3.3 would be considered at least "medium stakes" – the impact of promoting pharmacy services to the public has much wider benefits for the whole system, keeping people well as close to home as possible and freeing up capacity elsewhere. Generally, as a lone practitioner with leadership and management responsibilities, being able to achieve buy-in from your team is absolutely critical to success and to allowing the Pharmacist to focus on patient-facing activities. Similarly, understanding and balancing community and business needs enables a pharmacist to achieve efficiency and effectiveness in their service offering.	We recognise that some of the outcomes may be perceived as more important to pharmacists' roles in different sectors of practice but the stakes ratings refer to potential risk to patient safety.
76	Further clarity required on what "low stakes assessments can be aggregated to make high stakes decisions" looks like in practice	We will review the wording to make this clearer.
77	If the individual does not provide sufficient evidence of meeting high stakes ratings, does that deem them unfit to practice in the view of RPS?	The GPhC registration assessment and revalidation requirements ensure sure that all registrants have reached and continue to practise at the same minimum standard of ability required to practise as a pharmacist. The revalidation process helps demonstrate pharmacists keep their professional skills and knowledge up to date, reflect on how to improve, and how they provide safe and effective care. The level of performance required in the RPS post-registration foundation programme is higher than that required for registration. If an individual doesn't have sufficient evidence, it doesn't mean they are not fit to practise, it means they have not yet reached the enhanced level of post-registration performance articulated in the curriculum.
	Intermediate progress reviews	
78	How will the intermediate review meetings be documented and are they mandatory?	A template for the intermediate progress review has been developed through the e-portfolio user group which included representation from across the UK and all sectors. It will be available when the curriculum is launched. We strongly recommend intermediate progress reviews are included within training programmes but we cannot mandate them as some learners may not have access to an educational supervisor.

79	Should include discussion about whether there is any cause for concern/whether the pharmacist may need to delay completion in order to take time to learn other skills first.	These points are included in the intermediate progress review form.
80	It is not clear if intermediate progress reviews are mandated and who has overall responsibility for conducting the progress reviews. This brings potential for it not to be completed in a timely way/to a high standard.	We will make it clearer that intermediate progress reviews are strongly recommended within training programmes. We can't mandate as some individuals who don't have access to a formal training programme may create their own development pathway and generate a portfolio of evidence without the support of an educational supervisor. Responsibility will vary according to the training programme and may include the Educational Supervisor, the DMP/DPP, a member of the HEI team, or another role. We recommend training programmes include information about the process in their own programme guidance. We will make this clearer in the curriculum.
81	The reviews might be better carried out more frequently e.g. 3-4 monthly to pick up on any issues and make plans to resolve them in a more agile manner, and will prevent an excessive backlog of work should the learner find themselves in real difficulty.	The RPS recommends a minimum of six monthly and recognise that training programmes may decide to include more frequent reviews to meet their needs.
	Post-registration foundation competency committee (PFCC)	
82	PFCC requires validated as a process	The rationale for using decision making groups such as clinical competency committees in high-stakes assessment decisions is well documented in medical education literature with examples of learner performance being more accurately determined by group discussion than individual assessors. We have included additional references in the bibliography supporting their use.
83	Require clarification if some/all if the PFCC panel members need to have experience in the post-registration foundation pharmacist's sector of practice.	We don't think it is necessary for a panel member to have experience in the post-registration foundation pharmacist's sector of practice and the panel should include people with diverse opinions, skills and experiences to provide broad expertise. Diversity also helps to mitigate unconscious bias
84	Need clarification on how the consistency and diversity of PFCC's will be managed	All PFCC members will undergo mandatory virtual training prior to reviewing live portfolios. This includes attending a training session which covers mitigating bias and reviewing supplementary information. The RPS will actively promote recruitment to PFCCs to attract diverse panel members. The RPS will monitor EDI data of the PFCCs to monitor the diversity of those involved in the assessment pool.
85	It is not clear if the PFCC will be assessing the supervisors' ability to complete SLE feedback rather than the pharmacists' ability to perform at the correct level. Will candidates include evidence that does not demonstrate they are performing at the	The PFCC members will individually undertake a holistic review of the individual's e-portfolio and while this will include SLE feedback, it will also include other content including, but not limited to, patient surveys, multi-source feedback, other evidence formats, the learner's own reflections and review of action plans. Evidence is likely to show progress towards the outcomes throughout the programme and won't all be at

	correct level? More clarity required on how the PFCC will make its final judgement	the required level. The final decision will be made during the PFCC group discussion. We will make this clearer in the curriculum and further detail will be included in the candidate guidance.
86	The PFCC should be introduced in a gradual process	It is not possible to gradually introduce the PFCC to the programme of assessment. There needs to be a consistent approach to summative sign off from the outset but the RPS will ensure the process is clear for candidates and that PFCC receive sufficient training to support the process.
87	Require more detail about the PFCC including the process (local/regional/national), training requirements, frequency, if it is based on the e-portfolio, the timescale/requirements for resubmitting, and if educational supervisors from the individual's training provider or employer will be required.	We will include more information about the PFCC process and the resubmission process in our candidate guidance. PFCCs will be coordinated centrally by the RPS but the assessors will be recruited from across the UK. For integrated programmes, at least one member from the learner's HEI is required to be on the PFCC. We anticipate there will initially be three windows to submit portfolios for the first cohorts completing the programme and we will review the frequency and adjust accordingly. Prior to assessing a portfolio, PFCC members will need to declare any conflicts of interest in line with the RPS conflict of interest policy. Educational supervisor assessors should not be connected to the candidate. There will be no timescale for resubmission and the learner would be expected to reflect on the feedback provided by the PFCC and include additional evidence to ensure their portfolio demonstrates achievement of the curriculum outcomes.
88	Does the RPS have capacity to manage this model?	The RPS will administer the recruitment of pharmacist assessors from across the UK to participate as PFCC panel members. The pharmacists will be reimbursed for their time and we think this is a good opportunity to get involved in a national assessment process. The model replicates that use in national assessments ran by professional leadership bodies and Royal Colleges where the profession supports the assessment.
89	Need clarity if the RPS credential attracts any credits, apart from IP.	HEI delivered content may be credit bearing but the RPS credential does not attract any credits.
	Accreditation of prior certified learning (APCL)	
90	It is not clear if the RPS will accept APCL for the full curriculum if the learner has completed a HEI postgraduate qualification which fully maps to the RPS curriculum.	The maximum APCL accepted will be considered and determined by the RPS Education Standards Committee and we will update accordingly.
91	More detail is required about: • the APCL process • eligibility criteria • who can undertake the mapping (i.e. can the HEI do it) • who will be an RPS APCL assessor and how they will be accredited for this role?	We will include this detail in separate APCL guidance.

	quality assurance of PFCC panel decisions to ensure consistency	
92	• It should be clearer what the APCL process is for HEI-awarded IP and if HEI courses will be mapped against the RPS standardised curriculum, to help improve the consistency in the delivery and awarding of IP across the UK.	Individuals who have completed a GPhC accredited IP course will be exempt from the 'IP outcomes' in the RPS curriculum as these map to both the GPhC and RPS prescribing frameworks. We will include more information about the process for APCL relating to IP courses in our APCL guidance
93	It needs to be clear if pharmacists who have completed a PGDip in Clinical Pharmacy and undertaken a standalone IP course will be eligible to start the advanced credentialing pathway	The post-registration foundation curriculum helps ensure pharmacists have developed the appropriate skillset to progress to the advanced practice credentialing pathway. We would expect an individual who has completed a PGDip in Clinical Pharmacy and IP course which cover the breadth and depth of the RPS post-registration foundation curriculum will have developed the skill set to start advanced. The RPS post-registration foundation credential is not a prerequisite for starting advanced credentialing but has been designed to prepare pharmacists optimally to begin advanced credentialing.
94	It would be helpful for the RPS to compile and publish information regarding what is considered relevant and acceptable for APCL. This will bring efficiencies and avoid applications that are unlikely to be successful.	We agree this will be helpful and will include some guidance and populate with examples when we start to receive APCL applications.
95	It is not clear what the incentive for an individual who has completed a Diploma and a standalone IP course to apply for APCL and be credentialed by the RPS	The RPS credential is recognised across the UK and provides assurance that the individual has met the level articulated across all of the curriculum domains and the core clinical assessment skills. Although we would welcome a UK approach, the devolved nations / employers may take different approaches about linking the credential to career progression.
96	More clarity it required about the timing of the APCL. It is usually granted prospectively at the start of a period of study so that it is clear what is required and what is not. Having it at the end is too late if pharmacists need to change what they have done and risks them not meeting the standards or unnecessary duplication. If done prospectively, there is a risk the learner won't consolidate undergraduate learning to provide a suitable base for developing prescribing skills if they believe that it is not required other than as part of the prescribing course.	We recognise the issues around the timing of the APCL but anticipate not many newly qualified pharmacists will have undertaken formal training at the point of starting their programme. APCL can be applied for at any point during the programme and we will make it clear in our APCL guidance HEIs can apply for APCL for various parts of their programme. We anticipate the majority of APCL applications will be for standalone IP courses within modular programmes.
97	The models need to be interchangeable so that career path can be changed easily.	An individual could change from a modular to integrated programme (and vice versa) but this may have in impact on the funding associated with the training programme and may result in the learner having to generate additional evidence due to different assessment strategies.

	Training models	
98	The integrated model requires more information including what it will mean for HEIs, how IP will be integrated throughout,	We will prepare a separate guidance document for integrated courses.
99	The training models should be able to evolve to accommodate any new innovative models	The modular and integrated training models are only required until the education reforms are fully implemented and new registrants are qualified IPs. The models provide flexibility to accommodate different routes to achieving the IP qualification. The RPS welcome any innovative models that evolve during the transition phase, providing they are able to meet the curriculum requirements.
100	In modular programmes it is important prescribing-related activities and clinical development are included in year 1 so that the holistic approach is not lost	We agree and would encourage modular training programmes to incorporate some prescribing related learning and development before the formal IP course starts.
101	The different models won't be consistent and although the modular approach may be easier to manage, the integrated model provides a more holistic approach for the individual with clinical development throughout	The curriculum was designed for the IP and non-IP elements to be integrated throughout, but we recognise including IP within post-registration foundation has a limited lifespan and there may be a preference to continue with established standalone IP courses.
102	Need more information on what being a training provider entails to understand the implication of developing a programme or using a HEI to deliver elements.	Training providers are organisations which deliver training aligned to the curriculum outcomes. This could be for certain domains/outcomes or to meet the full curriculum. They may also provide supervision. As a minimum, each programme needs to include an HEI as the training provider for the IP part.
103	There is lack of equity of sectors for several aspects of the curriculum including supervision, support, services, access to learning opportunities, access to the patient health record, access to IP funding, research opportunities. Particular concerns noted for community pharmacy	We recognise the curriculum will be more challenging to achieve in certain work settings / sectors and will produce a separate document which includes some contextualised examples for how to demonstrate the outcomes in the different sectors. Through our task and finish groups we have tried to ensure the curriculum content can be achieved as flexibly as possible. We have not been too prescriptive about how support mechanisms and SLEs should be undertaken and hope that remote technology can support these. We are promoting the sharing of creative and innovative ways to deliver the curriculum through our post-registration foundation forum to help ensure some of the concerns can be mitigated. The RPS and other pharmacy organisations continue to campaign for read-write access for community pharmacists. We encourage post-registration foundation pharmacists to undertake a broad range of learning opportunities to develop their capabilities and some of this will involve spending time in other care settings where the pharmacist can view the patient health record as part of their learning.

	Inclusivity and flexibility	
104	Considering a significant number of pharmacists from BAME working in community pharmacy, the curriculum set up is likely to structurally embed this inequality and therefore cannot be regarded as inclusive.	The curriculum is achievable across all sectors but we recognise some parts will be more challenging to achieve in certain sectors. We hope the flexibility in the curriculum design helps mitigate some of this.
105	There is little flexibility to change jobs while in training	We anticipate training programmes will develop pathways to accommodate changes in employment. We have had feedback from some employers that the training programme will help stabilise the workforce at this level of practice and support retention. The RPS e-portfolio will allow evidence to be drawn from across different roles if the individual moves employer.
106	The curriculum applies to sectors such as hospital and community but not so much industry, research or academia.	We recognise that the curriculum is for those who work in more patient-focussed roles. The first phase of our assessment and credentialing strategy focussed on these roles as they represent the majority of the workforce and have the highest risk profile to patients. When the patient-focussed curricula are established, we will explore the potential and viability of credentialing for other roles. The RPS faculty is still available to recognise advancing practice for all pharmacist roles, including those in industry, academia and research.
107	Want to see new standards that support the development and careers of existing registrants as well as new pharmacists, to protect patient safety and improve reputation of the healthcare profession.	While this curriculum is primarily aimed at pharmacists in the early stages of their career, we expect some of the existing workforce may wish to use it to support development in areas where they have identified gaps, particularly those who wish to progress to the advanced credentialing pathway
108	Excludes foreign workers	As this is a structured work based training programme incorporating IP as a regulated component, individuals will need to practise in the UK
109	Pharmacists depending on their circumstance such as age, pregnancy, family, part-time, caring responsibilities or those who have had a career break/change, may be disadvantaged or taking longer to qualify. Any support mechanisms? Pharmacists working in the evenings or weekends will also be negatively impacted as there will be reduced availability of supervisors to undertake SLEs. Consider flexible time span and good support especially for those on maternity/paternity leave, who work part-time, have disability etc. Currency/validity of previously collected evidence will need to be considered to avoid discrimination.	We have stated in the curriculum that there is no time limit and recognise that some individuals will take longer to complete due to their circumstances. We recommend training programmes develop learning pathways to accommodate and ensure sufficient support structures are in place. We have tried to ensure the curriculum content can be achieved as flexibly as possible and have considered some of these points during the design. We ran an equality impact assessment workshop and many of these points were discussed. The equality impact assessment report can be accessed on our webpage.

	Formal education and learning or with documenting/writing papers for assessment may impact those with mental health conditions.	
110	Need to consider a process for people to be able to share/report concerns of bias or negative impact e.g. there has been examples in the past from attainment gaps with minority groups - how will these be considered or mitigated against?	The RPS will monitor for differential attainment in our assessment programme and publish equality data related to assessment performance. The Post-registration Foundation Assessment Panel (PFAP) and our Education & Standards committee are charged with monitoring differential attainment across RPS assessments. The final assessment process will include a number of measures to mitigate bias and discrimination against learners with protected characteristics. It will be necessary to share the name of the individual with the competency committee members to identify any potential conflicts of interest. No other personal information will be shared, including the individual's ethnicity. We recommend training programmes consider the Equality Impact Assessment report and their quality management structures include a process to raise and manage concerns of bias or negative impact throughout the duration of training.
111	Early career pharmacists are usually within fixed term contracts - will assessment deadlines be timely and fall in line with GPhC registration and termination of contracts?	The RPS will have 3-4 assessment windows annually to provide flexibility for training programmes and individuals. We will review the frequency of assessment windows annually.
112	Specialist service such as preparative services, clinical trials and QA should not be excluded from the programme as they are patient-focussed and excluding them may send the wrong message that will detract from the pharmacy profession being able to deliver a range of services.	The curriculum does not include explicit reference to specialist services which may be more common in certain sectors; the curriculum has to be achievable in all sectors. We believe the learning experiences and evidence developed from placements or rotations in specialist service areas can be used for several of the curriculum outcomes. Risk management, quality improvement, and governance activities are peppered throughout. Individual training programmes may include specific specialist services content, but this will sit out with the RPS programme of assessment.
113	Costs associated with e-portfolios and end point assessments are not outlined but to facilitate engagement, it is recommended no charge.	An assessment fee is required to cover the costs of providing the e-portfolio solution as well as for reimbursing Post-registration Foundation Competency Committee members.
114	It would be helpful if this resource provides practical, real-world examples of the types of evidence for each sector of practice.	We will develop the examples further

	Topic guide	
115	How will the topic guide be reviewed?	The topic guide will be reviewed annually by a reference group which comprises statutory education bodies, HEIs, training providers, employers and learners.
116	How is the evidence for the content of the topic guide assessed? Are there pieces of work aligned to the content?	For some of the outcomes and descriptors, it was felt that additional knowledge and skills may be required. Apart from the list of core clinical assessment skills, there are no specific evidence requirements aligned to the content. We anticipate training programmes and individuals will use to inform learning resources and/or self-direct learning.
117	Kolb's model of reflection is generally considered too superficial to be consistent with master's level reflection, which demands more criticality and synthesis. Since many pharmacists are not adept at reflection, Gibbs' or Johns' model would be more appropriate to support ongoing development	Our reflective account template is based on the Gibbs' Reflective Cycle and we will review the topic guide to ensure aligned.
	Other	
118	Concern how the programme aligns with other frameworks. This includes the joint vision outlined by the four Chief Pharmaceutical Officers, which called for a standardised continuum for post registration pharmacists education, to be overseen by GPhC and PSNI.	We understand the GPhC are currently exploring post-registration education and training. The RPS post-registration credentialing model supports a structured professional development pathway. The core domain structure is aligned to advanced multi-professional frameworks.
119	Supervised post-registration foundation training should be mandatory and full funded to provide the necessary level of training and support.	We agree that training programmes should be adequately resourced to ensure there is the required training, supervision and support, and that this should be equitable across sectors.
120	More detail on how RPS will work uniformly across the nations which may take a different direction and support in helping the community pharmacy sector/setting influence policy change that would allow for enhanced skills achieved through this curriculum to be equitably used across all pharmacy settings and sectors. It is important the effort to increase confidence and competence of pharmacists are aligned with opportunities to use skills within the community sector.	The RPS works closely with stakeholders from all countries and promotes sharing of best practice for post-registration foundation training. Scotland and Wales have community pharmacy services which require enhanced clinical skills and we hope these will evolve in England soon. Through its policy work, the RPS is campaigning for commissioners to develop pharmacist independent prescriber services.
121	There is no clear confirmation from GPhC to remove the 2-year experience requirement. It needs to be clear that this programme is not a route to accelerate eligibility to complete a prescribing course.	We are in dialogue with the GPhC about removal of the two year entry requirement, which will also be required for new registrants to be able to complete the requirements in this curriculum.

Specific outcomes

	Outcome	Feedback	Response
1.1	Communicates effectively with people receiving care and colleagues	Descriptor lacks detail about communication with colleagues (focusses on people receiving care)	We have been generic in the descriptors by referring to 'recipient', 'person', 'people' to make them relevant to people receiving care and colleagues
1.5	Always keeps the person at the centre of their approach to care	Determines capacity in people with differential communication needs and manages appropriately in situations when the person doesn't have capacity • Recommend that the wording of the above descriptor is reviewed as it may be interpreted that the foundation pharmacist is determining a person's mental capacity; which would not be within the expectations of their role. • Descriptor lacks detail on how to manage treatment decisions in those lacking capacity	We have reviewed the wording
1.6	Supports and facilitates the seamless continuity of care for each person	Manages situations where care is needed out of hours and enables the necessary arrangements – not sure this can be met in all sectors.	We have reviewed to make it clear that is also applies to when the GP practice is closed
1.9	Recognises the value of members of the pharmacy and multidisciplinary team across the whole care pathway, drawing on those both present and virtually, to develop breadth of skills and support own practice; delegates and refers appropriately, using the expertise and knowledge of others	Descriptor appears to place greater emphasis on the value of the members of the MDT rather than the pharmacy team	We have reviewed the wording
2.1	Applies evidence based clinical knowledge and up to date guidance to make suitable recommendations or take appropriate actions with confidence	• artificial intelligence, advanced therapeutic medicinal products" – this seems out of place in the context of this section. Perhaps either contextualise, remove or expand. • We agree with the specifying of genomic medicine, but the other points feel out of context / ambiguous. Suggest genomics as its own line.	These are included following recommendations in the Topol report and build on the revised IET standards. We grouped together under the umbrella of innovative technologies.

2.2	Undertakes a holistic clinical review of a person and their medicines to ensure they are appropriate	Descriptor could also take into account other inequalities such as geographic or socioeconomic. Describes drug history taking but would also need to include medicine reconciliation in relation to transfer of care (also in section 2.5 transfer of info about meds)	We have included additional text about health inequalities We have included
2.5	Manages uncertainty and risk appropriately	"Considers off label use" - Is this acceptable in community pharmacy? Does it need to be clarified in the context of prescribed medicines only? We read this in a variety of ways – considering the implications of this point, we recommend rephrasing to avoid ambiguity / misinterpretation.	Community pharmacists will need to make decisions about supplying off-label medicines which are prescribed and OTC. Examples include medicines for children and topical preparations that may be used out with their licence.
2.6	Takes the cost-effectiveness of a decision into account where necessary, working to the appropriate formulary	Applies decisions about medicines to delivery of locally commissioned services" – we did not understand this term. Recommend rephrasing to avoid misinterpretation.	We have removed this descriptor
2.7	Proactively recognises and corrects the overuse of medicines; positively impacts on the usage and stewardship of medicines at an individual and population level	Could also include something related to health inequalities here (clear link back to purpose statement, if included in purpose section) • Incorporates the population based impacts of antimicrobial resistance *and other communicable diseases* on decisions about prescribing antimicrobials; ensures treatment and *prevention measure* decisions are aligned to relevant local and national guidance. * note: prevention measure will include e.g. vaccination but also prophylactic antibiotics • Complies with, and promotes local and national medicines management policies, guidelines, strategies, and campaigns to positively impact on medicine use (e.g. unlicensed medicines, high risk medicines, public*/population* health, antimicrobial stewardship, infection control, shared-care, prescribing efficiency projects)	 We have changed We have changed
2.12	Recognises and works safely within own level of competence, understanding the importance of	• Could also add in assessment of risk here against professional limitations and link to safety netting.	We have added safety netting to the descriptors for outcome 2.5

	working within this; knows when it is appropriate to escalate a situation or refer	• Descriptor could include knowledge of when and how to use local escalation policies	We have included
3.1	Proactively demonstrates and promotes the value of pharmacy to the public and other healthcare professionals	Implements appropriate strategies in relation to the misuse of drugs This statement looks incomplete. Reduce misuse of drugs?	We have changed
3.6	Effectively identifies and raises concerns regarding patient safety; applies principles of risk management; seeks to improve the quality and safe use of medicines routinely	• would suggest addition of self-audit, related to professional and prescribing practices • Applies infection prevention, control measures and management measures in populations, environments and people • Need to be clear if contributing to QI projects or undertaking	Agree, we have added We have edited the wording We have made clearer
3.7	Demonstrates self-awareness and emotional intelligence within the role, reflects on and understands the impact a situation may have on one's own health and wellbeing	Descriptor could include an assurance that support would be accessed if own behaviours were at risk of impacting delivery of care	We have added
3.9	Effectively, efficiently and safely manages multiple priorities; maintains accuracy when in a challenging situation; manages own time and workload calmly, demonstrating resilience	Descriptors should include a line related to effective delegation.	Descriptor incudes effective delegation skills already
4.1	Demonstrates a positive attitude to self-development throughout current and towards future career; proactively seeks learning experiences to support own practice, and has a desire and motivation to try new things	Suggest including wording related to maintaining portfolio of evidence	We discussed this in our curriculum workstream and felt as this wasn't necessary to be included as a descriptor.
4.2	Develops a personal development plan that reflects the breadth of ongoing professional development and includes potential innovations in medicine and practice development	Specifies a development plan to maintain prescribing competence, would it not be a plan to maintain competence in all areas of practice?	Yes, we agree and have amended. Prescribing was specifically included to meet the outcomes in the GPhC and RPS prescribing frameworks.
4.3	Seeks feedback and support from colleagues where appropriate; is receptive to information or advice given to them by others to make changes to own practice	• outcome should include feedback from service users also (referenced in descriptor, but not in outcome) • suggest adding, "actively seeks opportunity for workplace assessment, using SLE tools and/or other evidence-based tools appropriate to the activity/task undertaken"	Agree, we have changed We feel this is covered by the first descriptor and the individual will need to actively seek SLEs to meet the curriculum requirements.

4.4	Acts as a positive role model and mentor within the pharmacy and multidisciplinary team, where appropriate	• could include more in the descriptor related to mentoring, as mentioned in outcome • "Contributes to creating an environment that promotes good physical and mental health and supports people with mental health problems" doesn't seem to reflect the outcome. • Descriptor describes supporting mental health problems of those in the MDT and pharmacy team. Would this not be more of a signposting/pastoral role as would not be trained to manage mental health problems of colleagues?	We have included mentor We feel that recognising the importance of this is good role modelling behaviour Yes, we have changed.